California Social Work Education Center

C A L S W E C

The Relationship Between Reunification Services, Service Utilization, and Successful Reunification:

An Empirically Based Curriculum

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2009

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ABSTRACT

In recent decades, state and federal child welfare legislation has shifted from emphasizing family preservation to emphasizing children's need for timely permanence. However, the responsibility of child welfare agencies to provide reunification services remains. Implicit in this responsibility is the assumption that such services are effective. This assumption gains even more importance since passage of the Adoption and Safe Families Act of 1997, which requires shorter timelines for reunification and focuses on quickly moving children to adoptive homes when reunification fails to occur in a timely fashion.

Research on reunification services is quite limited. Little is known about what factors are associated with parents' engagement with reunification services, and how that participation influences the likelihood of reunification. Regarding service effectiveness, some research has found specific service approaches to be associated with improved outcomes, but few of these studies focus on the child welfare population, and fewer still consider the effects of services on reunification.

Given the shorter timeframes and serious consequences of failing to reunify quickly, there is a need for studies that can shed light on factors associated with parents' use of services, as well as the effectiveness of those services in facilitating successful reunification. This quantitative study examined these issues via two different datasets. The curriculum is based on the study findings and on a review of relevant research, and uses interactive presentations and various activities to review the history

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of reunification services, how services are ordered for and used by parents, and how service use influences reunification outcomes.

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CALSWEC PREFACE

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

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

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

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

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

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ABOUT THE AUTHORS

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ACKNOWLEDGEMENTS

This study was conducted in partnership with the Santa Clara County Department of Family and Children's Services. Many staff members there played important roles in facilitating the completion of the study. Managers allowed the researchers' attendance at their regular meetings, and shared their expertise and ideas related to the study content. Reunification services managers, as well as Mike Clark, Senior Lead Deputy County Counsel, provided expert consultation in regards to the categories and types of services provided. Elizabeth Lipira and her staff at the Retention Center graciously accommodated our data collection at that location, and assisted in the identification and location of missing closed files. Open case files were obtained with the assistance of Bea Leall and her administrative staff, along with the active services social worker on the case. Greg Wilson provided consultation and expertise in providing the population files from which the samples were drawn. Lori Medina and, in particular, Randy Parker facilitated our work at all levels within the county, and were instrumental in the study's successful conduct and completion. Randy also provided valuable feedback and commentary at various points throughout the study. The study would not have been possible without the support of Will Lightbourne, Director of Santa Clara County Social Services Agency, and Norma Doctor Sparks, Director of the Department of Family and Children's Services.

In addition, four San José State School of Social Work Master's students—Melinda Davis, Jennifer Landivar, David Siddall, and Melanie Valdez—made important

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contributions as research assistants on the project. Thanks also to Heather LeGrand for assistance with conducting and interpreting the multivariate analysis.

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INTRODUCTION

RATIONALE FOR THE CURRICULUM MODULE

The provision of reunification services is one of the fundamental responsibilities of the child welfare system. Federal policy requires that state agencies make "reasonable efforts" to assist parents to address the problems that required the removal of their children; historically, these efforts have included either providing or paying for services to treat those problems. Social workers are responsible for outlining case plans that detail the set of services and activities that will address the problems of these parents. Yet social workers have little to go on in terms of an evidence base to guide them; little is known about what services are effective with what sorts of problems and/or what sorts of parents, what influences parents' engagement in services, or how service use influences reunification.

This curriculum offers an empirically based instruction tool on family reunification services for child welfare social workers or other related practitioners: the historical groundings and legal frameworks; the types of services that are offered to parents; factors associated with parents' use of services; and information on the effectiveness of services. The curriculum blends a literature review of current knowledge with a study on family reunification services, with the intent to provide contextual information to aid social workers in the development of appropriate and responsible case plans for parents receiving reunification services in the child welfare system.

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BACKGROUND AND LITERATURE REVIEW

A review of the historical context of child welfare in the U.S. suggests that efforts to reunify children with their birth parents after an incident of substantiated child maltreatment have been fairly limited. Formalized federal funding for family reunification services did not begin until the 1974 CAPTA, and mandates to make reasonable efforts to reunify children with their parents did not begin until the 1980 AACWA. Historically and currently, there has been a lack of consistency in the emphasis on and funding for services that focus on reunification vs. child safety vs. expedited alternative permanent placements. With the implementation of ASFA, the emphasis appears to be moving toward expedited permanency and adoption, rather than the provision of comprehensive services to improve parents' abilities to provide a healthy family setting for their child. In addition, wide variations in how ASFA is implemented exist, and there are few efforts to track these variations and their impact on family reunification.

Research on the assessment and service-planning process in child welfare is limited. Child welfare literature describes a number of issues related to risk assessment, including studies evaluating the use of structured decision-making tools in order to make a determination of a child's risk of imminent harm and the likelihood of future incidents of child maltreatment. Much less is known about how child welfare workers conduct assessments of family needs and strengths once child maltreatment is substantiated and the child is removed from the parent's care. A growing awareness exists that accurate assessment and case planning among families receiving reunification services involve substantial complexity due to the wide range of co-

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occurring problems among families (Marsh, Ryan, Choi, & Testa, 2006; Schene, 2005). A review of the first round of Child and Family Service Reviews found that at least 30 states reported problems in conducting assessments of children and families, and that service plans are often a “one size fits all” or a “boiler plate” model in which most families are ordered to participate in the same menu of services, regardless of their individual needs or strengths (Child Welfare Information Gateway, 2006). Individual characteristics of families and the circumstances surrounding entry into the system (type of maltreatment, child age, race/ethnicity, family structure) also need to be considered in the assessment process. Ultimately a thorough assessment process is intended to lead to the creation of an integrated service plan, ongoing case management, and regular re-assessments of progress (Marsh et al.).

Although there are clearly a number of complexities involved in assessment and case planning, there is evidence indicating that when family reunification services are appropriately matched with a family’s needs, there is a greater likelihood of family reunification (Choi & Ryan, 2007; Smith & Marsh, 2002).

There is a lack of information on service utilization patterns among parents in the child welfare system. Available information tends to categorize service use as either the parent completed services or not; information on service intensity, duration, and effect on outcomes is not known. It is generally thought that greater levels of participation in services results in greater exposure to the intervention, thereby increasing the likelihood of positive changes (Little, Alexander, & Reynolds, 2001). However, circumstances surrounding service delivery for families involved in the child welfare system, namely the

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court-ordered removal of their child(ren) and the mandated nature of the service plan, creates unique challenges to engaging clients. As a result “compliant” behavior may not always represent true engagement in services (Jellineck et al., 1992; Yatchmenoff, 2005). In addition, the involuntary nature of the services and the often adversarial characteristics of child welfare investigations and court proceedings can make engaging parents in services extremely difficult (Chapman, Gibbons, Barth, & McCrae, 2003). Moreover, the shortened timelines for provision of family reunification services associated with ASFA also create challenges to engagement in and use of services. Parents with children under 3 years of age are typically allowed just 6 months of services, and over age 3, 12 months of services. Given the complexity of family issues at entry into the child welfare system, this may simply not be enough time to assess parents, engage them in services, and monitor utilization and outcomes.

Research on the effectiveness of family reunification is limited. Studies conducted in the 1990s largely focused on “family preservation” services designed to provide intensive services to prevent out-of-home placement and found limited evidence of the effectiveness of these services in preventing out-of-home placements (Westat, 2002). Information on the degree to which these services contributed to family reunification was not reported. Despite the lack of information on the link between services and reunification and re-entry outcomes, there is some evidence linking specific services to reunification outcomes. More commonly the research presented in this review links specific services to improvements in functioning among parents and children, which, by extension, may be linked to an improved ability of parents to reunify

with their children. However, it should be noted that research that specifically measures family reunification and re-entry outcomes is slim.

Research on the impact of concrete assistance on the likelihood of reunification suggests that the provision and use of housing assistance may increase family reunification rates. One study examining outcomes of Illinois' Title IV-E alcohol and other drug abuse demonstration project found that parents receiving matched housing assistance (e.g., the housing assistance that is matched with their need for this service) were more likely to experience family reunification than parents not receiving matched housing assistance, suggesting that concrete assistance in obtaining housing may influence reunification (Choi & Ryan, 2007).

Although parent training programs are a mainstay of most mandated family reunification service plans, there is limited research on the effectiveness of these services in improving parenting and contributing to family reunification. Nevertheless, compliance with and completion of parenting education services is typically a requirement for return of the child to the birth parent. In a recent review of the evidence base for parent training programs within child welfare settings, Barth et al. (2005) identified parent training programs with research evidence indicating their effectiveness, and additional information on parent training programs was also gathered from the CBEC website (although no studies have linked these programs to family reunification). Programs identified in these reviews as well-supported by the research evidence include The Incredible Years, Multi-systemic Therapy, Oregon's Social Learning

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Center's Parent Management Training, Parent-Child Interaction Therapy, and Triple-P Positive Parenting Program.

A recent structured review of the effectiveness of substance abuse interventions for mothers involved in the child welfare system found very few studies that focused specifically on child welfare populations; however, a number of interventions that are relevant to child welfare settings were identified (Osterling & Austin, 2008). Overall, six program components for which there is some research evidence to support their effectiveness with substance-abusing women (who may or may not be involved in the child welfare system) were identified, including: a) woman-centered treatment involving children, which includes gender-specific services that involve children in treatment; b) substance abuse services that integrate health and mental health treatment; c) home visitation programs that incorporate substance abuse treatment; d) concrete support and assistance, such as transportation and child care; e) short-term and targeted interventions such as psychoeducational groups or contingency management programs; and f) comprehensive programs that incorporate all of these program components (Osterling & Austin). In addition, the California Evidence-Based Clearinghouse (CEBC) for Child Welfare has identified a number of substance abuse treatment services that have relevance to child welfare populations and some research to support their overall effectiveness, although research testing the effectiveness of these services on family reunification outcomes has not been conducted. The intervention identified by the CEBC as well-supported by the research evidence in Motivational Interviewing, involves

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clinical strategies to increase parents' motivation to enter treatment and stop using drugs or alcohol.

Despite a lack of research on the effectiveness of specific substance abuse service components on family reunification outcomes, there is evidence indicating that participation in and completion of substance abuse treatment services is a critical factor in family reunification outcomes. One study of substance-abusing parents in Cook County Illinois who had at least one child in out-of-home placement found that approximately 50% of parents completed substance abuse treatment and that treatment completion (defined as completing the last treatment episode self-reported sobriety for 3 months) was associated with an increased likelihood of reunification after controlling for the influence of other factors (Smith, 2003). Another study, using longitudinal methods and state-level data in Oregon found that mothers who experienced a quick entry into substance abuse treatment (average time to treatment was 147 days), lengthier stays in treatment (average length of treatment was 238 days) and treatment completion had a higher likelihood of family reunification, and their children had shorter stays in out-of-home care (Green, Rockhill, & Furrer, 2007). Quick entry into treatment was also associated with longer stays in treatment and an increased likelihood of treatment completion. The authors suggest that given the seriousness of the circumstances surrounding the removal of a child, the motivation for change among mothers during the initial stages of the case may be very high, and that immediate access to treatment may capitalize on this motivation, creating a foundation for engagement in services and positive treatment outcomes (Green et al.).

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There is limited information on the role of domestic violence interventions for batters and for victims of domestic violence in contributing to family reunification outcomes. The CEBC has identified domestic violence interventions for batterers that are supported by the research literature and/or relevant to child welfare populations, however there are no studies testing these interventions specifically within child welfare populations. None of these were considered "well-supported" by the research evidence.

Given the shortened timelines associated with ASFA, the effectiveness of family reunification services is critically important. Parents typically have 12-18 months to successfully participate in and complete the services listed in their case plan, and if their child is 3 or younger, 6 months of services are offered. If services are not effective in addressing the problems that brought the family to the attention of the child welfare system, then even if a parent is completely compliant with all services and the child is reunified with the parent, there is still a risk of future maltreatment and child welfare system involvement. Research has found that compliance with services is related to family reunification, but information on the effectiveness of services is lacking. There is also a lack of information that considers the impact of various patterns of service utilization on family reunification (e.g., considering multiple services at the same time—which is a better way to understand service effectiveness for reunification since parents are ordered to participate in multiple services). Moreover, we know little about interactions between services used and parental characteristics, such as age and race/ethnicity.

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CURRICULUM OVERVIEW

This curriculum provides training on family reunification (FR) services in the child welfare system. Information includes historical, policy/legal, and practice perspectives. A combination of empirical knowledge is presented from literature review findings and results from a current study on reunification services. Specifically, four topics are addressed:

- the history of reunification practice, and current federal and state legal frameworks;
- the types of reunification services offered to parents;
- factors associated with client utilization of reunification services; and
- information on the effectiveness of reunification services;

followed by an integrative summary exercise.

OBJECTIVES

The curriculum objectives for each section are described below.

Section I: History of Reunification Practice in Child Welfare, & Current Legal Frameworks

By the end of this section, participants will:

- Understand the historical context of reunification practice;
- Recognize the following acronyms and know their main intent: CAPTA, AACWA, and ASFA;
- Understand the tension between concerns for child safety, family reunification, and permanency planning;
- Be familiar with California's current child welfare legal framework, including time limits and reunification exceptions.

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Section II: Types of Reunification Services

By the end of this section, participants will:

- Understand the role of assessment and components of case planning,
- Be familiar with types of recommended reunification services; and
- Recognize the strengths and challenges of collaborative services.

Section III: Client Utilization of Reunification Services

By the end of this section, participants will:

- Be aware of factors that can affect reunification service utilization; and
- Recognize organizational factors that impact service delivery and use.

Section IV: Effectiveness of Reunification Services

By the end of this section, participants will:

- Understand the general state of research on the effectiveness of reunification services in the areas of: concrete assistance, parent training, substance abuse, domestic violence, mental health, and family team meetings;
- Appreciate the imperative nature of service effectiveness in the context of ASFA and reunification timeframes; and
- Be aware of the importance of assessing a parent's capacities and resources as well as their need for treatment in the development of case plans.

Section V: Summary and Conclusions

By the end of this section, participants will:

- Understand the current state of reunification services in relation to its historical context,
- Be familiar with current California mandates regarding reunification,
- Hold empirically-based knowledge relating to improving reunification service utilization and effectiveness, and
- Understand that this is an evolving body of knowledge and commit to staying abreast of evidence-based information in the service of best practice.

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INTENDED AUDIENCE

The primary audiences for this curriculum are Title IV-E MSW students and entry-level child welfare professionals. Social workers and students who regularly interface with the child welfare system may also benefit from this curriculum, such as those concentrating in school social work, children's mental health, and children and families. Although curriculum sections may be used with non-child welfare or non-social work students, instructors may need to cover essential background information related to child welfare service delivery.

ORGANIZATION OF CURRICULUM

The curriculum is divided into five class sections, which build upon one another. However, it is possible for instructors to use each of the first four sections independently or in combination. For this reason, each section re-lists the objectives that are itemized in the introduction above. The fifth session represents an integration of the previous four, thus is not recommended as a stand-alone module. Each written section in this curriculum guide includes a research review of the content area and if applicable, a discussion of empirical findings and implications from the current reunification utilization study. In addition, a PowerPoint (PPT) slide presentation with coordinated activities/handouts accompanies each section. Most material described in the written guide is not replicated in the slides due to the extensive nature, but is offered as background information for the instructor. The slides focus on highlights and activities to engage students. Handouts often accompany the PPT presentation, generally for two reasons: a) to structure a student activity, or b) to cover a large amount of important

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information that is ineffective to present in PPT format. An informal, generic feedback sheet is also provided in the handouts section for instructors who would like an evaluation form.

Section I: History of Reunification Practice in Child Welfare, and Current Legal Frameworks lays the groundwork for learning about FR services. The PPT slides address historical and legal highlights. Two handouts accompany this module: a *True/False Handout* that addresses general content (an instructor's version of the handout is included in the text) and a *California Bypass Criteria Handout* that lists the state's exclusion criteria.

Section II: Types of Reunification Services describes various FR services. The lesson includes a *Service Description Handout* (in which students search for the one incorrect statement in a set of descriptive statements of services), a *California Case Plan Contents for Child Receiving FR Services Handout* (which students can have as a handy resource), a *Flow Chart Handout* (showing the process from report to the ordering of services), and an optional *Case Summary Activity* (in which students are asked to find at least one strength and one weakness in the assessment process and case plan.)

Section III: Client Utilization of Reunification Services has a briefer PPT, because some of the didactic material focuses on two diagrams that are best for visual and verbal learners to have directly on hand. Each handout is tied to an activity, to engage the students in learning the model more completely. The *Treatment Participation Model Handout* provides a framework for client service utilization (an

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instructor's version is provided in the text), and the *Organizational Construct Model Handout* alerts students to the influence of structural factors on service outcomes.

Section IV: Effectiveness of Reunification Services discusses research on the effectiveness of FR services and introduces students to the California Evidence-Based Clearinghouse for Child Welfare. Since the module is largely organized around service types, a class activity provides the opportunity for students to briefly read about one program and present the highlights to the class. Findings from the current study are then discussed.

Section V: Summary Exercise assumes a different format and provides a *Jeopardy Game* around which to build the class (PPT format). This activity integrates material from all previous sessions.

The **Handout** section includes copies of the handouts.

Time Estimates and Tips for Training

Estimated time requirements for completing the sections are as follows:

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Section	Description	≈ Time
Section I: History & Legal Framework for FR Services	Content: History of Reunification Practice in Child Welfare & Current Legal Frameworks Activity: PowerPoint Slides Activity: California Bypass Criteria Handout Activity: True/False Handout Activity: Feedback Sheet (optional)	1 hour
Section II: Types of FR Services	Content: Types of Reunification Services Activity: PowerPoint Slides Activity: Service Description Handout Activity: California Case Plan Contents for Child Receiving FR Activity: Case Summary Handout Activity: Feedback Sheet (optional)	1 hour
Section III: Client Use of FR Services	Content: Client Utilization of Reunification Services Activity: PowerPoint Slides Activity: Treatment Participation Model Handout Activity: Organizational Constructs & Service Effectiveness Handout Activity: Feedback Sheet (optional)	1 hour
Section IV: Effectiveness of FR Services	Content: Effectiveness of Reunification Services Activity: PowerPoint Slides Activity: FR Service Program Examples Activity: Feedback Sheet (optional)	1 hour
Section V: Summary & Conclusions	Content: Summary and Conclusions Activity: FR Jeopardy Activity: Feedback Sheet (optional)	1 hour

Suggested tools and materials are listed for each section. Generally, these include access to PowerPoint Presentation (PPT) equipment and copies of handouts for paper and pencil activities. If PPT is not available, instructors are encouraged to copy the slides, using the six slide per page format, to help with class facilitation and

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effectiveness for visual learners. Typically, handouts for PPT slides are appreciated by students, but may be a distraction if handed out before the presentation. Instructors are encouraged to use their judgment and experience with the particular audience on this issue—for student engagement, it may be more effective to wait and hand out copies of slides after the PPT presentation is completed. Access to a whiteboard, blackboard, or flipchart may be helpful to record student responses to brainstorms or discussions. Instructors are encouraged to solicit student participation, even for volunteers to write on the board or pass out handouts. Student ownership of training typically increases attentiveness and learning.

MSW and BSW IV-E Competencies are likewise listed in each section, rather than duplicated here. Including the competency in the section list does not mean that the skill should be mastered by the end of the particular training, but instead that relevant issues are addressed in the content.

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SECTION I

HISTORY OF REUNIFICATION PRACTICE IN CHILD WELFARE AND CURRENT LEGAL FRAMEWORKS

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SECTION I
HISTORY OF REUNIFICATION PRACTICE IN CHILD WELFARE AND CURRENT LEGAL FRAMEWORKS

INSTRUCTIONAL GUIDE

Learning Objectives

This section provides an overview of the history of child welfare family reunification practice, beginning with the Children's Aid Society of the mid-1800s and ending with relevant current federal and state legislation. A review of research related to family reunification is integrated into the discussion of current frameworks.

By the end of this section, participants will:

- Understand the historical context of reunification practice;
- Recognize the following acronyms and know their main intent: CAPTA, AACWA, and ASFA;
- Understand the tension between concerns for child safety, family reunification, and permanency planning;
- Be familiar with California's current child welfare legal framework, including time limits and reunification exceptions.

Public Child Welfare Competencies (MSW)

3.17 Student understands the value base of the profession and its ethical standards and principles, and practices accordingly.

3.18 Student understands the dual responsibility of the child welfare social worker to protect children and to provide services that support families as caregivers.

3.19 Student understands state and federal policy issues and child welfare legal requirements and demonstrates the capacity to fulfill these requirements in practice.

3.20 Student understands child welfare legal process and the roles of social workers and other professionals in relation to the courts.

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Public Child Welfare Competencies (BSW)

2.5 Student demonstrates an understanding of the dual responsibility of the child welfare case worker to protect children and to provide appropriate services to enable families to care for their children, including pre-placement preventive services.

2.8 Student demonstrates a beginning understanding of legal process and the role of social workers and other professionals in relation to the courts, including policy issues and legal requirements affecting child welfare practice.

2.11 Student demonstrates awareness of the principles of concurrent and permanency planning with regard to younger children as well as planning for older children about to terminate from the child welfare system.

2.13 Student shows understanding of the value base of the profession and its ethical standards and principles, and practices accordingly.

Agenda and Suggestions for Instructors

- Time allocation: Approximately 1 hour
- Follow the PPT slides; particular slides solicit input from participants
- Final slide prompts the use of *True/False Handout*
- Wrap-up Discussion and Introduction that if following the curriculum, next topic will be on types of reunification services.
- Request completion of generic feedback form, if desired.

Materials Needed

- PowerPoint Slides for Section I and necessary projection equipment
- Blackboard, dry erase board, or flip chart tablet is recommended if the instructor prefers to write down ideas solicited from participants (along with appropriate writing tools)
- *True/False Handout* (one for each participant)
- Copies of PPT slides are recommended to be given out after the lecture
- Copies of feedback form, if desired

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SECTION I: HISTORY OF REUNIFICATION PRACTICE IN CHILD WELFARE AND CURRENT LEGAL FRAMEWORKS

HISTORY OF REUNIFICATION SERVICES IN THE U.S.

Nationally, in 2006, 49% of all children in the child welfare system living in out-of-home placements had a case goal of reunification with parent or principal caretaker, and 53% of all children exiting care were reunified (U.S. Department of Health and Human Services [USDHHS], 2008). Although family reunification is currently the case goal for a large proportion of families involved with the child welfare system, the history of reunification services in the U.S. suggests that efforts to reunify children with parents are a relatively new phenomenon. Major child welfare policies have fluctuated greatly from practices that stress child removal to maintain safety, to an emphasis on "reasonable efforts" to reunify families, to a focus on expedited case processes to ensure permanency for children. Understanding the historical foundations of reunification efforts and the ways in which these efforts have fluctuated according to child welfare policy frames the context of family reunification service delivery and utilization, as well as their impact on reunification and child welfare system re-entry.

Recognizing child maltreatment as a social problem deserving society's intervention began in the late 18th and 19th centuries (Downs, Moore, & McFadden, 2009). In 1848, the first organization dedicated to serving neglected, abandoned, or orphaned children, the New York Children's Aid Society (CAS), was founded. CAS initially offered training, support, and shelter to children and runaways. In 1853, the organization began placing children who were believed to be orphans, homeless,

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abandoned, or neglected with families living in rural areas. These first foster homes intended to protect children from urban problems and to remove “dangerous classes” from the city in an effort to maintain social control and social order (Reich, 2005, p. 30). Primary targets were orphans; however, among children with a living parent, parental consent was required for placement—although the degree to which consent procedures were followed, and the extent to which parents were adequately informed about the experiences of their children are a matter of debate (Reich). Between 1854 and 1930, approximately 150,000 children were placed in foster homes by the CAS, using what is popularly referred to as the “Orphan Trains.”

Family reunification was not the intent of these arrangements, and no efforts were made to reunify children with birth parents. While limited information is available about these placements, associated problems included the fact that most of the children were Catholic immigrants being placed with Protestant rural farmers and a general lack of oversight regarding foster home quality (Reich, 2005).

Despite the difficulties connected with the first foster care arrangements, the work of CAS and other late 18th and 19th century child-saving organizations did represent a movement toward using family and home settings as out-of-home placements, rather than orphanages and institutions. In 1909, a White House Conference on the Care of Dependent Children was held and brought widespread attention to the needs of dependent children. This conference provided a forum through which professionals articulated the growing belief that families and family settings are critical to the health and well-being of children and that children should remain with their

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birth parents in a home setting “except for urgent and compelling reasons” (Reich, 2005, p. 34), in which case they should be placed with another family. Moreover, conference participants publicly declared that poverty per se did not represent child maltreatment, and was not a reason, in and of itself, to remove a child from a parent’s care. These sentiments contributed to the creation of state-sponsored cash assistance programs that were intended for widows who did not have a means of supporting themselves and their children; unmarried mothers were largely excluded from access to this financial support. In addition, the 1909 conference led to the establishment of the U.S. Children’s Bureau, which was charged with studying child welfare, family settings, and child protection (Downs et al., 2009).

In 1935, Title IV-E of the Social Security Act created the first federally sponsored cash assistance program (again targeted to widows with children), as well as the first federally sponsored child welfare services in the form of small grants to states to provide services to dependent children—most of which funded foster care placements. Although the preference was for children to remain in their homes, government child welfare services in the 1930s-1950s did not provide direct services to improve parenting and the home setting. Instead, scholars note that welfare in the form of cash assistance to single mothers and child welfare services developed together as social welfare policies (Reich, 2005). Single mothers who applied for cash assistance were subject to home visits by social workers who determined home suitability and whether cash assistance should be provided. Women with out-of-wedlock births often had cash assistance revoked or denied, and their children removed under the belief that their

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homes were unsuitable for raising children (Frame, 1999, as cited in Reich, 2005). As such, although the prevailing ideology of the time viewed the family home as the optimal environment for children, reunification services aimed at improving parents' abilities to provide a "suitable" family setting for children were not offered.

Interest in the causes, effects, and prevention of child maltreatment grew in the 1960s, and 1970s, possibly stemming from advances in technology, such as the use of X-rays which could detect physical injuries in children. A series of medical reports describing a "battered child syndrome" brought public attention to the identification and effects of physical child abuse and prompted legislation mandating that professionals working with children (i.e., doctors, teachers, or other professionals) report suspected abuse (Reich, 2005). By 1968, mandated child maltreatment reporting laws existed in every state.

In 1974, the *Child Abuse Prevention and Treatment Act* (CAPTA) defined and expanded child maltreatment definitions, including emotional neglect, physical abuse, and sexual exploitation, and also expanded definitions of professional mandated reporters. This legislation also created the National Center for Child Abuse and Neglect (later re-named the Office of Child Abuse and Neglect). CAPTA has been amended several times, most recently with the *2003 Keeping Children and Families Safe Act*. The original legislation provided state grants for expanded child welfare services, which focused on: a) organizational needs, such as training, and development of triage procedures related improve child welfare investigations, and b) development of community-based efforts to prevent and treat child maltreatment. Notably, *CAPTA*

represents the first major federal legislation that provided concrete mechanisms through which states could implement family reunification services (Cornell University Law School, 2008).

Despite the creation of formal federal funding mechanisms for the prevention and treatment services stipulated within *CAPTA*, the number of children in the child welfare system continued to grow after passage of the legislation (Reich, 2005). The fact that many children in the child welfare system were spending unnecessarily long periods of time in out-of-home care with no permanency plans for reunification or adoption prompted the passage of the *Adoption Assistance and Child Welfare Act (AACWA) of 1980* (Knitzer, Allen, & McGowan, 1978; Pecora, Whittaker, & Maluccio, 1992). *AACWA* represents the first legislation to mandate that states receiving federal foster care matching funds make "reasonable efforts" to prevent children from being removed from their homes and to reunify children with their birth parents as soon as possible. The legislation was partly enacted to counter policies that allowed states to be reimbursed for foster care costs—but not for preventative or support services to keep children in their homes—a situation that appeared to reinforce child removal. *AACWA* also expanded funding for prevention and support services and promoted efforts toward adoption for children who were not reunified. Furthermore, AACWA mandated that all children in out-of-home care have a guiding case plan and that a permanency placement plan must be established within 18 months of a child first entering out-of-home care (Child Welfare Information Gateway, 2008).

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AACWA's goals of child maltreatment prevention, timely reunification and permanency were not met. In the years following legislation enactment, reports to the child welfare system, the number of children in the system, and the typical length of stay in the system all increased (National Commission on Children, 1991). Part of the legislation's failure may be related to the reality that although policies included prevention services, federal funds were still heavily concentrated on foster care and adoption. For instance, between 1984 and 1988, adoption assistance funding increased from $5 million to $108 million without equal increases for prevention (Pelton, 1989). The *Child Abuse Prevention, Adoption, and Family Services Act of 1988* established a number of state grants to expand adoption services through increased efforts to identify adoptive families, provide post-adoption services for families adopting a special needs child, and increase placements for foster children who are legally free for adoption (Child Welfare Information Gateway, 2008).

CURRENT FEDERAL POLICIES REGARDING REUNIFICATION PRACTICES

As foster care populations continued to increase during the 1980s and 1990s, policy makers and the public grew more concerned with the phenomenon of foster care drift, or the extended period of time that children spent in the system without achieving a permanent placement (Humphrey, Turnbull, & Turnbull, 2006). The *Adoption and Safe Families Act (ASFA) of 1997* reflected a reaction, in part, to foster care drift concerns. ASFA represents the current legal framework under which states and counties implement family reunification services. This legislation continued federal mandates to make reasonable efforts to reunify children, and also introduced new mandates that

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states make reasonable efforts to ensure an alternative permanent placement should reunification efforts be unsuccessful. The new ASFA guidelines were primarily aimed at meeting the needs of children who were deemed unlikely to reunify with their parents (D'Andrade & Berrick, 2006). These guidelines included the use of: *shortened timelines* for reunification services; *bypass criteria* that represent conditions under which states do not need to make reasonable efforts for reunification; *the option of concurrent planning*, the process of creating two case plans (one for reunification and one for an alternative permanent placement); *incentives for states to encourage adoption*; the creation of a national monitoring system for child welfare outcomes (the *Child and Family Review Service Review);* and defined *time-limited family reunification services* within re-authorization family preservation funds. Policy changes mandated by ASFA have potential impacts on the delivery and effectiveness of family reunification services.

ASFA contained a number of legislative components. *Shortened timelines* for decisions about permanent placements and the provision of reunification services represented an important policy shift. ASFA mandates that: a) permanency hearings be initiated within 12 months of a child entering out-of-home care; and b) termination of parental rights hearings be initiated whenever a child has been in out-of-home care for the last 15 out of 22 months (except when the child qualifies for an exemption when this is not in the best interests of the child or when the child is placed with extended family). The 12-month time limit for initiation of permanency hearings can be extended to 18 months at the recommendation of the child welfare worker so that parents can complete

the services on their case plan. These timelines dictate that reunification services for the parent must be delivered, and be effective, within a relatively short period of time.

ASFA also clarified the meaning of “reasonable efforts” by stating that a child’s health and safety should be the primary concern in all determinations of reasonable efforts, and identified specific conditions under which states are not required to provide reunification services and can bypass a case directly to permanency planning phases. When a family entering the child welfare system is determined to have one of these *reunification exceptions (or bypass criteria)* states were given the option of not providing services and moving a child directly into permanency planning services. These provisions intended to reduce time spent in out-of-home care by moving quickly toward an alternative permanent placement once it is established that a bypass criterion is present. ASFA specifies five circumstances under which reunification services can be bypassed, including when a parent has: a) committed murder of another child of the parent; b) committed voluntary manslaughter of another child of the parent; c) aided, abetted, attempted, conspired, or solicited to commit such murder or manslaughter; d) committed felony assault resulting in serious bodily injury to the child or another child of the parent; or e) had parental rights to a sibling of the subject child involuntarily terminated. ASFA also permits states to develop their own bypass criteria based on “aggravated circumstances” but suggests abandonment, torture, chronic abuse, and sexual abuse of the child (ASFA, 1997). Most states have formalized these reunification exceptions into their legal codes (NCSL, 1999, as cited in D’Andrade & Berrick, 2006).

In addition to clarifying reasonable efforts to reunify, ASFA mandated that states make reasonable efforts to ensure a permanent placement for children and stated that reasonable efforts toward family reunification could take place at the same time as reasonable efforts toward an alternative permanent placement. As a result, in addition to reunification exceptions, ASFA encouraged permanency by allowing states the option of using *concurrent planning* practices which call for the creation of dual service plans for a child: a plan for reunification and a plan for an alternative permanent placement, should reunification fail. These practices aim at reducing children's time spent in out-of-home care by starting efforts toward permanency from the beginning of the case. To identify families unlikely to reunify, a number of poor prognosis indicators have been used in child welfare practice, including such conditions as parental substance abuse, prior failures to reunify, or severe parental mental illness (Katz, 1999, as cited in D'Andrade & Berrick, 2006). Despite application of these indicators in child welfare practice, empirical evidence suggesting these are reliable predictors of a parent who is not capable of improving is extremely limited (D'Andrade & Berrick).

Other components of ASFA included a*doption incentives* that provided financial compensation for every child in a state in out-of-home care who is adopted, when the overall rate of adoption from foster care is higher than the previous year. Additional funds for post-adoption services and technical assistance to facilitate adoption processes were included in this provision. ASFA also legislated the creation of a national child welfare outcome monitoring system to define and measure key outcomes related to child safety, permanency, and well-being and rate each state's performance

on these outcomes. The *Child and Family Service Review* process was created to address these mandates.

Further, ASFA re-authorized and expanded family preservation and support services and provided a definition of "time-limited family reunification services." It identified the following services that could be provided to a family during the first 15 months a child is in out-of-home care: a) individual, group, and family counseling, b) inpatient, residential or outpatient substance abuse treatment services, c) mental health services, d) assistance to address domestic violence, e) services designed to provide temporary child care and therapeutic services for families, including crisis nurseries, and f) transportation to or from any of the services and activities described above.

CURRENT CALIFORNIA POLICIES REGARDING REUNIFICATION PRACTICES

California's state policies regarding reunification practices are related to the ways in which ASFA is interpreted and implemented. California child welfare statutes extend restrictions on time limits for family reunification by mandating that parents of children 3 years of age or older have 12 months of reunification services and parents of children under 3 years of age are allowed 6 months of reunification services (with extensions given on a case-by-case basis) before a permanency hearing is held. In addition, California extended the number of reunification exceptions used in the state to 15. In California, any one of the following bypass criteria can be used to deny reunification services:

1. Parents whereabouts unknown;
2. Mental disability rendering parent incapable of making use of services;

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3. Child or sibling removed from parent due to physical or sexual abuse and returned again, and now being removed again for physical or sexual abuse;
4. Parent caused another child's death through abuse or neglect;
5. Child made a dependent due to 300 (e) [under five and suffered severe physical abuse];
6. Child or sibling suffered severe sexual or physical abuse;
7. Child conceived by rape (applies only to the perpetrator);
8. Child has been willfully abandoned and endangered;
9. Sibling did not receive reunification services due to #3, #5, or #6;
10. Termination of parent rights ordered for sibling or half-sibling, and parent has not made reasonable efforts to treat problems;
11. Reunification services have been terminated for sibling or half-sibling because parent failed to reunify, and parent has not made reasonable efforts to treat problems;
12. Parent convicted of a violent felony;
13. Extensive, abusive, chronic history of substance use, and has resisted treatment within last 3 years, or failed case plan compliance for substance abuse treatment twice;
14. Parent has advised court wants no services nor to have child returned; or
15. Parent willfully abducted child, sibling or half-sibling and refuses to disclose whereabouts or return child.

RESEARCH REVIEW ON IMPLEMENTATION OF FEDERAL AND STATE POLICIES

The ways in which child welfare systems and the workers within these systems come to interpret and implement federal and state policies impacts a variety of factors surrounding family reunification, including family assessment, service delivery, service utilization, and ultimately, service effectiveness. For instance, in a review of two components of ASFA, that is, the use of bypass criteria and concurrent planning, D'Andrade and Berrick (2006) discuss variations in how these policies are implemented into practice and the potential implications of these variations for child welfare

outcomes. With respect to bypass criteria, ASFA allowed states to develop their own reunification exceptions based on “aggravated circumstances” suggested by the legislation, as well as other criteria developed by the state. As a result, in addition to the five reunification exceptions detailed in ASFA, states have developed an average of 5.66 additional bypass criteria for a total of approximately 10.5 criteria within each state (D’Andrade & Berrick).

The likelihood of achieving family reunification may vary as a result of differences in the ways in which states have operationalized and implemented reunification exceptions. Although some bypass criteria represent situations that appear fairly straightforward (e.g., murder of sibling or another child), others are far more subjectively determined (e.g., “severe” physical or sexual abuse, or chronic parental substance abuse), and there is little empirical evidence that many of these circumstances are not amenable to services (D’Andrade & Berrick, 2006). For instance, with respect to substance abuse, chronicity and relapse are increasingly recognized as part of the recovery process in substance abuse disorders; thus the presence of these indicators may represent a need for more intensive services and closer monitoring and support, rather than denial of services or incapacity to improve.

The presence of a bypass criterion is first determined by the child welfare worker who assesses a family when a child enters out-of-home placement and is ultimately decided upon by the dependency court judge overseeing the case. As a result, the ways in which ASFA bypass criteria are implemented will not only vary by the state statutes that define these criteria, but also by the ways in which individual agencies and workers

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assess families, agency resources, and the characteristics of the families entering the child welfare system within any given community (D'Andrade & Berrick, 2006). For instance, the use of bypass criteria in counties in California has been found to range from 1.5% of cases to 36.9% (Berrick, Choi, D'Andrade, & Frame, 2008). By extension, the delivery, utilization and impact of family reunification services may be more a result of the particular characteristics of an agency and community (which affect how policies are translated into practice), rather than the effectiveness of services per se (D'Andrade & Berrick).

Research describing the perspectives of professionals responsible for implementing ASFA describes mixed opinions about its use and effectiveness. One qualitative study of judges, social workers, foster care providers, parents, and youth in the Kansas system found that while some study participants viewed shortened timelines as positive, because they increased likelihood of a permanent placement, most described time limits as harmful because they did not allow parents to fully address all the long-standing issues that led to the removal of their child(ren) (Humphrey et al., 2006). Mixed feelings were also discussed regarding the push toward permanency and termination of parental rights. Many participants discussed frustrations that parental rights may be terminated when it is not in the best interests of the child, while others stressed that parental rights are terminated usually only when an alternative permanent placement is available for the child,and that permanency is in the best interests of the child (Humphrey et al.).

In addition, national survey findings from child welfare agencies on the impact of ASFA on child welfare service delivery describes the impact of the legislation on child welfare practice, as well as variations in policy implementation (Mitchell et al., 2005). Findings suggest that 60% of child welfare agencies reported a greater emphasis on child safety as a result of ASFA (as compared to an emphasis on family preservation). Shortened time lines and an emphasis on adoption, especially for older children and those in kinship care, were also described as major changes pre- and post-ASFA implementation. Although agencies reported no differences in the number of children being served by the child welfare system pre- and post-ASFA, approximately 60% reported increases in the amount of time workers spent on cases and the amount of regulations to be followed and paperwork to be completed; these changes were attributed to implementation of ASFA. The survey also suggested that ASFA may be implemented differently in state-administered child welfare systems, as compared to those that are county-administered. For instance, state-administered child welfare agencies reported the use of reunification exceptions at a higher rate (53%) than county-administered agencies (7%; Mitchell et al.). State-administered agencies also had significantly higher adoption placement rates than county-administered agencies. In addition, increased emphasis on adoption for children living in kin placements was reported more often in non-urban counties (84%) as compared to urban counties (37%).

As a result of variations in the way ASFA is perceived and implemented, it is difficult to understand its overall impact on family reunification or re-entry into the child welfare system. One Oregon study found that post-ASFA mothers began substance

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abuse services more quickly and had longer treatment duration than mothers in the child welfare system before the legislation; however, no differences were found in treatment completion before and after ASFA implementation. Child welfare outcomes indicated that after ASFA, children spent less time in out-of-home care, achieved permanency more quickly, and had higher rates of adoption; however reunification rates pre- and post-AFSA did not significantly differ (Green et al., 2006; Rockhill, Green, & Furrer, 2007). These findings suggest that ASFA may increase adoption and alternative permanent placements, with little effect on family reunification.

IMPLICATIONS OF RESEARCH REVIEW FOR CHILD WELFARE PRACTICE

A review of the historical context of child welfare in the U.S. suggests that efforts to reunify children with their birth parents after an incident of substantiated child maltreatment have been fairly limited. Formalized federal funding for family reunification services did not begin until the 1974 CAPTA, and mandates to make reasonable efforts to reunify children with their parents did not begin until the 1980 AACWA. Historically and currently, there has been a lack of consistency in the emphasis on and funding for services that focus on reunification vs. child safety vs. expedited alternative permanent placements. With the implementation of ASFA, the emphasis appears to be moving toward expedited permanency and adoption, rather than the provision of comprehensive services to improve parents' abilities to provide a healthy family setting for their child. In addition, wide variations in how ASFA is implemented exist, and there are few efforts to track these variations and their impact on family reunification.

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TRUE/FALSE HANDOUT (Instructors Guide)

In groups of 2-4, discuss these statements and decide if they are true or false. The statements refer to implications for child welfare practice based on the information presented in this family reunification (FR) module. If the statement is false, write a true statement underneath it in the space provided.

True	False	Statement
T	F	1 Formalized federal funding for FR services began in the early 1900s with the Children's Aid Society. *Formalized federal funding for FR services did not begin until 1974 CAPTA.*
T	F	2 Mandates to make reasonable FR efforts did not begin until 1980 AACWA (Adoption Assistance & Child Welfare Act).
T	F	3 Historically, US policy and legislation has always stressed FR over child safety, adoption, and other permanent placements. *Historically, emphasis varies between FR, child safety, and alternative permanent placements (funding varies, too).*
T	F	4 With ASFA (Adoption and Safe Families Act), emphasis seems to be on adoption & expedited permanency rather than the provision of comprehensive services to parents.
T	F	5 Some bypass criterion are very objective, while others are more subjective, making it hard to monitor their local, state, and national implementation.
T	F	6 Wide variations in implementation of ASFA exist, and there are few efforts to track these and their impact on FR.
T	F	7 Reliable poor prognosis indicators have been identified to help child welfare workers make decisions about FR, particularly in cases relating to substance abuse and severe parental mental illness. *Attempts have been made to identify such poor prognosis indicators, but research does not support their reliability.*
T	F	8 Under California law, children ≥ 3 years old have 12 months of FR services, while children < 3 years old have 6 months of FR services (case-by-case exceptions).
T	F	9 Child welfare workers, judges, and agencies have little impact on the implementation of ASFA or related state legislation, since the policies are law. *Despite national and state laws, individual workers, judges, and agencies can interpret wording such as those related to bypass criteria differently, thus creating variation in ASFA implementation.*
T	F	10 Concurrent planning refers to the practice mandated by ASFA of creating a state plan at the same time the worker is creating a local/county plan for a case. *Concurrent planning refers to the practice option outlined by ASFA of creating a FR plan at the same time the worker creates an alternative permanent placement plan in the event FR fails.*

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SECTION II

TYPES OF REUNIFICATION SERVICES

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SECTION II
TYPES OF REUNIFICATION SERVICES

INSTRUCTIONAL GUIDE

Learning Objectives

This section provides an overview of types of FR services, which are discussed in the context of assessment and case planning. It describes specific services and presents the results of the current study with respect to service types. Since FR services are vast, the lesson includes a *Service Description Handout*, in which students search for an incorrect descriptive statement for services. A *California Case Plan Contents for Child Receiving FR Services Handout* is also provided so students have this as a resource on hand. An optional *Case Summary* activity is provided as well, in which students are asked to find at least one strength and one weakness in the assessment process and case plan.

By the end of this section, participants will:

- Understand the role of assessment and components of case planning,
- Be familiar with types of recommended reunification services, and
- Recognize the strengths and challenges of collaborative services.

Public Child Welfare Competencies (MSW)

3.11 Student recognizes the importance of working with biological families, foster families, and kin networks, as well as involving them in assessment and planning strategies.

3.14 Student understands the principles of concurrent and permanency planning that takes into account the educational, health, and emotional needs of children.

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4.4 Student demonstrates the ability to identify service/treatment plan requirements and to construct measurable objectives for the service plan.

7.9 Student is able to utilize collaborative skills and techniques to enhance service quality in organizational settings.

Public Child Welfare Competencies (BSW)

2.6 Student demonstrates understanding of the dynamics of all forms of family violence, and the importance of culturally sensitive case plans for families and family members to address these problems.

2.10 Student is developing an understanding of the importance of evidence-based practice and has a basic understanding of empirical research.

2.12 Student is developing the capacity to utilize the case manager's role in creating a helping system for clients, including working collaboratively with other disciplines and involving and working collaboratively with biological families, foster families, and kin networks.

Agenda and Suggestions for Instructors

- Time allocation: Approximately 1 hour
- Follow the PPT slides; particular slides solicit input from participants
- Complete FR Service Description Handout Activity
- Distribute California Case Plan Contents for Child Receiving FR and Flow Chart Handout
- Complete or assign Case Summary Handout, if desired
- Wrap-up Discussion & Introduction that if following the curriculum, next topic will be on types of reunification services.
- Request completion of generic feedback form, if desired.

Materials Needed

- PowerPoint Slides for Section II and necessary projection equipment
- Blackboard, dry erase board, or flip chart tablet is recommended if the instructor prefers to write down ideas solicited from participants (along with appropriate writing tools)

- Handouts for each participant (*Service Description*, *California Case Plan Contents for Child Receiving FR*, *Flow Chart,* and optional *Case Summary*)
- Copies of PPT slides for each participant are recommended to be given out, after the lecture
- Copies of feedback form, if desired

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SECTION II
TYPES OF REUNIFICATION SERVICES

ASSESSMENT AND CASE PLANNING

Before a family reunification service plan can be established, the child welfare worker must gather information from parents, children, family members, and service providers to make an assessment of family problems that have contributed to child maltreatment and the types of services recommended to address these problems. This assessment and service delivery plan is to be completed and presented to the dependency court within a maximum of 60 days from when the child is initially removed. The child welfare worker's written assessment is provided to the dependency court judge, as well as participating legal staff on a case, including legal representation for the parent and the child. Ultimately, the judge in the dependency court case makes the final decision regarding the specific family reunification services that the parent(s) are ordered to complete. This decision is based largely on the child welfare worker's assessment. As a result, the constellation of family reunification services that parents must complete in order to regain custody of their child(ren) depends heavily on this assessment process.

Research on the assessment and service planning process in child welfare is limited. Child welfare literature describes a number of issues related to risk assessment, including studies evaluating the use of structured decision-making tools in order to make a determination of a child's risk of imminent harm and the likelihood of future incidents of child maltreatment. Much less is known about how child welfare workers

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conduct assessments of family needs and strengths once child maltreatment is substantiated and the child is removed from the parent's care. A growing awareness exists that accurate assessment and case planning among families receiving reunification services involves substantial complexity due to the wide range of co-occurring problems among families (Marsh et al., 2006; Schene, 2005). A review of the first round of Child and Family Service Reviews found that at least 30 states reported problems in conducting assessments of children and families, and that service plans are often a "one size fits all" or a "boiler plate" model in which most families are ordered to participate in the same menu of services, regardless of their individual needs or strengths (Child Welfare Information Gateway, 2006). Individual characteristics of families and the circumstances surrounding entry into the system (type of maltreatment, child age, race/ethnicity, family structure) also need to be considered in the assessment process. Ultimately a thorough assessment process is intended to lead to the creation of an integrated service plan; ongoing case management; and regular re-assessments of progress (Marsh et al.).

Legislation in California (Welfare and Institutions Code 16501.1) describes the components that must be included in a case plan for a child and family receiving family reunification, including:

- An assessment of the circumstances that required child welfare services intervention
- Specific goals and the appropriateness of the planned services in meeting those goals

- The original allegations of abuse or neglect, or the conditions cited as the basis for declaring the child a dependent of the court, and the other precipitating incidents that led to child welfare services intervention
- A description of the schedule of the social worker contacts with the child and the family or other caretakers
- When out-of-home services are used, the frequency of contact between the natural parents or legal guardians and the child
- When out-of-home placement is made, the provisions made for the development and maintenance of sibling relationships
- If out-of-home placement is made in a foster family home, group home, or other childcare institution that is either a substantial distance from the home of the child's parent or out of State, the reasons why that placement is in the best interest of the child
- If out-of-home services are used, or if parental rights have been terminated and the case plan is placement for adoption, a recommendation regarding the appropriateness of unsupervised visitation between the child and any of the child's siblings
- If out-of-home services are used and the goal is reunification, a description of the services to be provided to assist in reunification and the services to be provided concurrently to achieve legal permanency if efforts to reunify fail
- If out-of-home services are used, the child has been in care for at least 12 months, and the goal is not adoptive placement, documentation of the compelling reason or reasons why termination of parental rights is not in the child's best interest
- If the case plan has as its goal for the child a permanent plan of adoption or placement in another permanent home, documentation of the steps the agency is taking to find an adoptive family or other permanent living arrangement for the child; to place the child with an adoptive family, an appropriate and willing relative, a legal guardian, or in another planned permanent living arrangement; and to finalize the adoption or legal guardianship
- When appropriate, for a child who is 16 years of age or older, a written description of the programs and services that will help the child, consistent with the child's best interests, prepare for the transition from foster care to independent living
- When a child who is 10 years of age or older has been in out-of-home placement in a group home for 6 months or longer, an identification of individuals, other than the child's siblings, who are important to the child and actions necessary to

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maintain the child's relationship with those individuals, provided that those relationships are in the best interest of the child

Research on the types of assessment strategies and practices used by child welfare workers to create a case plan is limited. Schene (2005) presents a number of guidelines for use in child welfare settings that describe components of comprehensive family assessments that are intended to accurately identify the issues facing a family and the types of services and supports needed to address these issues within the context of family reunification. Specifically, five major components to a comprehensive family assessment are specified (p. 6):

- Recognize patterns of parental behavior over time;
- Examine the family strengths and protective factors to identify resources that can support the family's ability to meet its needs and better protect the children;
- Address the overall needs of the child and family that affect the safety, permanency, and well-being of the child;
- Consider contributing factors such as domestic violence, substance abuse, mental health, chronic health problems, and poverty; and
- Incorporate information gathered through other assessments and focuses on the development of a service plan or plan for intervention with the family. The service plan addresses the major factors that affect safety, permanency, and child well-being over time.

In addition, four specific principles for effective family assessment are also articulated and include:

- Partnering with and involving families in the assessment process,
- Individualizing the assessment and service-planning process,
- A cross-system focus with respect to family reunification service delivery,
- Use of assessment information for service planning and decision-making

Although there are clearly a number of complexities involved in assessment and case planning, there is evidence indicating that when family reunification services are appropriately matched with a family's needs, there is a greater likelihood of family reunification (Choi & Ryan, 2007; Smith & Marsh, 2002).

TYPES OF SERVICES FOR PARENTS: CONCRETE, EDUCATIONAL, CLINICAL, AND COMPREHENSIVE

After assessment of the family, the types of services recommended by the child welfare worker and ordered by the dependency court judge may include: concrete, educational, clinical, and comprehensive. *Concrete services* are intended to address problems associated with poverty or low-income status and are considered to facilitate a parents' ability to participate in services and complete their case plan. These services may include linkages with housing assistance or public assistance programs to assist with poverty and socioeconomic problems (e.g., public health insurance and assistance obtaining health or dental care; linkages with welfare programs to provide cash assistance and job training; food stamps enrollment); or bus passes or financial assistance with transportation so that parents without cars may attend services at various sites, as well as their court hearings.

Educational services are aimed at increasing parents' knowledge around the problems that led to the child's removal and are based on the assumption that increasing information and knowledge will help parents better cope with their lives and develop improved parenting skills. Educational services may include didactic sessions or experiential activities designed to promote learning on specific issues such as:

parenting skills and child development; non-violent communication; coping skills; the impact of past trauma on current behavior (for parents abused as children); or the impact of substance abuse on parenting.

Clinical services are aimed at addressing specific problems in functioning or behavior that are compromising the parents' ability to provide adequate care for their child. Clinical services may include: counseling, therapy or other mental health treatment; substance abuse treatment; or domestic violence treatment. Within many programs, clinical services are integrated with educational services.

Some family reunification services involve *comprehensive services* that represent systems of care designed to provide concrete, educational, and clinical services to the child's larger family system. Comprehensive services are designed to provide integration between all service systems and a coordinated and individualized response to child and family needs.

DESCRIPTIVE SUMMARIES OF SPECIFIC SERVICES

Parent training services are often educational in nature (although some include clinical components) and are intended to educate parents on child development and parenting strategies in order to improve parenting skills and correct problems that led to the abuse or neglect. Parent training programs are the most frequently ordered service for parents who have had a child removed from their care and are typically delivered in the form of an educational class, which may include parents in voluntary or family preservation services (Barth et al., 2005; Johnson et al., 2006). The types of parenting classes a county or state child welfare system offers a parent may vary widely, and

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while some may be specifically for parents who have had a child removed, others may be more generally focused on parenting skills. There is a also lack of consistency between jurisdictions in the types of parenting classes offered and concern in the field has been raised about the use of parenting classes due to a lack of research on effectiveness, and a concern that didactic forms of interventions may not be successful with parents involved in child welfare, many of whom have not graduated from high school or who have learning difficulties (Lederman & Osofosky, 2006).

In general, components of parenting classes include educational sessions focused on learning positive parenting strategies and how to address common parenting challenges that are aligned with developmental stages in children (e.g., testing boundaries/limit setting, family routines). Parenting classes also include instruction for parents on addressing more complex parenting issues such as fighting, or severe oppositional behavior in children. Many parenting classes also address issues related to the family system, including martial conflict and family communication, as well as teaching general coping skills and problem-solving skills. Parents must generally attend from 10-20 sessions that are held once a week for 1-2 hours. Parenting classes may include homework for parents or role-playing exercises.

Substance abuse services are generally clinical in nature and focus on addressing the parent's problems with drugs and/or alcohol. The effectiveness of substance abuse services within family reunification service plans is a critical issue, as the presence of parental substance abuse within child welfare cases is linked to an increased likelihood of reentry into the child welfare system (Shaw, 2006). Substance

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abuse among parents in the child welfare system is a common problem, and orders to attend various forms of substance abuse treatment are common in child welfare case plans. Substance abuse treatment within child welfare case plans may include attendance at 12-step meetings, out-patient or residential treatment; case plans also typically include orders for random drug testing. Twelve-step programs, including Alcoholics Anonymous, are self-help groups directed toward recovery from substance abuse. Twelve-step programs follow a medical model view of substance abuse and view substance abuse as a disease over which one has little control. Participants of 12-step groups are typically linked with a "sponsor" who assists them in abstaining from drug or alcohol use.

Outpatient and residential substance abuse services include various interventions and follow differing treatment philosophies. There is a growing awareness that effective outpatient and residential substance abuse services should be gender-specific. For mothers with substance abuse problems in the child welfare system, many substance abuse services are woman-centered and address relationship issues, family issues, and past histories of trauma that are linked with substance abuse behaviors. Outpatient services may include psycho-educational or support groups and individual therapeutic sessions. Residential services include these elements in a more intensive manner, while parents live within the treatment facility.

Domestic violence services typically include both clinical and educational components; separate services are targeted toward the perpetrator of the violence (generally the father), and the victim of the violence (generally the mother), and most

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interventions focused on the mother also integrate a child and parenting component. For perpetrators of domestic violence, the Duluth model of batterer intervention programs is widely used and assumes that issues of control and entitlement underlie domestic violence and encourages awareness of controlling attitudes and didactic education to teach batterers alternative ways of interacting with their partners (Pence & Paymar, 1993). Other models and adaptations of the Duluth model focus on incorporating cognitive behavioral components to address errors in thinking and anger management among batterers. Domestic violence services for batterers are generally outpatient services that last anywhere from 20-52 weeks and typically meet once a week for 1-2 hours. Domestic violence services for victims of domestic violence are typically focused on providing support to women who have experienced abuse, educating women on the cycles of abuse and the process of healing, and teaching women skills to maintain their safety and well-being. Support and educational services for victims of domestic violence are generally outpatient and can be time limited from 10 weeks to ongoing.

Mental health services for parents may also be included in a case plan and generally include outpatient individual counseling, marital counseling, family therapy, or linkages with assessment and support for psychiatric medications. There is a lack of information on the specific nature of mental health treatment for parents involved in the child welfare system, and the effectiveness of these interventions. However, there is a growing awareness that many parents with co-occurring mental health and substance abuse problems have significant histories of abuse and trauma. For instance, among

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women in substance abuse treatment, childhood abuse, sexual abuse, and experiences of violence are common (Clark, 2001; Dore & Dorris, 1998; Miller, Downs, & Gondoli, 1989). As a result, some child welfare agencies are moving toward the integration of trauma-recovery services within mental health and substance abuse services for parents. This movement is fueled in part from research suggesting PTSD symptoms can worsen once sobriety is achieved, making the recovery process more challenging, and requiring clinicians to be attuned to the role of trauma in the recovery process (Najavits, 2007). Trauma-recovery services generally integrate a cognitive-behavioral approach to symptom reduction and many curriculum-based programs incorporate substance abuse components within a gender-specific framework. These services tend to be psycho-educational and focus on the effects of trauma, specific strategies to address symptoms, and maintain sobriety (Najavits).

The use of *family team meetings, such as family group conferencing, family group decision making, and team decision making*, represent a family reunification service that is designed to create a structure for professionals to share information about a case, and for families to have input into their own case plan and placement decisions for the child. Family group conferencing developed as a practice model in New Zealand and legislation mandating its use in New Zealand was passed in 1989 (Sieppert, Hudson, & Unrau, 2000). A review of outcomes from the first Child and Family Service Reviews indicated that a number of states use some type of family team meeting as a part of their reunification efforts (Child Welfare Information Gateway, 2006). Although there are variations in the form these team meetings may take, the

overall goal is to bring parents, family members, alternative caregivers, service providers, and others involved in the case together in order to share assessment information (including family strengths and challenges) develop case plans, identify placements for children, and monitor progress (Crampton, 2007). In addition, family team meetings are also intended to empower parents, create “buy-in” for their case plan, and facilitate cooperation and collaboration among the child welfare system, service providers, and families. Family team meetings generally occur at the beginning of a case and continue throughout as needed (Pennell & Burford, 2000).

In addition to services directed toward the parent, services for the child may also be included in family reunification service plans. Most notably, many children in the child welfare system have mental health problems and family reunification plans often contain orders for mental health assessment and treatment for children. Mental health problems among children in the child welfare system have been linked to a reduced likelihood of family reunification, as well as an increased likelihood of maltreatment recurrence and reentry into care (Davis, Landsverk, Newton, & Ganger, 1996; Jones, 1998;).

Mental health problems among children in the child welfare system may influence the reunification process in a number of ways. For instance, a child’s emotional and behavioral status may impact caseworker decisions to reunify a family. In an effort to prevent the worsening of psychological problems among children, reunification decisions regarding children with mental health problems may be made more cautiously. In addition, emotional and behavioral problems among children may be considered an indicator of a more problematic family situation and thus, may reduce the

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likelihood of reunification. As a result, interventions that address the mental health problems of children in the child welfare system have the potential to increase reunification (Davis et al., 1996). Indeed, studies indicate that the presence of emotional and behavioral problems among children in the child welfare system is related to a decreased likelihood of reunification and an increased likelihood of maltreatment recurrence or placement in out-of-home care (Davis et al., 1996; Jones, 1998;).

Information is lacking on specific models of mental health treatment for children in the child welfare system. Two recent studies of public mental health service use among children in Santa Clara County's child welfare system found outpatient treatment to be the most common intervention utilized by children in the child welfare system, including individual, group, and family therapy, and the use of psychiatric medications (Hines, Lee, & Osterling, 2006, 2007). Other children's mental health interventions might include residential or inpatient programs or comprehensive delivery models that seek to integrate services to parents, alternate caregivers, and the child. For instance, Treatment Foster Care (TFC) aims to place youth with mental health problems in community and family settings and provide intensive, family-centered aid to address children's behavioral and emotional problems (Farmer, Wagner, Burns, & Richards 2003). Other service delivery models used by the child welfare system for children with mental health needs include "wraparound services" which represent "family-centered, strength-based, needs-driven planning process for creating individualized services and supports for children and their families" (CDSS, 2001, p. 1). This intervention involves cross-system collaboration to plan and deliver services to children (Toffalo, 2000).

In addition, some family reunification services are designed as comprehensive models that incorporate a number of services mentioned above. For instance, specific models, including the Homebuilders program, Project Connect, or the Intensive Reunification Program represent concentrated and integrated interventions to reduce child maltreatment, family conflict, and child behavior problems, as well as teaching skills needed to achieve reunification (CEBC, 2008).

CROSS-SYSTEM COLLABORATION BETWEEN CHILD WELFARE, SUBSTANCE ABUSE, DOMESTIC VIOLENCE, AND MENTAL HEALTH SYSTEMS

Cross-system collaboration between child welfare, substance abuse, domestic violence, and mental health systems aims at strengthening linkages in an effort to improve service access and delivery. Child welfare systems are mandated to ensure the safety, permanency, and well-being of children in the child welfare system, while providing an array of services to parents. Because many families involved in child welfare present with numerous co-occurring issues, cross-system collaboration is becoming increasingly necessary to address this wide range of issues, as well as monitor parental progress and child well-being.

Research on cross-system collaboration within the context of child welfare service delivery points to several domains that help to foster cross-system collaboration, including: a) out-stationing substance abuse, domestic violence, and/or mental health professionals within child welfare settings (i.e., the court, or agencies where services are delivered, b) joint case planning to facilitate shared service delivery goals and to ensure that service system goals are not in conflict with one another, c) official

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structures to guide the collaboration, such as committees, memorandums of understanding, d) ongoing mechanisms for training and cross-training of all workers involved with families, e) formal and informal mechanisms for workers at all levels of the organization to meet with one another and share information, f) clear establishment of each partner's role and purpose in the collaboration and in service delivery to families, and g) established protocols for sharing confidential information among all professionals working with a family (Darlington & Feeney, 2008; Moles, 2008; Osterling & Austin, 2008).

In addition, some child welfare agencies have implemented collaborative models in the form of family treatment drug courts (also referred to as Dependency Drug Courts), which are modeled after adult criminal drug courts and are aimed at facilitating utilization of substance abuse service among parents in the child welfare system (Boles, Young, Moore, & DiPirro-Beard, 2007). Currently, there are 225 family treatment drug courts operating in 49 states (Bureau of Justice Assistance [BJA] Drug Court Clearinghouse, 2008). Family treatment drug courts require collaboration between the dependency court system, the child welfare system, the substance abuse delivery system, and community-based agencies delivering services. Three models of court oversight within family treatment drug courts are used within these collaborative practices. First, within integrated models, one dependency court judge is involved in overseeing the case throughout the family's involvement within the dependency court system, including court petitions and parental compliance with substance abuse treatment (this is the type of model used in Santa Clara County). Second, dual-track or

two-tiered models are broad in scope and target a "first track" of service delivery focused on offering substance abuse services and recovery management services to every parent identified with a substance abuse problem. Among parents who do not comply with treatment, a "second track" is offered that includes the family treatment drug court, which operates separately from other dependency court hearings and includes one judge who oversees child welfare case processes and one judge who oversees compliance with substance abuse treatment. Third, parallel to family drug treatment courts, court hearings regarding the child welfare case are heard within the usual family court proceedings; at the first hearing, a parent is given the option of participating in a specialized drug treatment court where substance abuse treatment issues are heard (Boles et al.).

STUDY FINDINGS RELATED TO SERVICES DELIVERED/SERVICES ORDERED

Broad study questions related to reunification services ordered were:

- What reunification services are ordered for parents whose children are removed from their care, and do there appear to be distinct patterns to the way these services are ordered?
- How do types or patterns of reunification services ordered differ by parental characteristics?

To answer these questions, univariate and bivariate analyses were conducted to examine the services parents were ordered to receive, and how those services might be related to various parental characteristics. These analyses were conducted on both the Santa Clara (SC) and CWR datasets. Because of the differences in time periods and sample sizes, direct comparisons between the two sets of analyses are not necessarily

useful; more meaningful is to consider similarities and differences in patterns between the two analyses.

Who was offered services? First, we were interested in which parents were offered or not offered services. Cases were only included in the sample if at least one parent received services. In both data sets, the large majority of parents were ordered to receive services. Mothers were much more likely to be ordered to receive services than fathers, as were parents who had custody of their children at the time of the initial referral. In the SC data, non-custodial mothers and fathers were equally likely to receive services (63% of non-custodial mothers and 53% of non-custodial fathers), while in the CWR data, noncustodial mothers were more likely to receive services (63%) than noncustodial fathers (32%; see Appendix A: Table 2-1). Parents who did not receive services are excluded from all subsequent analyses.

What kind of services were parents ordered to receive? Next, we considered the nature of the services parents received. Services were grouped into five general categories representing broad service classifications: a) parenting education services, b) domestic violence services, c) substance abuse services, d) psychological or counseling services, and e) general services. Within each broad type were a number of distinct subtypes. For example, in the SC study, within the category of parenting education services are four specific types of parenting services: a basic parenting class, an advanced parenting class, a "parenting without violence" class, and a parenting class of some other type. A less detailed breakdown of services was available in the CWR dataset.

Certain services are ordered for most parents. In the SC study, these services included: *basic parenting* education; drug treatment in the form of *assessment*, *drug testing*, and *12-step program* meeting attendance; *individual counseling*; and *visitation* with their children. In the CWR data, services ordered for most parents are similar: a parenting class, substance abuse treatment and testing, individual counseling, and visitation with their children (see Appendix A: Table 2-2).

We also considered whether there were patterns of service receipt by service type. Using the general types described above—parenting education services (P), substance abuse services (SA), domestic violence services (DV), and counseling/psychological services (C)—and excluding from consideration the general services of visitation and orientation, we created four basic patterns of services receipt: Pattern 1 = C & P only (No SA or DV); Pattern 2 = SA no DV, Pattern 3 = DV no SA, and Pattern 4 = SA & DV. As counseling and psychological services were commonly ordered for most parents, the primary consideration for the pattern creation was whether or not substance abuse services or domestic violence services were received. Table 2-3 (Appendix A) shows the number of parents who received each pattern, for both sets of data.

In both datasets, most parents were ordered services to treat at least one of the major problems of domestic violence and substance abuse, and in SC a substantial proportion of parents were ordered to receive services to treat both problems. The most commonly used pattern in both datasets was Pattern 2. In this pattern, parents were

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ordered to receive SA services but not DV services, and may or may not have received parenting or counseling services.

How many services were parents ordered to receive? There were differences in how the services were counted in the two studies. For example, in the SC study, inpatient and outpatient treatment were counted as two separate services; in the CWR study, these were considered "drug treatment," and counted as a single service. Therefore, direct comparisons between datasets are not appropriate.

In the SC data, the average number of services received was just over seven, and the median number of services received was also seven. The number of services ordered ranged from 1-12. Table 2-4 (Appendix A) shows the number and percentage of parents who received either three or fewer, 4-6, 7-9, or 10 or more services. In the SC dataset, the largest percentage of parents, almost half, were ordered to receive between 7 and 9 services. In the CWR dataset, the largest percentage of parents were ordered to receive 4-6 services, but again this difference is likely due to the differences in how services were counted in the CWR study.

In the SC study, we also considered the frequency with which parents were ordered to attend some of these services. For services of drug testing, 12-step attendance, and visitation, the order for the service often included a designation of the number of times per week the parent was to undertake the service (Appendix A: Table 2-5). The most common frequency with which these services were ordered was twice per week; for 12-step meeting attendance, three times per week was almost as commonly ordered as twice per week. This data was not available in the CWR dataset.

Relation of Service Number and Service Pattern

These two aspects of services ordered—number of services and types of services—are related. Within one type of service treatment, such as substance abuse, a parent might be ordered multiple services such as drug abuse assessment, drug testing, in-patient treatment, and 12-step meeting attendance. In SC, these would account for a total of 4 services just in the area of drug abuse treatment alone. Since there are more possible services within the drug treatment service area than in the other service areas, not surprisingly parents who are ordered to receive any drug abuse services are ordered to have more services than those who are not ordered to receive drug abuse services.

Table 2-6 (Appendix A) displays the average number of services ordered for each of the different service type patterns. For both datasets, parents who receive both SA and DV services have the highest service burden. Those who receive only SA are next, followed by DV only, and finally by those who are ordered neither SA nor DV services. This pattern was true across both datasets. For the SC data, differences between all patterns except Pattern 1 and Pattern 3 (the two patterns where SA services are not ordered) are statistically significant. For the CWR data, differences between all patterns except Pattern 2 and pattern 3 are statistically significant. In essence, parents who receive SA services have a higher service burden than parents who do not receive SA services.

How does the number of services ordered differ by parental characteristics? We considered whether the number of services ordered differed by

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parents' *demographics*, such as gender, ethnicity, language, or custodial status; by parents' *problems* of current substance abuse issue, current domestic violence situation, or current mental health problem; and by the *type of maltreatment* to which the parent subjected a child: *physical abuse; neglect* (incorporating medical neglect, failure to provide adequate food or housing, or inadequate supervision); or *emotional abuse* (cruelty or abandonment over 24 hours). In the SC study, an additional maltreatment type was gathered: *failing to protect* a child from maltreatment by another.

In both studies, mothers received more services on average than fathers, and custodial parents received more services on average than parents who were non-custodial at the time of the child's removal. There was no significant difference in the number of services ordered by parent ethnicity. Regarding parental problems, parents who at the time of the referral had substance abuse issues, domestic violence issues, or mental problems were ordered to receive a higher number of services on average than parents without those characteristics. Regarding maltreatment, parents who had neglected a child were ordered significantly more services than parents who had not committed those actions. Table 2-7 (Appendix A) shows the difference in the average number of services ordered for parents with various characteristics.

How does the type of service ordered differ by parental characteristics? We considered next how the type of services ordered differed by parents' demographics, problems, or type of maltreatment.

Parenting Education Services. In the SC study, we found no differences in the proportion of parents ordered to receive parenting education services by parental

characteristics. In the CWR dataset, mothers, custodial parents, and parents who neglected their children were somewhat more likely to receive parenting education services than parents without those characteristics (see Appendix A: Table 2-8).

Domestic Violence Services. In both studies, parents who had the current problem of domestic violence were much more likely to receive DV services than parents without that problem. In the CWR dataset, fathers, non-English speakers, and parents with maltreatment types of physical abuse and emotional maltreatment were more likely to be ordered to receive DV services (see Appendix A: Table 2-9).

Substance Abuse Services. In both studies, English language speakers, substance-abusing parents, and parents with maltreatment types of physical abuse and neglect were more likely to be ordered to receive substance abuse services than parents without those characteristics. In the SC study, while a high proportion of parents from most ethnic groups were ordered to receive substance abuse services, only 18% of Asian/Pacific Islander parents were ordered to receive this service. Also in the SC study, parents with the problem of domestic violence were more likely to be ordered to receive substance abuse services than parents without the problem, while parents with the maltreatment type of failure to protect were less likely to be ordered to receive it; in the CWR study, mothers, custodial parents, and parents with the maltreatment type of emotional maltreatment were more likely to be ordered to receive substance abuse services (see Appendix A: Table 2-10).

Counseling/Psychological Services. In both datasets, custodial parents and mothers were more likely to be ordered to receive counseling services compared to

non-custodial parents and fathers. In the SC dataset, parents with mental health problems and parents with maltreatment type of neglect were more likely to be ordered counseling services than parents without those issues. In the CWR dataset, parents with the maltreatment types of physical abuse and emotional maltreatment were more likely to be ordered counseling services than parents without those maltreatment types (see Appendix A: Table 2-11).

Often, associations found tended to connect the nature of the problem and the nature of the service. Parents with mental health problems were more likely to receive counseling services. Parents with substance abuse services were more likely to receive substance abuse treatment, and parents with domestic violence issues more likely to receive domestic violence treatment, than parents without those problems. In fact, 100% of parents with the problems of substance abuse and mental health, and 85% of parents with domestic violence problems, received services that appeared to target the problems. Interestingly, substantial portions of parents who were *not* described as having these problems were ordered to receive services targeted at the problems. For example, 79% of parents *not* described as experiencing mental health problems were ordered to receive counseling or psychological services; 24% of parents *not* described as experiencing current domestic violence problems were ordered to receive domestic violence treatment services, and 42% of parents *not* described as having current substance abuse issues were ordered to receive substance abuse treatment services.

SUMMARY OF FINDINGS

- The majority of parents are offered six specific services:

- Basic parenting
- Drug abuse assessment
- Drug testing
- 12-Step program attendance
- Individual counseling
- Visitation

- In SC, the average number of services ordered was 7, and about half of parents were ordered to receive between 7 and 9 services. For three of these services, parents were usually ordered to attend twice a week.

- Four patterns of service ordering were identified:

  - Just parenting (P) and counseling (C) services
  - Substance abuse (SA) treatment services, with or without P and C
  - Domestic violence (DV) services, with or without P and C
  - Both DV and SA treatment services, with or without P and C

  The most commonly used pattern was Pattern 2; the next most commonly used was Pattern 4.

- Parents with certain characteristics were ordered to receive more services. In both studies, mothers, English language speakers, and custodial parents were ordered to receive more services than fathers, speakers of other languages, and non-custodial parents respectively. Parents with problems of substance abuse, domestic violence, and mental health were ordered to receive more services than parents without those problems. And parents with maltreatment types of neglect, allowing or failing to prevent witnessing domestic violence, and endangerment related to drug use were ordered to receive more services than parents without those maltreatment types.

- Different service types were more or less likely to be ordered for parents with certain characteristics, as compared to parents without those characteristics.

  - *Substance abuse treatment* was less likely to be ordered for Asian parents, and more likely to be ordered for parents with current drug abuse issues and maltreatment type of neglect.
  - *Domestic violence treatment* was more likely to be ordered for parents with the current problem of domestic violence.
  - *Counseling services* were more likely to be ordered for mothers, custodial parents, parents with mental health problems, and parents with maltreatment type of neglect.

IMPLICATIONS OF STUDY FINDINGS FOR CHILD WELFARE PRACTICE

Study findings related to the types and numbers of reunification services ordered for parents, combined with information from the research literature review in this area, point to a number of implications for practice:

- Study findings suggest that most parents are ordered to receive a substantial number of reunification services, including several that require attendance a number of times weekly. For parents with multiple problems to be addressed, the service burden is even higher. While it is logical that parents with more problems would require more treatment, *social workers should carefully construct case plans that are realistic and feasible for clients, taking into account the number and frequency of services, as well as client's resources (time, transportation, finances, and capabilities).*

- Findings from the study suggest that while for the most part parents with particular problems were ordered to services to treat those problems, some parents were ordered to receive services intended to address problems the parents didn't appear to have. *Social workers should take care to order for clients only those services intended to treat problems with which parents are currently struggling.*

- Findings from the study show that Parenting services and Counseling services were ordered to the majority of parents, regardless of the existence of mental health problems or known problems with parenting skills. *More research is needed to determine whether these services are in fact appropriate for so large a percentage of parents, or whether it would be more efficient to target these services more narrowly.*

SECTION III

CLIENT UTILIZATION OF REUNIFICATION SERVICES

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SECTION III
CLIENT UTILIZATION OF REUNIFICATION SERVICES

INSTRUCTIONAL GUIDE

Learning Objectives

This section provides information on client use of FR services. The module has a briefer PPT, because some of the didactic material focuses on two diagrams that are best for visual and verbal learners to have directly on hand. Each handout is tied to an activity, to engage students in learning the model more completely. One is the *Participation Model Handout* that provides a framework for client service utilization, and the other is the *Organizational Construct Model Handout* that alerts students to the impact of structural factors on service outcomes.

By the end of this section, participants will:

- Be aware of factors that can affect reunification service utilization, and
- Recognize organizational factors that impact service delivery and use.

Public Child Welfare Competencies (MSW)

1.3 Student demonstrates the ability to conduct an ethnically and culturally competent assessment of a child and family and to develop an effective intervention plan.

4.3 Student works collaboratively with biological families, foster families, and kin networks, involving them in assessment and planning and helping them access services and develop coping strategies.

4.4 Student demonstrates the ability to identify service/treatment plan requirements and to construct measurable objectives for the service plan.

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Public Child Welfare Competencies (BSW)

1.2 Student demonstrates the ability to conduct an ethnically and culturally sensitive assessment of a child and family and to develop an appropriate intervention plan.

2.10 Student is developing an understanding of the importance of evidence-based practice and has a basic understanding of empirical research.

Agenda and Suggestions for Instructors

- Time allocation: Approximately 1 hour
- Follow the PPT slides; particular slides solicit input from participants
- Complete *Participation Model Handout* Activity and *Organizational Construct Model Handout*
- Wrap-up Discussion & Introduction that if following the curriculum, next topic will be on effectiveness of reunification services.
- Request completion of generic feedback form, if desired.

Materials Needed

- PowerPoint Slides for Section III and necessary projection equipment
- Blackboard, dry erase board, or flip chart tablet is recommended if the instructor prefers to write down ideas solicited from participants (along with appropriate writing tools)
- Handouts for each participant (*Treatment Participation Model* and *Organizational Construct Model*)
- Copies of PPT slides for each participant are recommended to be given out, after the lecture
- Copies of feedback form, if desired

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SECTION III: CLIENT UTILIZATION OF REUNIFICATION SERVICES

RESEARCH ON FACTORS CONTRIBUTING TO REUNIFICATION SERVICES UTILIZATION

There is a lack of information on service utilization patterns among parents in the child welfare system. Available information tends to categorize service use as either the parent completed services or not; information on service intensity, duration, and effect on outcomes is not known. It is generally thought that greater levels of participation in services results in greater exposure to the intervention, thereby increasing the likelihood of positive changes (Littell et al., 2001). However, circumstances surrounding service delivery for families involved in the child welfare system, namely the court-ordered removal of their child(ren) and the mandated nature of the service plan, creates unique challenges to engaging clients. As a result "compliant" behavior may not always represent true engagement in services (Jellineck et al., 1992; Yatchmenoff, 2005). In addition, the involuntary nature of the services, and the often adversarial characteristics of child welfare investigations and court proceedings can make engaging parents in services extremely difficult (Chapman et al., 2003). Moreover, the shortened timelines for provision of family reunification services associated with ASFA also create challenges to engagement in and use of services. Parents with children under 3 years of age are typically allowed just 6 months of services, and over age 3, 12 months of services. Given the complexity of family issues at entry into the child welfare system, this may simply not be enough time to assess parents, engage them in services, and monitor utilization and outcomes.

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To understand the broader mechanisms through which individuals and families come to participate in mental health, substance abuse, and child welfare services Littell et al. (2001) developed a conceptual model of service participation that identifies pre-treatment and external influences to participation, as well as within treatment factors. This framework integrates aspects of other conceptual service engagement models including the "barriers to treatment participation model" (Kazdin & Wassell, 1999) and the "self-regulatory systems model of medication compliance" (Leventhal, Lambert, Diefenbach, & Leventhal, 1997). Although this model does not apply directly to court-ordered family reunification services, it provides a useful framework for understanding the various factors that may influence service utilization. Figure 1 provides an illustration of the conceptual model of treatment participation articulated by Littell et al.

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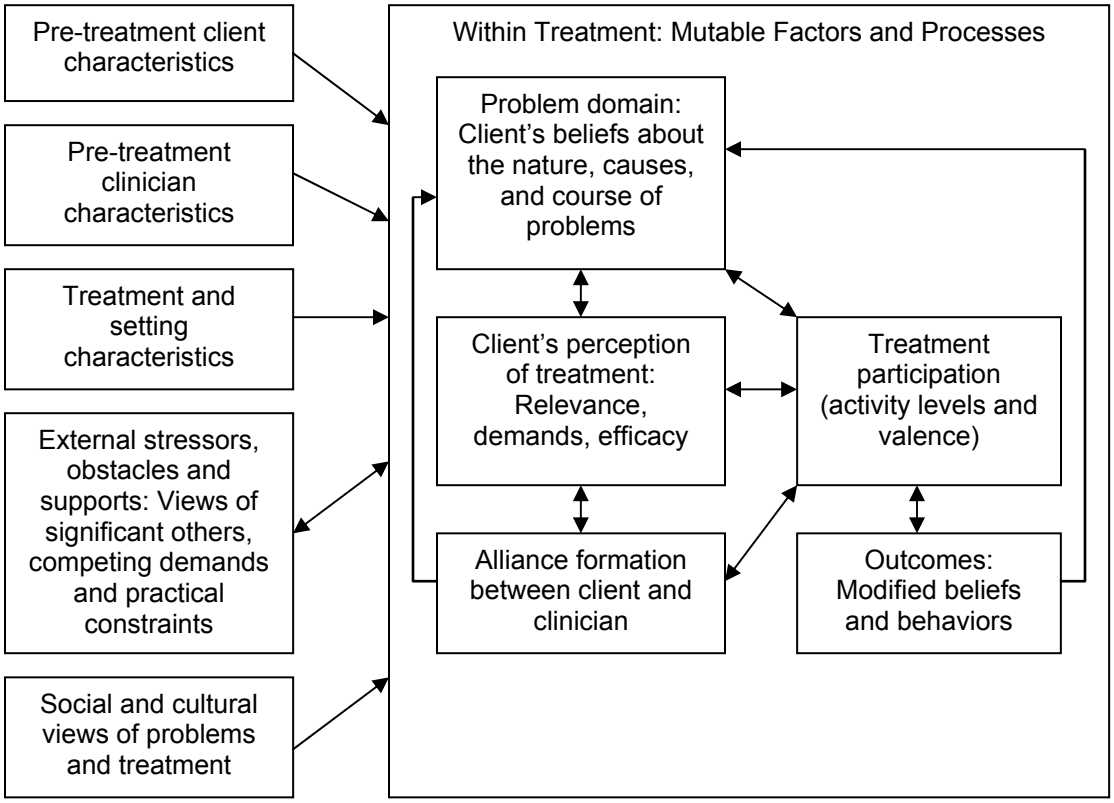
***Figure 1*. A Conceptual Model of Treatment Participation (Littell et al., 2001)**



Pre-treatment client characteristics are external to the intervention itself and consist of demographics such as age, family structure, race/ethnicity, and socioeconomic status. These factors may affect the ways in which families use services. In addition, the severity of the initial problems that brought a family to the attention of the child welfare system may also impact engagement in services. Multiple problems including substance abuse, mental health problems, and domestic violence are associated with a lack of compliance with services among parents in the child welfare system (Butler, Radia, & Magnatta, 1994; Famularo, Kinscherff, Bunshaft, Spivak, & Fenton, 1989; Murphy et al., 1991).

Pre-treatment clinician characteristics, such as beliefs about the origins of parents' problems, prior training, and experience levels may impact the degree to which social workers form an alliance with parents, thereby impacting parents' willingness to use mandated services. In addition to the individual social worker characteristics, the treatment and service setting also impact utilization. Treatment characteristics include whether services are voluntary or involuntary and the degree of coercion or persuasion employed to engage parents. In addition, aspects of the larger organizational setting in which services are delivered also impact service utilization.

External stressors, obstacles, and supports reflect a number of characteristics that affect the extent to which parents are willing and able to participate in family reunification services. These may include whether significant others in the parents' life support the parents' participation in services; competing demands, such as work or a lack of child care; and practical constraints, such as a lack of transportation to services. Within the child welfare system, external stressors and obstacles include a lack of services, long waiting lists for services, as well as a lack of culturally competent services (Child Welfare Information Gateway, 2006). Social and cultural factors may have a significant impact on parents' participation in family reunification services—this is an area of particular concern given that African Americans are overrepresented in the child welfare system and in some locations, Hispanic/Latino families are also overrepresented. Cultural factors may influence a family's problems and strengths, as well as participation in, comfort with, and gain from services.

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Within treatment characteristics also impact service engagement. The Littell et al. (2001) conceptual model describes the problem domain as including the overall problem conceptualization. Beliefs about the types of challenges impacting a parent, their etiology, and their impact are either implicitly or explicitly articulated in treatment approaches. These beliefs are considered to be "working hypotheses" subject to revision through the course of treatment. Client perceptions of interventions also impact utilization. Perceptions of services as unnecessary or too demanding are linked to low utilization of child mental health services (Kazdin, Holland, & Crowley, 1997).

Furthermore, the alliance formed between a caseworker and a parent will likely influence service utilization. Frequent contact between a caseworker and family, as well as the establishment of a positive caseworker/parent relationship is related to greater engagement in and use of family reunification services (Maiter, Palmer, & Manji, 2006). Positive parent/caseworker relationships are facilitated by the caseworker providing emotional support, including acknowledging parents' feelings, giving praise, and responding promptly to phone calls; and efforts to involve parents in the formulation of their own case plan, including choices about the out-of-home placement for their child and fully explaining the system and court processes (Maiter et al., 2006). Of similar importance are worker accessibility to and consistent contact with the parent and establishing an egalitarian working relationship (Ribner & Knei-Paz, 2002). Negative experiences contributing to a lack of engagement in services includes inadequate services (e.g., being ineligible, not getting enough help, feeling depersonalized by service providers), unfair treatment (e.g., feeling unfairly judged, given too little

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information by child welfare system, or feeling misled by the information given), harassment (e.g., feeling scrutinized, invaded, or controlled), and experiencing an abrupt removal of children (e.g., feeling traumatized by the removal; Maiter et al., 2006). The ongoing outcomes of service participation are also likely to impact continued or subsequent service utilization. If initial outcomes bring about positive outcomes, further engagement in services may result.

ORGANIZATIONAL CHARACTERISTICS THAT IMPACT SERVICE DELIVERY AND UTILIZATION

The conceptual model of treatment participation described by Littell et al. (2001) addresses factors affecting engagement in services, many of which child welfare agencies can influence. For instance, child welfare agencies can provide training and support to promote social worker skills that foster alliance-building with parents as well as the provision of concrete support to facilitate service use and improved treatment settings. However, to develop the ideal circumstances under which parents may fully engage in all services, the organizational characteristics that are specific to each child welfare agency must be taken into consideration. Research suggests that child welfare organizations are often chaotic and crisis-driven environments in which high workloads and staff turnover are the norms (Smith & Donovan, 2003; Vinokur-Kaplan & Hartman, 1986). This organizational atmosphere, or culture, affects workers' job satisfaction and the quality of services delivered. Yoo, Brooks, and Patti (2007) propose a conceptual framework that describes how organizational constructs operate as predictors of service effectiveness in the context of child welfare services. Figure 2 provides an illustration of

this framework, which specifies a number of interacting organizational influences that affect service delivery, service utilization, and service effectives.

Moving in a clockwise direction, the first domain within this conceptual model refers to the overall *structure of the organization and the types of external factors that influence this structure*. For instance, child welfare agencies are organized in a bureaucratic manner with specified hierarchies, roles, and divisions of labor. Power may be centralized and the individual decision-making power of line staff may be limited. External factors including funding streams and political support affect the ways in which the organization delivers services (and by extension the degree of service utilization).

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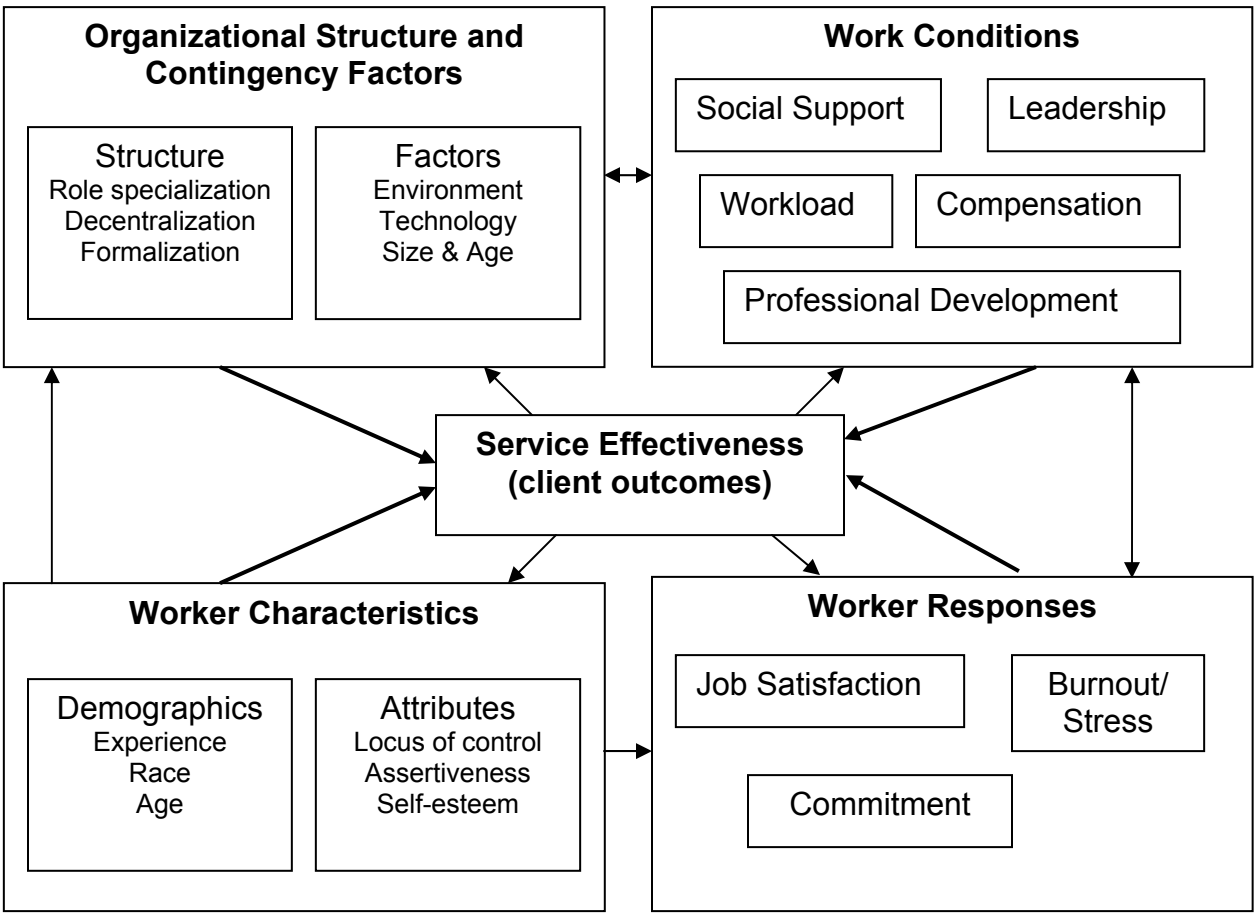
***Figure 2*. A Conceptual Framework of Organizational Constructs of Predictors of Service Effectiveness**



The second domain refers to the day-to-day realities that represent *working conditions* within the organization, including leadership, social support, workload, compensation, and professional development opportunities. These workplace conditions then come to affect the third domain, *worker responses* to working conditions, which encompasses job satisfaction, burnout/stress and commitment. Research suggests that strong leadership, adequacy of staffing, and workplace support all impact worker job satisfaction—and at times the quality of services delivered (Glisson & Hemmelgarn, 1998; Glisson & James, 2002; Grasso, 1994; Smith &

Donovan, 2003; Yoo, 2002). For instance, a positive organizational climate, including elements related to low conflict, cooperation, role clarity, and personalization, is linked to better service quality and improved client outcomes within agencies serving children and families (Glisson & Hemmelgarn). Similarly, in an investigation into the relationship between organizational variables and client outcomes within a child welfare agency, it was found that employees tended to rate their job satisfaction as low, their jobs as stressful, and their workload as too high; they also reported an overall lack of leadership in the organization, resulting in feelings of disconnection between workers and management and an overall chaotic working environment. However, the impact of these negative organizational factors on service quality tended to be buffered by a supportive organizational culture in which direct supervisors and co-workers provided important sources of workplace support, suggesting that even in a stressful work environment, certain positive organizational characteristics can benefit service quality (Yoo).

In the fourth domain, service effectiveness is impacted by the *individual characteristics of the worker*, such as experience level, age, and race/ethnicity, as well as worker attributes such as locus of control, assertiveness, and self-esteem. These characteristics are linked with job satisfaction and the ways in which individual workers respond to organizational stressors.

Taken together, the Littell et al. (2001) conceptual model of factors affecting participation in services and the Yoo et al. (2007) organizational framework describe the wide range of factors that may influence a parent's willingness and ability to utilize family reunification services. Within the context of child welfare and family reunification

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service utilization, the alliance between a family and a child welfare worker appears to play an important role in a parent's engagement in services (Maiter et al., 2006; Ribner & Knei-Paz, 2002). In turn, a child welfare worker's ability and willingness to engage a parent in family reunification services is influenced by the organizational context in which she or he is working. Positive organizational climates characterized by support, leadership, and professional development foster commitment and job satisfaction among child welfare workers (Smith & Donovan, 2003; Yoo, 2002). These organizational contexts have been linked to service effectiveness, and by extension to service utilization (Glisson & Hemmelgarn, 1998).

STUDY FINDINGS RELATED TO PARENTS' UTILIZATION OF SERVICES

The broad study questions related to parents' use of reunification services were:

- How does parents' utilization of services differ by type or pattern of services ordered?
- How does parents' utilization of services differ by parental characteristics?
- How does parents' utilization of services affect the likelihood of successful reunification?

To answer these questions, univariate and bivariate analyses were conducted to examine the degree to which parents utilized services they were ordered to receive, whether the degree of use varied by type of service or parental characteristic, and whether use was associated with successful reunification (no re-entry within 6 months).

We had hoped to be able to gather information not just on whether parents complied with services, but also whether they had made true progress with the services, at least according to the social worker describing the situation for the court report.

However, we did not find this level of detail consistently recorded in case files. We did gather information related to compliance; this variable was categorized as full, partial, or incomplete/poor. “Utilization” is operationalized as the proportion of services ordered for a parent with which she or he was fully compliant.

How does parents’ utilization of services differ by service type? We first considered whether services had different patterns of use. Were there some services parents were more or less likely to use?

Using the same typology of services, for each service we summarized the proportion of parents who had full compliance with the services (of those for whom compliance was recorded). Table 3-1 (Appendix B) reports the results. Services were reported if at least 10 parents had recorded compliance data.

Utilization varied by service type. In SC, higher utilization rates were seen with advanced parenting over other parenting classes, substance abuse assessment over other substance abuse treatment services, and psychological evaluation and medication monitoring over individual therapy. Orientation also had a fairly high rate of compliance overall.

Services with lower utilization rates included domestic violence treatment for batterers, with less than 22% of recorded service users fully complying with the service, and substance abuse testing services, with less than 42% of service users fully complying with the services. Other services approaching a relatively low rate of 50% utilization were individual counseling, 12-step treatment, outpatient substance abuse

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treatment, aftercare substance abuse treatment, and the parenting without violence parenting class.

The CWR dataset had less detail on service types, and scores overall were substantially lower. One similar pattern that can be seen is that the utilization rate for the psychological evaluation is higher than the rate for individual counseling, as is true in the SC dataset as well.

How does parents' utilization of services differ by parental characteristics? We next considered whether utilization varied by parental characteristics. To do this, we grouped parents into four categories: a) parents who did not fully comply with any service; b) parents who fully complied with some but less than half of their services; c) parents who fully complied with half or more (but not all) of their services; and d) parents who fully complied with every service (see Appendix B: Table 3-2).

These categories were given ranks of 1, 2, 3, and 4 respectively. The means of these ranks are reported in Table 3-2, to provide a sense of whether compliance was higher or lower for parents with certain characteristics. For testing differences between the ranks, a non-parametric test called a Mann-Whitney was used. In SC, there are few differences between utilization scores that are statistically significant. Parents who have a current problem of either substance abuse or domestic violence have lower utilization scores than parents without these problems.

In the CWR dataset, higher utilization rates were also found for non-English speakers, custodial parents, mothers, and physically abusive parents. Parent who had substance abuse problems or had been neglectful were less likely to utilize services.

Note that the sample size in the CWR dataset is much larger, thus smaller differences can be detected (see Appendix B: Table 3-3).

In the CS data, parental age is associated with utilization scores: parents with the highest utilization scores are older than parents with lower utilization scores. Follow-up tests between each group show that the significant difference is between the ages of parents with utilization scores of 2 and parents with utilization scores of 4. No difference in age by utilization score exist in the CWR dataset (see Appendix B: Table 3-4).

Finally, we looked at whether utilization scores were associated with successful reunification (defined as reunification that did not result in a substantiated referral within 6 months of reunification). Not surprisingly, parents who successfully reunified had higher utilization scores than parents who did not successfully reunify (see Appendix B: Table 3-5).

SUMMARY OF FINDINGS

- Utilization varies by service.
    - Higher utilization was found for advanced parenting classes, substance abuse assessment, psychological evaluation, medication monitoring, and family therapy.
    - Lower utilization was found for batterer's domestic violence programs, and substance abuse testing.
- Utilization was lower for parents with current problems of substance abuse and domestic violence than for parents without those problems. Older parents had higher utilization scores than younger parents.
- Parents who successfully reunified had higher utilization scores than parents who did not successfully reunify.

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IMPLICATIONS OF STUDY FINDINGS FOR CHILD WELFARE PRACTICE

Study findings related to parents' use of services, combined with information from the research literature review in this area, suggest a number of implications for practice:

- Study findings show that batterer's treatment programs had very low utilization rates. *These programs may need to pay increased attention to strategies to involve parents and maintain their participation over the course of the service. County agencies that contract with service providers should incorporate client involvement/non-drop-out as an important process measure.*

- Utilization scores were higher for those services parents attend only once, such as orientation, assessment, and psychological evaluations. While certainly it is likely to be more difficult to maintain participation in on-going services, these one-time, well-utilized appointments may be critical moments at which engagement and involvement in other services can be coordinated and encouraged. *Assessment services and on-going services should be coordinated to facilitate smooth transitions for clients and encourage on-going participation and involvement in services.*

- Parents struggling with the issue of domestic violence appear to have particular difficulty utilizing services. Batterer's treatment programs had low utilization rates, and parents with the problem of domestic violence overall had lower utilization scores. Some aspect of the phenomenon of domestic violence may cause particular challenges for participating in services. *Parents struggling with this issue may require additional attention and supports to maintain involvement in services. Further research into how domestic violence hinders reunification services processes is called for.*

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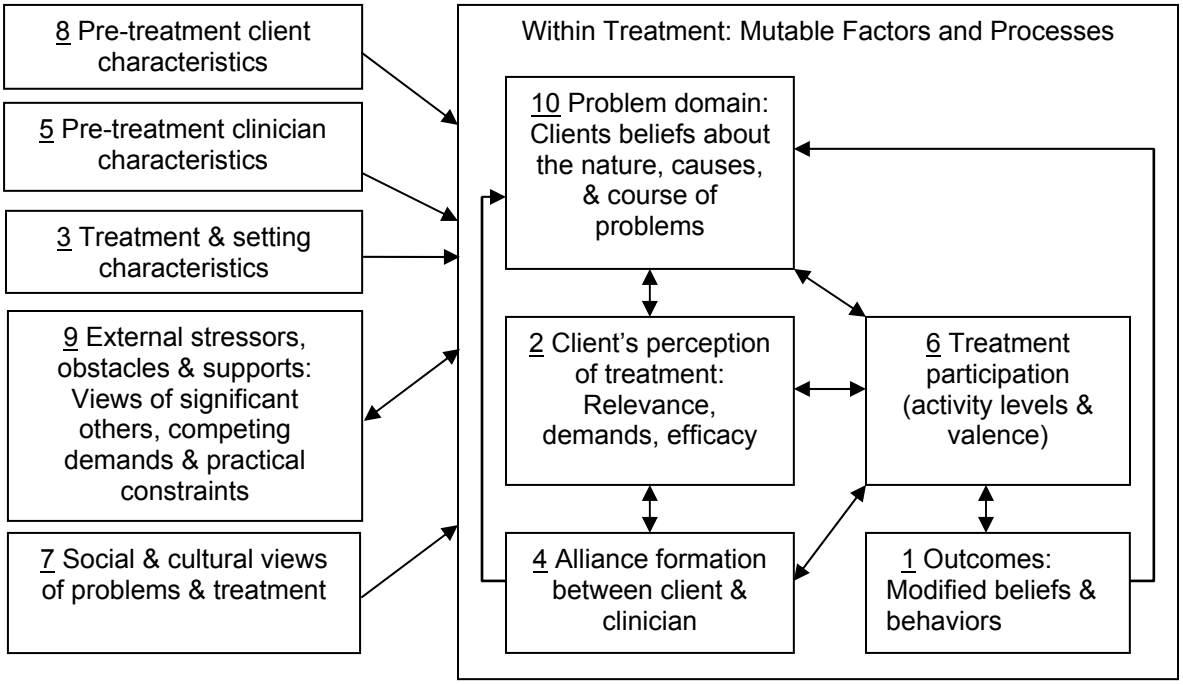
Treatment Participation Model
Matching Activity (Instructor Guide)

This model can be used to understand the various factors that influence service use. First, take a moment to review the model. Next, match the example statements below to the appropriate box in the model. Number 1 is already matched with the "Outcome" box, as an example.

A conceptual model of treatment participation (Littell et al., 2001)



1. Client's positive experience with mental health services and seeing that medication helped her depression
2. A grandmother's belief that the RF services ordered for her were too many and too overwhelming
3. Court ordered, involuntary services for a batterer
4. A father believes the child welfare worker is "in his corner" & has his & his child's best interests at heart
5. Caucasian male MSW with unresolved abuse issues in his own past history
6. A parent complies with all ordered services and even with assigned counseling homework
7. General distrust of child welfare by communities of color due to historical oppression and racist interventions
8. Non-English speaking, Laotian woman with history of DV with 6-month-old baby in child welfare system
9. Lack of transportation to court ordered Alcoholics Anonymous meetings
10. A mother's belief that she can learn new ways to parent and break her family cycle of physical abuse

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SECTION IV

EFFECTIVENESS OF REUNIFICATION SERVICES

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SECTION IV
EFFECTIVENESS OF REUNIFICATION SERVICES

INSTRUCTIONAL GUIDE

Learning Objectives

By the end of this section, participants will:

- Understand the general state of research on the effectiveness of reunification services in the areas of: concrete assistance; parent training; substance abuse; domestic violence; mental health; and family team meetings;

- Appreciate the imperative nature of service effectiveness in the context of ASFA and reunification timeframes.

- Be aware of the importance of assessing parents' capacities and resources as well as their need for treatment in the development of case plans.

Public Child Welfare Competencies (MSW)

1.3 Student demonstrates the ability to conduct an ethnically and culturally competent assessment of a child and family and to develop an effective intervention plan.

4.3 Student works collaboratively with biological families, foster families, and kin networks, involving them in assessment and planning and helping them access services and develop coping strategies.

4.4 Student demonstrates the ability to identify service/treatment plan requirements and to construct measurable objectives for the service plan.

Public Child Welfare Competencies (BSW)

1.2 Student demonstrates the ability to conduct an ethnically and culturally sensitive assessment of a child and family and to develop an appropriate intervention plan.

2.10 Student is developing an understanding of the importance of evidence-based practice and has a basic understanding of empirical research.

Agenda and Suggestions for Instructors

- Time allocation: Approximately 1 hour

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- Follow the PPT slides
- Instructor is encouraged to demonstrate accessing CBEC site http://www.cachildwelfareclearinghouse.org/
- Wrap-up Discussion & Introduction that if following the curriculum next topic will be a summary exercise.
- Request completion of generic feedback form, if desired.

Materials Needed

- PowerPoint Slides for Section IV and necessary projection equipment
- Blackboard, dry erase board, or flip chart tablet is recommended if the instructor prefers to write down ideas solicited from participants (along with appropriate writing tools)
- Copies of FR Program Service Example Cards
- Copies of PPT slides for each participant are recommended to be given out, after the lecture
- Copies of feedback form, if desired

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SECTION IV
EFFECTIVENESS OF REUNIFICATION SERVICES

RESEARCH SUMMARY ON FAMILY REUNIFICATION SERVICES EFFECTIVENESS

Research on the effectiveness of family reunification is limited. Studies conducted in the 1990s largely focused on "family preservation" services designed to provide intensive services to prevent out-of-home placement and found limited evidence of the effectiveness of these services in preventing out-of-home placements (Westat, 2002). Information on the degree to which these services contributed to family reunification was not reported. Despite the lack of information on the link between services and reunification and re-entry outcomes, there is some evidence linking specific services to reunification outcomes. More commonly the research presented in this review links specific services to improvements in functioning among parents and children, which, by extension, may be linked to an improved ability of parents to reunify with their children. However, it should be noted that research that specifically measures family reunification and re-entry outcomes is slim.

Concrete Assistance

Research on the impact of concrete assistance on the likelihood of reunification suggests that the provision and use of housing assistance may increase family reunification rates. One study examining outcomes of Illinois' Title IV-E alcohol and other drug abuse demonstration project found that parents receiving matched housing assistance (e.g., the housing assistance that is matched with their need for this service) were more likely to experience family reunification than parents not receiving matched

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housing assistance, suggesting that concrete assistance in obtaining housing may influence reunification (Choi & Ryan, 2007).

Parent Training

Although parent training programs are a mainstay of most mandated family reunification service plans, there is limited research on the effectiveness of these services in improving parenting and contributing to family reunification. Nevertheless, compliance with and completion of parenting education services is typically a requirement for return of the child to the birth parent. In a recent review of the evidence base for parent training programs within child welfare settings, Barth et al. (2005) identified parent training programs with research evidence indicating their effectiveness, and additional information on parent training programs was also gathered from the CBEC website (although no studies have linked these programs to family reunification):

- **The Incredible Years** (scientific rating of 1, well supported by the research literature). This intervention includes components for parents, teachers, and children and is designed to address problem behaviors in children by increasing parenting skills. A psycho-educational curriculum is used with parents to develop communication skills, coping skills, positive discipline, and problem-solving skills. Services directed toward children focus on encouraging social development and reducing conduct problems. Experimental studies have linked this intervention to improved parenting skills (Baydar, Reid, & Webster-Stratton, 2003; Reid, Webster-Stratton, & Baydar, 2004).

- **Multi-systemic therapy** (no scientific rating on the CEBC website, but identified by Barth et al. (2005) as a leading evidence-based parent training program). This intervention is family focused and strength based and seeks to provide comprehensive (usually home-based) services that draw on cognitive-behavioral approaches, linkages to resources in the community, and case management. Experimental studies examining the impact of this intervention among populations of youth with mental health problems has found some support for positive outcomes, however, follow-up studies suggest that positive changes may not be sustained over time (Henggeler et al., 2003).

- **Oregon Social Learning Center's Parent Management Training** (no scientific rating by the CEBC, but identified by Barth et al. (2005) and colleagues as a leading evidence-based parent training program). This psycho-educational intervention is delivered in a group format and focuses on positive discipline strategies, positive reinforcement, monitoring, and problem-solving strategies. Most research on this intervention has examined its effectiveness on addressing child mental health problems, and there is evidence indicting its effectiveness in this domain (Costin & Chambers, 2007)

- **Parent-Child Interaction Therapy** (scientific rating of 1, well supported by the research literature). This intervention includes observation of parent and child interactions by a clinician through a one-way mirror during which the clinician coaches the parent on parenting strategies through a microphone in the parent's ear. Both child- and parent-directed skills are taught in the experiential settings. Although PCIT was designed to address behavioral and emotional problems among children, one experimental study did test the effectiveness of this intervention in reducing further abuse reports among a sample of parents with a substantiated physical abuse incident, suggesting that this parent training intervention may be effective in addressing physically abusive parenting behaviors (Chaffin et al., 2004).

- **Triple P Positive Parenting Program** (scientific rating of 1, well supported by the research literature). This intervention includes a number of multiple-faceted services. Parent training sessions are differentiated by the developmental stage of the child and use a self-regulatory framework to encourage self-sufficiency, self-efficacy, and problem-solving skills of parents. The specific aspects of the intervention are intended to be tailored to the needs of each family. Most experimental studies on this intervention have been conducted in Australia and results link the intervention to improvements in parenting skills and reductions in child behavioral and emotional problems (Bor, Sanders, & Markie-Dadds, 2002; Sanders, Markie-Dadds, Tully, & Bor, 2000).

- **1, 2, 3 Magic** (scientific rating of 2, supported by research evidence). This intervention is directed toward parents of children ages 2-12 and focuses on three essential components: a) eliminating and controlling negative child behaviors, b) encouraging positive child behaviors, and c) strengthening the parent-child relationship. The intervention is psycho-educational in nature with one to two sessions per week for 4-8 weeks and is delivered in a group format. One experimental study conducted in Canada found improvements in parenting and child behavior associated with the intervention (Bradley et al., 2003).

- **Attachment and Biobehavioral Catch-up** (ABC) (scientific rating of 3, promising research evidence). This intervention was designed specifically for use with

maltreating parents or among parents and children who have experienced a period of separation. The intervention is focused on educating parents about child development issues among children who have experienced maltreatment or separation from caregivers and encouraging parents to provide nurturing care. The intervention is delivered in weekly 1-hour sessions for 10 sessions. Experimental studies among parents and children involved in the child welfare system have produced mixed findings with some studies suggesting improved child behaviors among parents and children in this intervention, and other studies finding little differences between intervention and control groups receiving a strictly didactic and educational program (Dozier, Brohawn, Lindheim, Perkins, & Peloso, in press; Dozier, Peloso, Lewis, Laurenceau, & Levine, in press).

- **Nurturing Parenting Programs** (scientific rating of 3, promising research evidence). This family-based intervention was designed to prevent and treat child maltreatment issues within families. Interventions are tailored to the developmental stage of the child and are psycho-educational in nature, focusing on a) teaching parents age-appropriate expectations, b) developing parent and child empathy and self-worth, c) using positive discipline strategies, d) empowering to promote healthy decision-making, and e) increasing self-awareness to promote communication and relationship building. This intervention is delivered both in a group format and a home-based format with a recommended four sessions per month for 12-48 months. Quasi-experimental studies with at-risk parents (some of whom were involved in the child welfare system) found improvements in parenting skills associated with the intervention (Cowen, 2001; Devall, 2004).

- **Parenting Wisely** (scientific rating of 3, promising research evidence). This intervention is an interactive, self-administered, computer-based program for parents of children 9-18 that is focused on improving parent-child relationships and reducing conflict. Nine video scenarios are presented within a CD-Rom curriculum that focuses on specific parenting problems that may arise with adolescents. Parents then select appropriate ways to solve these challenges based on three choices and are then given feedback on their choice. The program lasts 2-3 hours and is intended to be implemented twice within a 6-month period. Experimental studies on the effectiveness of this intervention have not yielded consistent findings as to its effectiveness in improving parenting skills, however one study did find improvements in parenting and child behavior for parents receiving the intervention versus a control group receiving no intervention (Kacir & Gordon, 1999).

- **SafeCare** (scientific rating of 3, promising research evidence). This intervention is designed specifically to prevent child maltreatment and uses an in-home model of service provision that includes direct training in improved parenting skills to promote child well-being and health, as well as planned activities training centering around skills such as time management, explaining rules and expectations to

children, preparing for activities, or the use of reinforcement. Training on maintaining a safe home and monitoring child health are also included. The intervention is designed to be delivered with weekly in-home sessions lasting about 1½ hours for a period of 18-20 weeks. Two quasi-experimental studies of SafeCare that tested effectiveness among parents referred to the child welfare system for child maltreatment suggest the program is linked with a reduced likelihood of re-report of child maltreatment to the child welfare system, as well as improvements in parenting skills and home safety. However, one study found a high attrition rate with only 10% of families actually completing the program, suggesting that caution is necessary in interpreting the findings and that may be reflective of problems associated with engaging families into services.

- **STEP: Systematic Training for Parenting Effectiveness** (scientific rating of 3, promising research evidence). This intervention is a psycho-educational curriculum-based service that is delivered in a group format and is tailored to the developmental stages of children that focuses on positive discipline skills and education around child development and developmental stages. The intervention is designed to be implemented with weekly sessions lasting 1-1½ hours for 7 weeks. Studies with child welfare populations have not been conducted; other quasi-experimental studies suggest some improvements in parenting skills when compared to a comparison group.

- **Teaching Family Model** (scientific rating of 3, promising research evidence). This intervention uses "teaching parents" who are a pair of individuals who work toward creating a family setting within group homes, in-home services, foster care settings, schools, or psychiatric institutions. Within residential settings, the teaching parents are in the setting at all times for up to 9 months; for home-based services there are 10-15 sessions a week for 6-10 weeks. Most quasi-experimental studies of this intervention have focused on youth outcomes in residential settings and results provide some evidence that the intervention is effective at improving outcomes (Jones & Timbers, 2003; Larzelere, Daly, Davis, Chmelka, & Handwerk, 2004). One quasi-experimental study of this intervention applied to an in-home setting found improvements in resources and physical care; no differences in parent effectiveness, parent-child relationship, or child behavior problems were found (Lewis, 2005).

Substance Abuse Services

A recent structured review of the effectiveness of substance abuse interventions for mothers involved in the child welfare system found very few studies that focused specifically on child welfare populations; however a number of interventions that are

relevant to child welfare settings were identified (Osterling & Austin, 2008). Overall, six program components for which there is some research evidence to support their effectiveness with substance-abusing women (who may or may not be involved in the child welfare system) were identified, including: a) woman-centered treatment involving children, which includes gender-specific services that involve children in treatment, b) substance abuse services that integrate health and mental health treatment, c) home visitation programs that incorporate substance abuse treatment, d) concrete support and assistance, such as transportation and child care, e) short-term and targeted interventions such as psychoeducational groups or contingency management programs, and f) comprehensive programs that incorporate all of these program components (Osterling & Austin).

In addition, the California Evidence-Based Clearinghouse (CEBC) for Child Welfare has identified a number of substance abuse treatment services that have relevance to child welfare populations and some research to support their overall effectiveness, although research testing the effectiveness of these services on family reunification outcomes has not been conducted. Included in the interventions are:

- **Motivational Interviewing** (scientific rating of 1, indicating that it is well-supported by the research evidence). Motivational interviewing includes clinical strategies designed to increase parents motivation to enter treatment and stop using drugs or alcohol and has been linked to positive outcomes (Hettema, Steele, & Miller, 2005).
- **Community Reinforcement + Vouchers Approach** (scientific rating of 2, indicating that it is supported by the research evidence). This intervention includes a comprehensive package of services that are behavioral interventions (counseling, vocational training, coping skills, social and recreational activities) designed to support and reinforce sobriety, as well as a contingency management approach were participants can earn vouchers to purchase products in the

community as a reinforcement for staying in treatment and remaining sober. This intervention has been linked with increased retention in services and greater duration of sobriety (Higgins et al., 1995). A community reinforcement approach that does not include vouchers was rated with a scientific rating of 3, indicating that it has promising research evidence (Smith, Meyers, & Miller, 2001).

- **Alcoholics Anonymous** (scientific rating of 3, indicating that it has promising research evidence). Alcoholics Anonymous is a well known substance abuse intervention based on self-help principles in which participants support one another by working through a series of 12 steps to address their substance abuse. There is not consistent evidence on the effectiveness of Alcoholics Anonymous; some studies report positive effects, others find little effect (Kownacki & Shadish, 1999).

- **Celebrating Families** (scientific rating of 4, indicating that it lacks adequate research evidence and there are no published peer-reviewed studies). This intervention includes a curriculum designed to improve family skills and strengthen family functioning as a parent recovers from substance abuse. Interventions are focused on the entire family.

- **Helping Women Recover** (scientific rating of 4, indicating a lack of adequate research). This intervention includes a curriculum that integrates recovery from trauma and recovery from substance abuse among women. Practices are psyco-educational in nature and include cognitive-behavioral methods, expressive arts, and relational approaches.

- **Nurturing Program for Families in Substance Abuse Treatment and Recovery** (scientific rating of 4, indicating a lack of adequate research). This intervention is psycho-educational and experiential in nature and includes exercises to improve parenting skills, the parent-child bond, parents' knowledge of child development, and self-awareness about the impact of substance abuse and parenting on the family.

- **Specialized Treatment and Recovery Services** (scientific rating of 4, indicating a lack of adequate research). This intervention matches a parent in the child welfare system with a Recovery Specialist who acts as a liaison between the substance abuse treatment service provider and the child welfare system, helps to facilitate entry into treatment among parents, and monitors progress.

Despite a lack of research on the effectiveness of specific substance abuse service components on family reunification outcomes, there is evidence indicating that participation in and completion of substance abuse treatment services is a critical factor

in family reunification outcomes. One study of substance-abusing parents in Cook County, Illinois who had at least one child in out-of-home placement found that approximately 50% of parents completed substance abuse treatment and that treatment completion (defined as completing the last treatment episode—self-reported sobriety for 3 months) was associated with an increased likelihood of reunification after controlling for the influence of other factors (Smith, 2003). Another study, using longitudinal methods and state-level data in Oregon found that mothers who experienced a quick entry into substance abuse treatment (average time to treatment was 147 days), lengthier stays in treatment (average length of treatment was 238 days), and treatment completion had a higher likelihood of family reunification, and their children had shorter stays in out-of-home care (Green, Rockhill & Furrer, 2006). Quick entry into treatment was also associated with longer stays in treatment and an increased likelihood of treatment completion. The authors suggest that given the seriousness of the circumstances surrounding the removal of a child, the motivation for change among mothers during the initial stages of the case may be very high, and that immediate access to treatment may capitalize on this motivation, creating a foundation for engagement in services and positive treatment outcomes (Green et al.).

Efforts to improve timely access to substance abuse treatment and engagement of parents into treatment have focused on cross-system collaborative models directed toward improving the ways in which systems work together to assess families, provide services, and monitor progress. Family treatment drug courts represent a formal collaborative model between the child welfare system, the substance abuse treatment

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field, and the dependency court system. A recent quasi-experimental evaluation of four family treatment drug courts found that participants entered treatment more quickly, spent more days in treatment, were more likely to complete treatment, were more likely to have at least one child reunified than were comparison families, and had children who entered a permanent placement more quickly than a comparison group (Green, Furrer, Worcel, Burrus, & Finigan, 2007). Further analysis suggested four types of treatment experiences: a) rapid success treatment experiences were characterized by the parent entering treatment within 60 days of the first petition, had one or two treatment episodes, and completed 100% of treatment; b) later success treatment experiences were characterized by the parent taking longer than the first 60 days to enter treatment, had more than two treatment episodes, and completed 100% of treatment; c) mixed success treatment experiences were characterized by two or more treatment episodes with mixed completion; and d) unsuccessful treatment experiences characterized by parents who did not complete any treatment. Parents in the family treatment drug court were more likely than comparison parents to have a mixed success pattern of services, and were less likely to experience later success or unsuccessful treatment experiences. Both groups were equally likely to experience the rapid success (Green et al., 2007).

In addition to the potential effectiveness of family treatment drug courts, findings from the Illinois Title IV-E Alcohol and other Drug Waiver Demonstration project, suggest that the integrated service model used in Illinois may improve family reunification outcomes. The model of substance abuse service delivery used in this

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project included intensive case management for parents in child welfare and substance abuse services and the use of recovery coaches to facilitate entry into treatment and monitoring of parent's progress. Recovery coaches serve as a liaison between child welfare and substance abuse treatment fields; their role is to engage parents in treatment, improve their access to treatment, and provide close monitoring to ensure parents complete treatment (Ryan, Marsh, Testa, & Louderman, 2006). An experimental evaluation indicated that parents with a recovery coach entered treatment more quickly than control group parents who received treatment-as-usual (50% of parents with a recovery coach entered within 40 days of the initial court hearing, compared to 50% of the control group entering within 100 days); and family reunification rates among parents with a recovery coach were significantly higher. However, the authors note, that overall only 10% of all parents in the study reunified with their children; 7% of the control group and 12% of the intervention group (Ryan et al., 2006).

Domestic Violence Services

There is limited information on the role of domestic violence interventions for batters and for victims of domestic violence in contributing to family reunification outcomes. The CEBC has identified domestic violence interventions for batterers that are supported by the research literature and/or relevant to child welfare populations; however, there are no studies testing these interventions specifically within child welfare populations:

- **AMEND, Inc. (Abusive Men Exploring New Directions)** (scientific rating of 3, indicating promising research evidence). This intervention includes a psycho-educational group format designed to eliminate abusive behaviors increasing

awareness and education among perpetrators of domestic violence. In non-experimental studies, this intervention is linked with reduced likelihood of domestic violence (Jones, D'Agostino, & Gondolf, 2004).

- **Domestic Abuse Intervention Project** (scientific rating of 3, indicating promising research evidence). This intervention is the founding program based on the Duluth model of batterer interventions and includes a 28-week psycho-educational program for batterers (many of whom are court-ordered to attend), as well as a Coordinated Community Response that includes efforts to improve interagency collaboration and community responses to domestic violence. Non-experimental studies link this intervention to a reduced likelihood of re-assault (Taylor, Davis, & Maxwell, 2001).

- **The New York Model for Batterer Programs** (scientific rating of 4, indicating a lack of research). This intervention is not specifically focused on direct practice with batterers, but instead reflects efforts to more closely monitor participation and progress of batterers who are court-ordered to services.

Other domestic violence services focus on interventions for the victims of domestic violence and their children and are directed toward supporting women, improving parenting, reducing child behavior problems, and increasing awareness of the impact of domestic violence on the family. The CEBC has identified a number of these interventions that have relevance for child welfare populations, (although no research has linked these interventions with family reunification outcomes) including:

- **Project SUPPORT** (scientific rating of 2, indicating that it is supported by the research evidence). This intervention focuses on providing concrete and emotional support to women who have entered emergency housing at domestic violence shelters, as well as training in parenting skills to address behavior problems in children. The intervention is home-based and is focused on supporting women transitioning home from the shelter; it is designed to be delivered weekly for 1-1½ hours for 26 weeks. Experimental research found support for the intervention in improving parenting and child behavior and these effects have been maintained at a 2-year follow-up, although differences in rates of re-abuse were not statistically different between the two groups (Jouriles et al., 2001; McDonald, Jouriles, & Skopp, 2006).

- **Child-Parent Psychotherapy for Family Violence** (scientific rating of 2, indicating that it is supported by the research evidence). This intervention is

focused on recovery from trauma and improvements in child-parent relationships and interactions through the use of a psychodynamic therapeutic approach delivered weekly for approximately 50 weeks. Results of experimental studies with children who have witnessed domestic violence and their mothers suggest that the intervention is effective in reducing mental health problems among mothers and improving child behavior (Lieberman, Ippen, & Van Horn, 2006; Lieberman, Van Horn, & Ippen, 2005).

- **The Community Advocacy Project** (scientific rating of 2, indicating that it is supported by the research evidence). This intervention focuses on supporting women who have experienced domestic violence through the use of advocacy services to help women and children obtain resources and support in this process. Services are both home-based and community-based and are delivered 4-6 hours per week for 10 weeks. Experimental studies link the intervention with a reduced likelihood that women will experience domestic violence, as well as improvements in quality of life—however follow-up studies suggest comparable rates of re-abuse 3 years post-intervention (Bybee & Sullivan, 2002; 2005).

- **Kids Club and Moms Empowerment** (scientific rating of 3, promising research evidence). This intervention includes two components. Kids Club, which is designed to increase children's knowledge of domestic violence and their own reactions to it, is delivered in a small group format for children ages 6-12. Moms Empowerment is a parent training intervention that provides support to mothers and focuses on improving parenting skills. The groups meet concurrently for 1 hour a week for 10 weeks. One quasi-experimental study of this intervention that included some children and mothers involved in child welfare found reductions in child behavior problems (Graham-Bermann, Lynch, Banyard, Devoe, & Halabu, in press).

- **Domestic Violence Home Visitation Intervention** (scientific rating of 4, indicating a lack of research). This intervention provides comprehensive services to women and children who have experienced domestic violence. The intervention provides an initial home visit from a team of advocates and police officers. Information on court processes, children's reactions to trauma and violence, and referrals to community resources are provided, as well as ongoing case management.

- **San Diego Family Justice Center** (scientific rating of 4, indicating a lack of research). This intervention is a cross-system collaboration between 25 agencies working together in a "one stop" center that coordinates and provides services for victims of domestic violence, elder abuse, and child abuse. Services are comprehensive and range from social support to emergency housing, food, and legal services.

- **The Child Witness to Violence Project** (scientific rating of 4, indicating a lack of research). This intervention is directed toward children ages 8 and younger who have witnessed domestic or community violence. It is a trauma-focused clinical intervention that involves strengthening parent-child relationships and provides ongoing case management, advocacy, and support. Sessions are weekly for 1-1½ hours for a minimum of 5 months.

Mental Health Services

Mental health services for parents and children are included in many of the parenting, substance abuse, and domestic violence services described above. Other specific mental health services that may be included in a family reunification service plan may include the use of trauma-recovery services for women. For instance, *Seeking Safety* is a curriculum-based trauma-recovery program for women experiencing Post Traumatic Stress Disorder and substance abuse. An experimental study of low-income urban women compared *Seeking Safety* to manualized cognitive behavioral therapy (CBT) that addresses substance abuse (but not trauma), and standard community care found that women in the *Seeking Safety* treatment condition and in the CBT condition had a reduction in symptoms at 3-, 6-, and 9-month follow-ups compared to the standard community treatment group (Hien, Cohen, Miele, Litt, & Capstick, 2004).

Family Team Meetings

Research on the impact of family team meetings, such as family group conferences, family group decision-making and team decision-making on family reunification is limited. Crampton (2007) recently reviewed research on child welfare outcomes associated with family group decision-making and found some evidence relating this practice to improved outcomes, although the research is inconsistent in this

area. One quasi-experimental study conducted in the United Kingdom found that families receiving a family group conference had fewer re-reports to the child welfare system than a matched comparison group (Pennell & Burford, 2000). A second quasi-experimental study conducted in Michigan found that families who received a family group conference had fewer re-reports to the child welfare system, a reduced likelihood of the child being placed in an institutional setting, moved less between temporary placements, and were more likely to have a legal guardianship established with an extended family member (Crampton & Jackson, 2007). A third quasi-experimental study conducted in Sweden found that families receiving family group conferencing actually had a higher rate of re-referral to the child welfare system (Sunndell & Vinnerljung, 2004). Last, an experimental study conducted in Fresno and Riverside Counties in California also found that families receiving family group conferencing had higher rates of re-reports to the child welfare system when compared to control group families, and no differences were found between groups with respect to placement stability or permanency outcomes—including family reunification (Berzin, 2006).

IMPORTANCE OF EFFECTIVENESS IN ASFA CONTEXT AND CALIFORNIA POLICIES SHORTENING REUNIFICATION TIMEFRAMES

Given the shortened timelines associated with ASFA, the effectiveness of family reunification services is critically important. Parents typically have 12-18 months to successfully participate in and complete the services listed in their case plan, and if their child is 3 or younger, 6 months of services are offered. If services are not effective in addressing the problems that brought the family to the attention of the child welfare

system, then even if a parent is completely compliant with all services and the child is reunified with the parent, there is still a risk of future maltreatment and child welfare system involvement. Research has found that compliance with services is related to family reunification, but information on the effectiveness of services is lacking. There is also a lack of information that considers the impact of various patterns of service utilization on family reunification (e.g., considering multiple services at the same time—which is a better way to understand service effectiveness for reunification since parents are ordered to participate in multiple services). Moreover, we know little about interactions between services used and parental characteristics, such as age and race/ethnicity.

STUDY FINDINGS RELATED TO THE EFFECTIVENESS OF SERVICES

The broad study questions related to effectiveness of reunification services were:

- How does parental utilization of the types of service affect the likelihood of successful reunification?
- How do parental characteristics affect the likelihood of successful reunification?
- Is there an interaction between the type of services and parental characteristics? That is, are certain reunification services more or less effective for parents with particular characteristics?

To answer the first two questions, multivariate analyses were conducted to examine the effects of parents' utilization of different services on the hazard of successful reunification (no re-entry within 6 months). Interaction terms were used to consider the difference between the risk for parents with certain problems who used particular services targeted at those problems, versus the risk for parents with the same

problems who did not use services. We had hoped to answer the third question by combining the CWR and SC datasets to increase the sample size to the size necessary to support a three-way interaction. As noted earlier, combining datasets was not appropriate due to differences in times of entry to foster care and changes in how some variables were measured. As a result, most aspects of this last analysis were not possible.

Variables representing parental demographic characteristics, parental problems, parent maltreatment types, and parental utilization of various services were first tested individually against the hazard of successful reunification. Various demographics such as ethnicity, language, and maltreatment type did not show any significant relationship with the outcome, and were not included in multivariate models. The model building process involved testing interactions between parental problems and services targeted at those problems, as well as interactions between problems and general services of parenting and individual counseling. Interactions between substance abuse problems and substance abuse services, substance abuse problems and individual counseling, and domestic violence and domestic violence services were found to be statistically significant and remained in the full model (see Appendix C: Table 4-1).

How does parents' utilization of services affect the likelihood of successful reunification? Parents' use of services makes a dramatic difference in their likelihood of reunification. Parents with domestic violence problems who did not use services were much less likely to reunify than parents without domestic violence problems. When parents with the issue of domestic violence fully used domestic violence services, they

were much more likely to reunify than parents with the issue of domestic violence who did not use services.

Similarly, parents with substance abuse problems who did not fully utilize substance abuse services were less likely to reunify than parents without substance abuse problems. But parents with substance abuse problems who used services were much more likely to reunify than parents with substance abuse problems who did not use services.

This association is not surprising, as social workers' decisions about reunification rely heavily on parents' compliance with services. A parent who fully complies with services is believed to be more likely to have made the changes necessary to safely parent than a parent who has not fully complied with services. However, not every parent who fully complies with services reunifies. Additionally, it appears that not every service has the same positive result. In this study, while parents who did not have substance abuse problems benefited from utilization of individual counseling (it increased the likelihood of reunification substantially), parents who did have substance abuse problems did not; when these parents fully utilized individual counseling, they were significantly *less* likely to reunify than parents who had substance abuse problems and did *not* fully utilize individual counseling.

How do parental characteristics affect the likelihood of successful reunification? Parental demographics and maltreatment types were not significantly associated with the likelihood of reunification in this study.

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SUMMARY OF FINDINGS

- Parent utilization of problem-targeted services increases the likelihood of reunification.
    - Parents with problems of substance abuse or domestic violence who did not fully utilize services were much less likely to reunify than parents who did not have these problems.
    - Parents with problems of substance abuse or domestic violence who did fully utilize services were much more likely to reunify than parents with the same problems but who did not fully utilize services.
- Utilization of individual therapy appeared to decrease the likelihood of reunification for parents with substance abuse problems, though it increased the likelihood for parents without substance abuse problems.
- Age, custody, ethnicity, maltreatment type, gender, child previously removed, and overall number of services ordered did not have a significant effect upon successful reunification.

IMPLICATIONS OF STUDY FINDINGS FOR CHILD WELFARE PRACTICE

Study findings related to the effectiveness of reunification services, combined with information from the research literature review in this area, suggest a number of implications for practice:

- Parents with the serious problems of substance abuse and domestic violence can greatly increase the likelihood of reunification by utilizing services. It is the utilization of services that appears to be more important that the existence of any particular problem. *Existence of these problems should not be seen as evidence the parent cannot or will not reunify; social workers should do everything possible to support parental engagement and full participation in services.*
- Parents with substance abuse problems have a higher service burden than other parents. Requiring them to attend individual counseling in addition to substance abuse treatment, orientation, and parenting classes may result in their being overloaded, and their overall reunification efforts hampered rather than helped. *Social workers should take care not to overload parents with substance abuse problems with multiple simultaneous services. If individual counseling is determined to be necessary, social workers should consider delaying parents'*

requirement to participate until substance abuse treatment has been completed, and the service burden is somewhat reduced.

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SECTION V

SUMMARY EXERCISE

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SECTION V
SUMMARY EXERCISE

INSTRUCTIONAL GUIDE

Learning Objectives

This section provides an opportunity to integrate and review the material on FR services covered in the first four sections. For a change of pace, the PPT is presented in a *Jeopardy* game format.

By the end of this section, participants will:

- Understand the current state of reunification services in relation to it's historical context,
- Be familiar with current California mandates regarding reunification,
- Hold empirically based knowledge relating to improving reunification service utilization and effectiveness,
- Understand that this is an evolving body of knowledge and commit to staying abreast of evidence-based information in the service of best practice.

Public Child Welfare Competencies

Since this module integrates material from the first four sessions, the MSW and BSW competencies cited in the previous modules should be considered targets of this session as well.

Agenda and Suggestions for Instructors

- Time allocation: Approximately 1 hour
- Divide the class into two teams. Some instructors enjoy allowing teams to choose a relevant team name.
- Follow the PPT slides for the Jeopardy Game; actual Jeopardy rules need not be followed.

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- Wrap-up Discussion; goodbyes if relevant
- Request completion of generic feedback form, if desired.

Materials Needed

- PowerPoint Slides for Section V and necessary projection equipment
- Blackboard, dry erase board, or flip chart tablet is recommended for score keeping (along with appropriate writing tools)
- Copies of Jeopardy answers for students after game, if desired
- Copies of feedback form, if desired

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ACTIVITIES AND HANDOUTS

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CALIFORNIA BYPASS CRITERIA

California extended the number of reunification exceptions used in the state to 15 from the original 5 listed under the federal Adoption and Safe Families Act legislation. Any one of the following bypass criteria can be used in California to deny family reunification services:

1. Parents whereabouts unknown;
2. Mental disability rendering parent incapable of making use of services;
3. Child or sibling removed from parent due to physical or sexual abuse and returned again, and now being removed again for physical or sexual abuse;
4. Parent caused another child's death through abuse or neglect;
5. Child made a dependent due to 300 (e) [under five and suffered severe physical abuse;
6. Child or sibling suffered severe sexual or physical abuse;
7. Child conceived by rape (applies only to the perpetrator);
8. Child has been willfully abandoned and endangered;
9. Sibling did not receive reunification services due to #3, #5, or #6;
10. Termination of parent rights ordered for sibling or half-sibling, and parent has not made reasonable efforts to treat problems;
11. Reunification services have been terminated for sibling or half-sibling because parent failed to reunify, and parent has not made reasonable efforts to treat problems;
12. Parent convicted of a violent felony;
13. Extensive, abusive, chronic history of substance use, and has resisted treatment within last 3 years, or failed case plan compliance for substance abuse treatment twice;
14. Parent has advised court wants no services nor to have child returned; or
15. Parent willfully abducted child, sibling or half-sibling and refuses to disclose whereabouts or return child.

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TRUE/FALSE HANDOUT

In groups of 2-4, discuss these statements and decide if they are true or false. The statements refer to implications for child welfare practice based on the information presented in this family reunification (FR) module. If the statement is false, write a true statement underneath it in the space provided.

True	False		Statement
T	F	1	Formalized federal funding for FR services began in the early 1900s with the Children's Aid Society.
T	F	2	Mandates to make reasonable FR efforts did not begin until 1980 AACWA (Adoption Assistance & Child Welfare Act).
T	F	3	Historically, U.S. policy and legislation has always stressed FR over child safety, adoption, and other permanent placements.
T	F	4	With ASFA (Adoption and Safe Families Act), emphasis seems to be on adoption and expedited permanency rather than the provision of comprehensive services to parents.
T	F	5	Some bypass criterion are very objective, while others are more subjective, making it hard to monitor their local, state, and national implementation.
T	F	6	Wide variations in implementation of ASFA exist, and there are few efforts to track these and their impact on FR.
T	F	7	Reliable poor prognosis indicators have been identified to help child welfare workers make decisions about FR, particularly in cases relating to substance abuse and severe parental mental illness.
T	F	8	Under California law, children ≥ 3 years old have 12 months of FR services, while children < 3 years old have 6 months of FR services (case-by-case exceptions).
T	F	9	Child welfare workers, judges, and agencies have little impact on the implementation of ASFA or related state legislation, since the policies are law.
T	F	10	Concurrent planning refers to the practice mandated by ASFA of creating a state plan at the same time the worker is creating a local/county plan for a case.

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SERVICE DESCRIPTION HANDOUT
FIND THE FALSE STATEMENTS!

Common FR services are listed below with their characteristics. For each service type, **one** item is not correct. Try to find the false statements. Mark the answer for group discussion.

I. Parent Training

1. Educational, sometimes with clinical components; usually in the form of a class
2. Teaches parents child development and positive parenting strategies, in context of common challenges
3. Most frequently ordered service for parents who have had children removed
4. Wide variation in target audience—some for parents with removed kids, others just to teach general skills
5. Concern in field over lack of consistency and limited research on effectiveness
6. Concern that didactic interventions may not work well for many parents who have not graduated from high school or who have learning challenges
7. Many classes address complex issues (fighting, oppositional behavior, marital conflict, communication, coping, and problem-solving skills
8. Format varies but often 10-20 sessions, 1-2 hours once a week
9. Classes refrain from using homework or role-playing since most participants are court mandated and compliance with work outside the class is usually not completed; similarly parents are resistant to role-plays

II. Substance Abuse

1. Generally clinical in nature and focus on the parent's problems with drugs and/or alcohol.
2. Effectiveness of substance abuse services within FR plans is critical, since parental substance abuse within child welfare cases is linked to an increased likelihood of reentry into the child welfare system
3. Parental substance abuse in the child welfare system is common, as are orders to attend treatment
4. May require attendance at 12-step meetings, such as Alcoholics or Narcotics Anonymous, which are self-help recovery groups. View addiction from a medical model as a disease over which one has little control. Participants typically linked with a "sponsor" who assists them in abstaining from drug or alcohol use
5. May also require out-patient or residential treatments which have various philosophies

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6. Growing awareness that effective services should be gender-specific
7. Services for mothers are often woman-centered and address relationship and family issues, and past trauma
8. Outpatient services may include psycho-educational or support groups and individual therapy sessions
9. Residential services include these elements, but more intensive, while parent lives in the treatment facility
10. For children who have NOT been removed from the mother's care, arrangements can easily be made for them to stay in the residential facility with her while she undergoes detoxification and treatment
11. Case plans typically include orders for random drug testing

III. Domestic Violence

1. Include both clinical and educational components
2. Joint services for perpetrator and the victim (survivor), such that sessions are held together
3. Most interventions focused on the mother also integrate a child and parenting component
4. For perpetrators, the Duluth model of batterer intervention programs is widely used; assumes issues of control and entitlement underlie DV and encourages awareness of controlling attitudes; didactic education teaches batterers alternative ways of interacting with their partners
5. Other models and adaptations of Duluth use cognitive behavioral work to address thinking and anger management
6. Batterers' services are generally outpatient; last anywhere from 20-52 weeks, once a week for 1-2 hours
7. Services for victims (survivors) typically focus on providing support, while educating women on the cycles of abuse, the process of healing, and skills to maintain their safety and well-being
8. Victim services are generally outpatient and can be time limited from 10 weeks to ongoing

IV. Mental Health

1. Services for parents may include outpatient individual counseling, marital counseling, family therapy or linkages with assessment, and support for psychiatric medications
2. While these services can be on case plans, they must be optional. Courts cannot mandate mental health care
3. Limited information on the specific nature of these services and their effectiveness
4. Growing awareness that many parents with co-occurring mental health and substance abuse problems have significant trauma histories; example: for

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women in substance abuse treatment, childhood abuse, sexual abuse, and experiences of violence are common (Clark, 2001; Dore & Dorris, 1998; Miller, Downs, & Gondoli, 1989)
5. Some movement toward integrating trauma-recovery services in mental health and substance abuse services
6. Research suggests PTSD symptoms can worsen once sobriety is achieved (Najavits, 2007)
7. Trauma-recovery services generally integrate a cognitive-behavioral approach
8. Many curriculum-based trauma programs incorporate substance abuse components within a gender-specific framework; tend to be psycho-educational, and focus on trauma effects, and strategies to address symptoms and maintain sobriety (Najavits, 2007)

V. Family Team Meetings:

1. Include meetings such as *family group conferencing, family group decision making, and team decision making*
2. FR service that creates a structure for professionals to share information about a case and for families to have input into their own case plan and placement decisions for the child
3. Family group conferencing developed in New Zealand and legislation mandating its use in New Zealand was passed in 1989
4. A review of outcomes from the first Child and Family Service Reviews indicated that a number of states use some type of family team meeting
5. Overall goal is to bring together parents, family members, alternative caregivers, service providers, and others involved in the case to share assessment information (including family strengths and challenges), develop case plans, identify placements for children, and monitor progress
6. Family team meetings are intended to empower parents, create “buy-in” for their case plan, and facilitate cooperation and collaboration among the child welfare system, service providers, and families
7. Most states wait to have the family team meeting just prior to case termination, as it has proved to be too difficult to pull all parties together earlier than that

VI. Children’s Mental Health:

1. Fortunately, few children in the child welfare system experience mental health challenges
2. Children’s mental health problems have been linked to a reduced likelihood of FR, as well as an increased likelihood of maltreatment recurrence and reentry into care (Jones, 1998; Davis et al., 1996).

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3. Influence of child's mental health on case may result from the impact a child's emotional and behavioral status has on caseworker decisions to reunify a family
4. Effort to prevent the worsening of psychological problems among children--reunification decisions may be made more cautiously
5. Emotional and behavioral problems among children may be considered an indicator of a more problematic family situation and thus, may reduce the likelihood of reunification
6. Interventions that address mental health problems of children have the potential to increase reunification (Davis et al., 1996)
7. Limited information is available on specific mental health treatment used for children in the child welfare system
8. Two recent studies of public mental health service use among children in Santa Clara County's child welfare system found outpatient treatment is most common, including individual, group, and family therapy, and the use of psychiatric medications (Hines et al., 2006, 2007).
9. Other interventions might include residential or inpatient services, or comprehensive models that integrate services to parents, alternate caregivers, and the child; or wraparound services with cross-system collaboration

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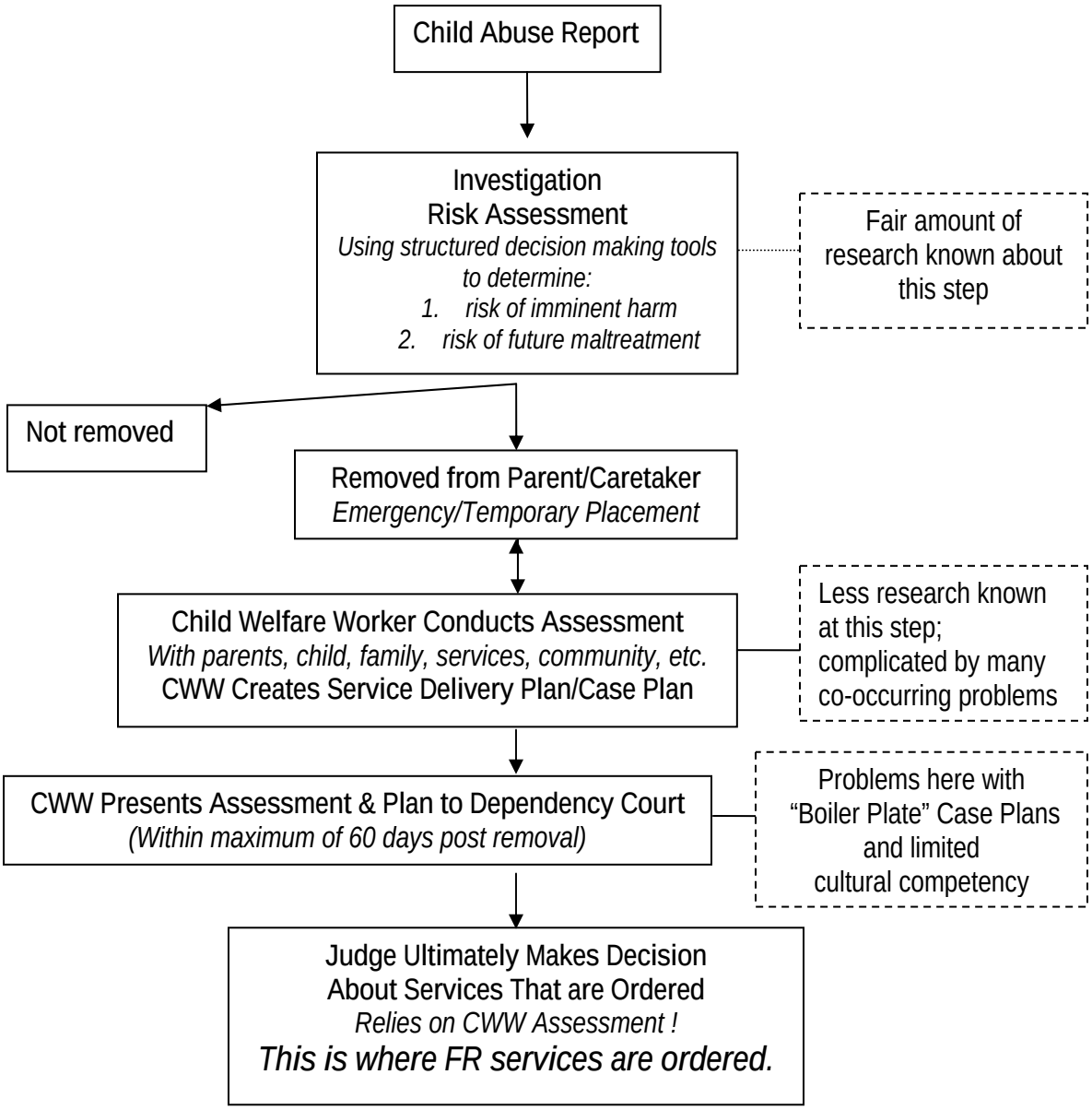
FLOW CHART

Series of Steps Before Family Reunification Services With notations on research knowledge base of critical steps)



A THOROUGH ASSESSMENT PROCESS IS INTENDED TO LEAD TO AN INTEGRATED SERVICE PLAN, ONGOING CASE MANAGEMENT, AND REGULAR REASSESSMENTS.

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CALIFORNIA CASE PLAN CONTENTS FOR CHILD RECEIVING FR

The California Welfare and Institutions Code 16501.1 (www.leginfo.ca.gov) states that the following must be included in a case plan for a child receiving FR services:

- An assessment of the circumstances that required child welfare services intervention
- Specific goals and the appropriateness of the planned services in meeting those goals
- The original allegations of abuse or neglect, or the conditions cited as the basis for declaring the child a dependent of the court, and the other precipitating incidents that led to child welfare services intervention
- A description of the schedule of the social worker's contacts with the child and the family or other caretakers
- When out-of-home services are used, the frequency of contact between the natural parents or legal guardians and the child
- When out-of-home placement is made, the provisions made for the development and maintenance of sibling relationships
- If out-of-home placement is made in a foster family home, group home, or other childcare institution that is either a substantial distance from the home of the child's parent or out of State, the reasons why that placement is in the best interest of the child
- If out-of-home services are used, or if parental rights have been terminated and the case plan is placement for adoption, a recommendation regarding the appropriateness of unsupervised visitation between the child and any of the child's siblings
- If out-of-home services are used and the goal is reunification, a description of the services to be provided to assist in reunification and the services to be provided concurrently to achieve legal permanency if efforts to reunify fail
- If out-of-home services are used, the child has been in care for at least 12 months, and the goal is not adoptive placement, documentation of the compelling reason or reasons why termination of parental rights is not in the child's best interest
- If the case plan has as its goal for the child a permanent plan of adoption or placement in another permanent home, documentation of the steps the agency is taking to find an adoptive family or other permanent living arrangement for the child; to place the child with an adoptive family, an appropriate and willing relative, a legal guardian, or in another planned permanent living arrangement; and to finalize the adoption or legal guardianship
- When appropriate, for a child who is 16 years of age or older, a written description of the programs and services that will help the child, consistent with the child's best interests, prepare for the transition from foster care to independent living
- When a child who is 10 years of age or older has been in out-of-home placement in a group home for 6 months or longer, an identification of individuals, other than the child's siblings, who are important to the child and actions necessary to maintain the child's relationship with those individuals, provided that those relationships are in the best interest of the child

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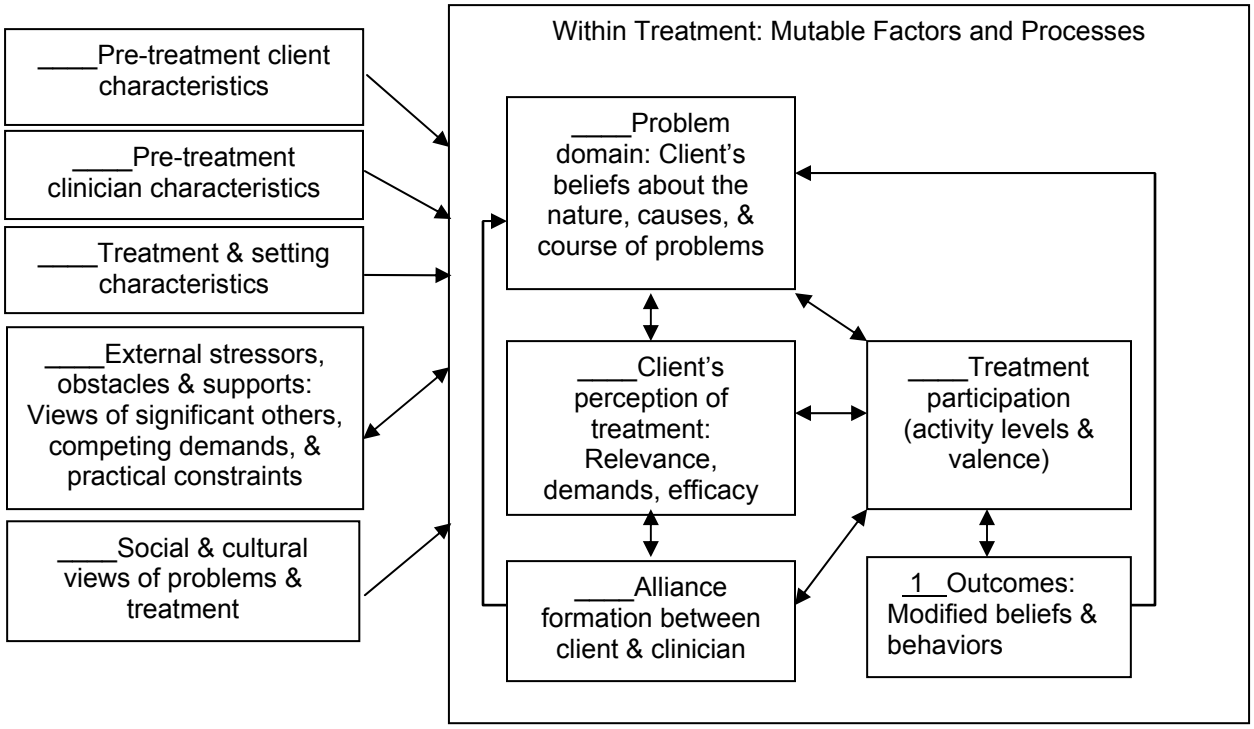
Treatment Participation Model
Matching Activity

This model can be used to understand the various factors that influence service use. First, take a moment to review the model. Next, match the example statements below to the appropriate box in the model. Number 1 is already matched with the "Outcome" box, as an example.

A conceptual model of treatment participation (Littell et al., 2001)



1. Client's positive experience with mental health services and seeing that medication helped her depression
2. A grandmother's belief that the RF services ordered for her were too many and too overwhelming
3. Court ordered, involuntary services for a batterer
4. A father's believes the child welfare worker is "in his corner" and has his and his child's best interests at heart
5. Caucasian male MSW with unresolved abuse issues in his own past history
6. A parent complies with all ordered services and even with assigned counseling homework
7. General distrust of child welfare by communities of color due to historical oppression and racist interventions
8. Non-English speaking, Laotian woman with history of DV with 6-month-old baby in child welfare system
9. Lack of transportation to court-ordered Alcoholics Anonymous meetings
10. A mother's belief that she can learn new ways to parent and break her family cycle of physical abuse

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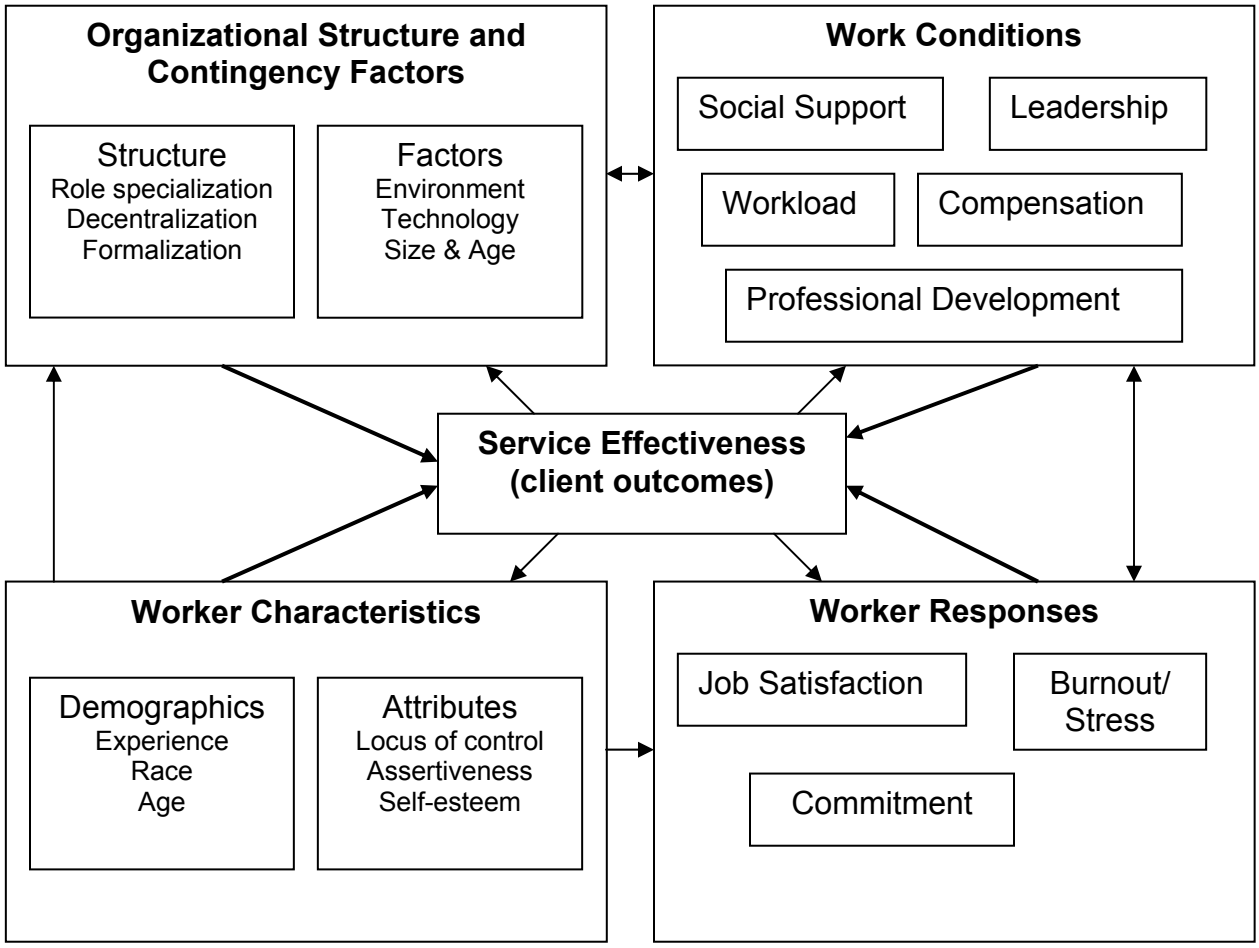
ORGANIZATIONAL CONSTRUCTS AND SERVICE EFFECTIVENESS
(Yoo, Brooks, & Patti, 2007)

This model illustrates the interaction between organizational structure and contingency factors, work conditions, worker characteristics, and worker responses and how all of these impinge upon service outcomes.

A Conceptual Framework of Organizational Constructs of Predictors of Service Effectiveness



Activity

1. Brainstorm a situation that would promote poor service effectiveness
2. Brainstorm a situation that would promote ideal service effectiveness

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FR Service Program Examples

Cut out each program as an individual card, and distribute to individuals or groups in the class to discuss and then briefly present the highlights.

Parent Training: The Incredible Years

(Scientific rating of 1, well supported by the research literature). This intervention includes components for parents, teachers, and children and is designed to address problem behaviors in children by increasing parenting skills. A psycho-educational curriculum is used with parents to develop communication skills, coping skills, positive discipline, and problem-solving skills. Services directed toward children focus on encouraging social development and reducing conduct problems. Experimental studies have linked this intervention to improved parenting skills (Baydar et al., 2003; Reid et al., 2004).

Parent Training: Multi-systemic therapy

(No scientific rating on the CEBC website, but identified by Barth et al. (2005) as a leading evidence-based parent training program). This intervention is family-focused and strength-based and seeks to provide comprehensive (usually home-based) services that draw on cognitive-behavioral approaches, linkages to resources in the community, and case management. Experimental studies examining the impact of this intervention among populations of youth with mental health problems has found some support for positive outcomes, however, follow-up studies suggest that positive changes may not be sustained over time (Henggeler et al., 2003).

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Parent Training: **Oregon Social Learning Center's Parent Management Training**

(No scientific rating by the CEBC, but identified by Barth et al. as a leading evidence-based parent training program). This psycho-educational intervention is delivered in a group format and focuses on positive discipline strategies, positive reinforcement, monitoring, and problem-solving strategies. Most research on this intervention has examined its effectiveness on addressing child mental health problems, and there is evidence indicating its effectiveness in this domain (Costin & Chambers, 2007)

Parent Training: **Parent-Child Interaction Therapy**

(Scientific rating of 1, well supported by the research literature). This intervention includes observation of parent and child interactions by a clinician through a one-way mirror during which the clinician coaches the parent on parenting strategies through a microphone in the parent's ear. Both child-directed and parent-directed skills are taught in the experiential settings. Although PCIT was designed to address behavioral and emotional problems among children, one experimental study did test the effectiveness of this intervention in reducing further abuse reports among a sample of parents with a substantiated physical abuse incident, suggesting that this parent training intervention may be effective in addressing physically abusive parenting behaviors (Chaffin et al. 2004).

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Parent Training: Triple P Positive Parenting Program

(Scientific rating of 1, well supported by the research literature). This intervention includes a number of multiple-faceted services. Parent training sessions are differentiated by the developmental stage of the child and use a self-regulatory framework to encourage self-sufficiency, self-efficacy, and problem-solving skills of parents. The specific aspects of the intervention are intended to be tailored to the needs of each family. Most experimental studies on this intervention have been conducted in Australia and results link the intervention to improvements in parenting skills and reductions in child behavioral and emotional problems (Bor et al., 2002; Sanders et al., 2000).

Parent Training: 1, 2, 3 Magic

(Scientific rating of 2, supported by research evidence). This intervention is directed toward parents of children ages 2–12 and focuses on three essential components: a) eliminating and controlling negative child behaviors, b) encouraging positive child behaviors, and c) strengthening the parent-child relationship. The intervention is psycho-educational in nature with one to two sessions per week for 4-8 weeks and is delivered in a group format. One experimental study conducted in Canada found improvements in parenting and child behavior associated with the intervention (Bradley et al., 2003).

Substance Abuse Services: Motivational Interviewing

(Scientific rating of 1, indicating that it is well-supported by the research evidence). Motivational interviewing includes clinical strategies designed to increase parents' motivation to enter treatment and stop using drugs or alcohol and has been linked to positive outcomes **(**Hettema et al., 2005).

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Substance Abuse Services: Alcoholics Anonymous

(Scientific rating of 3, indicating that it has promising research evidence). Alcoholics Anonymous is a well known substance abuse intervention based on self-help principles in which participants support one another by working through a series of 12 steps to address their substance abuse. There is not consistent evidence on the effectiveness of Alcoholics Anonymous; some studies report positive effects, others find little effect (Kownacki & Shadish, 1999).

Domestic Violence Services Batterers: AMEND, Inc. (Abusive Men Exploring New Directions)

(Scientific rating of 3, indicating promising research evidence). This intervention includes a psycho-educational group format designed to eliminate abusive behaviors, increasing awareness and education among perpetrators of domestic violence. In non-experimental studies, this intervention is linked with reduced likelihood of domestic violence (Jones et al., 2004).

Substance Abuse Services: Community Reinforcement + Vouchers Approach

(Scientific rating of 2, indicating that it is supported by the research evidence). This intervention includes a comprehensive package of services that are behavioral interventions (counseling, vocational training, coping skills, social and recreational activities) designed to support and reinforce sobriety, as well as a contingency management approach where participants can earn vouchers to purchase products in the community as a reinforcement for staying in treatment and remaining sober. This intervention has been linked with increased retention in services and greater duration of sobriety (Higgins et al., 1995). A community reinforcement approach that does not include vouchers was rated with a scientific rating of 3, indicating that it has promising research evidence (Smith et al., 2001).

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Domestic Violence Services Batterers: **Domestic Abuse Intervention Project**

(Scientific rating of 3, indicating promising research evidence). This intervention is the founding program based on the Duluth model of batterer interventions and includes a 28-week psycho-educational program for batterers (many of whom are court-ordered to attend), as well as a Coordinated Community Response that includes efforts to improve interagency collaboration and community responses to domestic violence. Non-experimental studies link this intervention to a reduced likelihood of re-assault (Taylor et al., 2001).

Domestic Violence Services Victims and Children: **Project SUPPORT**

(Scientific rating of 2, indicating that it is supported by the research evidence). This intervention focuses on providing concrete and emotional support to women who have entered emergency housing at domestic violence shelters, as well as training in parenting skills to address behavior problems in children. The intervention is home-based and is focused on supporting women transitioning home from the shelter; it is designed to be delivered weekly for 1-1½ hours for 26 weeks. Experimental research found support for the intervention in improving parenting and child behavior and these effects have been maintained at a 2-year follow-up, although differences in rates of re-abuse were not statistically different between the two groups (Jouriles et al., 2001; McDonald et al., 2006).

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Domestic Violence Services Victims and Children: **Child-Parent Psychotherapy for Family Violence**

(Scientific rating of 2, indicating that it is supported by the research evidence). This intervention is focused on recovery from trauma and improvements in child-parent relationships and interactions through the use of a psychodynamic therapeutic approach delivered weekly for approximately 50 weeks. Results of experimental studies with children who have witnessed domestic violence, and their mothers, suggest that the intervention is effective in reducing mental health problems among mothers and improving child behavior **(**Lieberman et al., 2006; Lieberman et al., 2005).

Domestic Violence Services Victims and Children: **The Community Advocacy Project**

(Scientific rating of 2, indicating that it is supported by the research evidence). This intervention focuses on supporting women who have experienced domestic violence through the use of advocacy services to help women and children obtain resources and support in this process. Services are both home-based and community-based and are delivered 4-6 hours per week for 10 weeks. Experimental studies link the intervention with a reduced likelihood that women will experience domestic violence, as well as improvements in quality of life—however follow-up studies suggest comparable rates of re-abuse 3 years post-intervention (Bybee & Sullivan, 2002, 2005).

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Domestic Violence Services Victims & Children: **Kids Club and Moms Empowerment** (Scientific rating of 3, promising research evidence). This intervention includes two components. Kids Club, which is designed to increase children's knowledge of domestic violence and their own reactions to it, is delivered in a small group format for children ages 6-12. Moms Empowerment is a group parent training intervention that provides support to mothers and focuses on improving parenting skills. The groups meet concurrently for 1 hour for 10 weeks. One quasi-experimental study of this intervention that included some children and mothers involved in child welfare found reductions in child behavior problems (Graham-Bermann et al., in press).

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APPENDIXES

Vugia, H., Osterling, K. L., & D'Andrade, A. (2009). *The relationship between reunification services, service utilization, and successful reunification.* Berkeley: University of California at Berkeley, California Social Work Education Center.

Table 2-1: Proportion of Parents Offered Services

	SC (n = 277) %	CWR (n = 1888) %
Whole Sample	81.2	70.1
Gender (SC***; CWR***)		
Mother	95.8	88.0
Father	65.7	52.1
Custodial (SC***; CWR***)		
Yes	97.2	89.6
No	53.5	35.7
Gender (CWR***) (Non-custodial parents)	(n = 176)	(n = 678)
Yes	62.5	63.2
No	52.7	31.6

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

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Table 2-2: Proportion of Parents Ordered to Each Service Type

Service	SC (n = 225) %	CWR (n = 1323) %	
Any Parenting Service	92.9	82.3	
Basic	57.3		
Advanced	7.1		
Parenting without violence	26.2		
Other type	17.8		
Any Domestic Violence Service	42.2	22.4	
DV assessment	6.7		
Batterers program	12.0	19.8	(batterers or victims)
Victims program	25.3		
Anger management	4.0	3.9	
Any Substance Abuse Service	78.2	73.4	
Substance abuse assessment	64.0		
Testing	76.4	70.7	
Inpatient	17.8		(inpatient, outpatient, or 12 step)
Outpatient	42.7	67.6	
12-Step program	65.8		
Aftercare program	19.6		
Other type	7.1		
Any Psychological/Counseling Service	83.1	63.1	
Psychological evaluation	18.2	7.4	
Individual counseling	77.8	55.0	
Medication/Med management	6.7		
Family therapy	8.4	13.8	
Group	1.3	8.2	
Couples	1.8	0.6	
General			
Orientation	34.7		
Visitation	93.8	81.5	
Other service	4.9	8.2	

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Table 2-3: Service Type Patterns

	SC		CWR	
	#	%	#	%
Pattern 1: C & P (no SA or DV)	30	13.3	276	20.9
Pattern 2: SA no DV	97	43.1	751	56.8
Pattern 3: DV no SA	16	7.1	76	5.7
Pattern 4: DV and SA	79	35.1	220	16.6
Not available	3	1.3	0	0.0
Total	225	99.9	1323	100.0

Table 2-4: Number of Services Ordered

	SC		CWR	
	#	%	#	%
3 or fewer services	14	6.2	371	28.0
4-6 services	70	31.1	874	66.1
7-9 services	112	49.8	78	5.9
10 or more services	29	12.9	0	0.0
Total	225	100.0	1323	100.0

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Table 2-5: Attendance Required per Week by Service (SC)

Service	#	%
Visitation	211	100.00
Once or less per week	61	28.9
Twice per week	99	46.9
Three or more times per week	2	0.9
Unknown/Unable to determine	49	23.2
Drug Testing	172	100.00
Once or less per week	29	16.9
Twice per week	120	69.8
Three or more times per week	6	3.5
Unknown/Unable to determine	17	9.9
12-Step Meeting Attendance	148	100.0
Once or less per week	10	6.8
Twice per week	56	37.8
Three or more times per week	53	35.8
Unknown/Unable to determine	29	19.6

Table 2-6: Average Number of Service by Service Type Pattern

	SC	CWR
Pattern 1: C & P only (no SA or DV)	4.2	2.5
Pattern 2: SA no DV	7.1	4.4
Pattern 3: DV no SA	5.4	4.1
Pattern 4: DV and SA	8.6	5.8

SC: ANOVA F 58.606, p<.001; Bonferroni for P1-P2, P1-P4, P2-P4 p<.001
CWR: ANOVA F 379.550, p<.001; Bonferroni for P1-P2, P1-P3, P1-P4, P2-P4, P3-P4 p<.001.

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Table 2-7: Average Number of Services by Parental Characteristics

	SC		CWR	
	#	mean	#	mean
Gender (SC***; CWR**)				
Mother	137	7.5	831	4.4
Father	88	6.2	492	3.9
Language (SC***)				
English	197	7.3	1231	4.2
Spanish/Other	21	5.7	82	4.0
Custody (SC***;				
Yes	171	7.4	1070	4.3
No	54	5.8	242	3.7
Ethnicity (SC*; CWR***)				
African American	17	6.9	239	3.9
Asian/Pacific Islander	11	5.2	99	4.0 (& Native Amer.)
Hispanic/Latino	116	7.3	270	4.2
Native American	5	7.0		
White	69	7.0	643	4.4
Substance Abuse Problem(SC***; CWR***)				
Yes	142	8.1	730	4.6
No	82	5.3	593	3.7
Domestic Violence Problem (SC***; CWR***)				
Yes	68	8.3	258	4.8
No	154	6.5	1065	4.1
Mental Health Problem (SC**)				
Yes	44	7.9	167	4.4
No	179	6.8	1156	4.2
Physical Abuse				
Yes	23	6.4	164	4.4
No	202	7.1	1159	4.2
Neglect (SC***; CWR**)				
Yes	82	7.7	847	4.4
No	143	6.8	476	3.8
Emotional Maltreatment (CWR***)				
Yes	19	6.8	392	4.6
No	206	7.0	931	4.1
Failure to Protect			(not available	
Yes	41	6.6	in dataset)	
No	184	7.1		

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

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Table 2-8: Percentage of Parents Ordered to Parenting Class/Education

	SC		CWR	
	#	%	#	%
Total sample	225	92.9	1323	82.3
Gender (CWR**)				
Mother	137	94.9	831	84.6
Father	88	89.8	492	78.5
Ethnicity (CWR*)				
African American	17	94.1	239	84.1
Asian/Pacific Islander	11	100.0	99	73.7 (and Native American)
Hispanic/Latino	117	94.8	270	84.4
Native American	5	80.0		
White	69	88.4	643	81.2
Language				
English	197	92.4	1231	82.2
Spanish/Other	21	100.0	82	82.9
Custody (CWR***)				
Yes	171	94.7	1070	84.5
No	54	87.0	242	73.6
Mental Health Problem				
Yes	44	93.2	167	84.4
No	179	93.3	1156	82.0
Substance Abuse Problem				
Yes	142	94.4	730	83.6
No	82	91.5	593	80.8
Domestic Violence Problem (CWR*)				
Yes	68	95.6	258	87.6
No	154	92.2	1065	81.0
Physical Abuse				
Yes	23	95.7	164	82.3
No	202	92.6	1159	82.3
Neglect (CWR*)				
Yes	82	92.7	847	83.9
No	143	93.0	476	79.4
Emotional Maltreatment				
Yes	19	94.7	392	83.4
No	206	92.7	931	81.8
FailureTo Protect				
Yes	41	95.1	(not available	
No	184	92.4	in dataset)	

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

Vugia, H., Osterling, K. L., & D'Andrade, A. (2009). *The relationship between reunification services, service utilization, and successful reunification.* Berkeley: University of California at Berkeley, California Social Work Education Center.

Table 2-9: Percentage of Parents Ordered to Domestic Violence Services

	SC		CWR		
	#	%	#	%	
Total sample	225	42.2	1323	22.4	
Gender (CWR***)					
Mother	137	45.3	831	19.1	
Father	88	37.5	492	27.8	
Ethnicity (CWR**)					
African American	17	52.9	239	13.4	
Asian/Pacific Islander	11	36.4	99	27.3	(and Native American)
Hispanic/Latino	117	45.7	270	24.8	
Native American	5	40.4			
White	69	34.8	643	23.2	
Language (CWR*)					
English	197	42.6	1231	21.8	
Spanish/Other	21	42.9	82	31.7	
Custody					
Yes	171	44.4	1070	22.2	
No	54	35.2	242	23.1	
Mental Health Problem					
Yes	44	38.6	167	18.6	
No	179	43.6	1156	22.9	
Substance Abuse Problem					
Yes	142	45.8	730	22.2	
No	82	36.6	593	22.6	
Domestic Violence Problem (SC***; CWR***)					
Yes	68	85.3	258	58.1	
No	154	24.0	1065	13.7	
Physical Abuse (CWR***)					
Yes	23	43.5	164	32.3	
No	202	42.1	1159	21.0	
Neglect					
Yes	82	42.7	847	20.9	
No	143	42.0	476	25.0	
Emotional Maltreatment (CWR***)					
Yes	19	31.6	392	37.5	
No	206	43.2	931	16.0	
Failure To Protect					
Yes	41	43.9	(not available		
No	184	41.8	in dataset)		

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

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Table 2-10: Percentage of Parents Ordered to Substance Abuse Services

	SC		CWR	
	#	%	#	%
Total sample	225	78.2	1323	73.4
Gender (CWR***)				
Mother	137	80.3	831	77.7
Father	88	75.0	492	66.1
Ethnicity (SC***; CWR***)				
African American	17	88.2	239	72.8
Asian/Pacific Islander	11	18.2	99	71.7 (and Native American)
Hispanic/Latino	117	83.6	270	68.1
Native American	5	100.0		
White	69	76.8	643	75.9
Language (SC***; CWR***)				
English	197	84.8	1231	74.8
Spanish/Other	21	28.6	82	48.8
Custody (CWR***)				
Yes	171	78.9	1070	76.2
No	54	75.9	242	61.2
Mental Health Problem				
Yes	44	81.8	167	70.7
No	170	77.7	1156	73.8
Substance Abuse Problem(SC***;CWR***)				
Yes	142	100.0	730	96.2
No	82	41.5	593	45.4
Domestic Violence Problem (SC**;				
Yes	68	89.7	258	77.1
No	154	74.0	1065	72.5
Physical Abuse(SC*; CWR***)				
Yes	23	60.9	164	61.0
No	202	80.2	1159	75.2
Neglect (SC**; CWR***)				
Yes	82	89.0	847	83.1
No	143	72.0	476	56.1
Emotional Maltreatment (CWR*)				
Yes	19	63.2	392	77.6
No	206	79.6	931	71.6
Failure To Protect (SC***)				
Yes	41	56.1	(not available	
No	184	83.2	in dataset)	

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

Vugia, H., Osterling, K. L., & D'Andrade, A. (2009). *The relationship between reunification services, service utilization, and successful reunification.* Berkeley: University of California at Berkeley, California Social Work Education Center.

Table 2-11: Percentage of Parents Ordered to Counseling or Psychological Services

	SC		CWR		
	#	%	#	%	
Total sample	225	83.1	1323	63.3	
Gender (SC**; CWR***)					
Mother	137	89.8	831	68.1	
Father	88	72.7	492	54.7	
Ethnicity (CWR***)					
African American	17	76.5	239	46.4	
Asian/Pacific Islander	11	81.8	99	58.6	(and Native American)
Hispanic/Latino	117	81.0	270	66.7	
Native American	5	100.0			
White	69	88.4	643	68.1	
Language					
English	197	83.2	1231	68.3	
Spanish	21	90.5	82	63.0	
Custody (SC***; CWR***)					
Yes	171	91.2	1070	66.2	
No	54	57.4	242	50.2	
Mental Health Problem (SC***; CWR***)					
Yes	44	100.0	167	77.2	
No	179	79.3	1156	61.1	
Substance Abuse Problem					
Yes	142	80.3	730	61.1	
No	82	82.9	593	65.6	
Domestic Violence Problem (CWR*)					
Yes	68	88.2	258	69.4	
No	154	81.2	1065	61.6	
Physical Abuse (CWR**)					
Yes	23	95.7	164	73.8	
No	202	81.7	1159	61.6	
Neglect (SC*)					
Yes	82	90.2	847	64.6	
No	143	79.0	476	60.5	
Emotional Maltreatment (CWR***)					
Yes	19	89.5	392	70.7	
No	206	82.5	931	59.9	
Failure To Protect					
Yes	41	92.7	(not available		
No	184	81.0	In dataset)		

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

Vugia, H., Osterling, K. L., & D'Andrade, A. (2009). *The relationship between reunification services, service utilization, and successful reunification.* Berkeley: University of California at Berkeley, California Social Work Education Center.

Table 3-1: Utilization of Services Ordered by Service Type

Service	SC #	SC %	CWR #	CWR %	
Parenting Service			939	49.3	
Basic	113	63.7			
Advanced	13	84.6			
Parenting without violence	55	58.2			
Other type	34	64.7			
Domestic Violence Service			223	39.0	
DV assessment	11	63.6			
Batterers program	23	21.7			
Victims program	54	61.1			
Substance Abuse Service					
Substance abuse assessment	104	76.0			
Testing	158	41.8	839	37.3	
Inpatient	36	66.7	803	38.0	(all forms
Outpatient	90	56.7			treatment)
12-Step Program	132	53.8			
Aftercare program	21	52.4			
Psychological/Counseling Service					
Psychological evaluation	37	86.5	80	71.2	
Individual counseling	153	56.2	631	46.8	
Medication/Med management	11	81.8			
Family	13	100.0	160	51.2	
General					
Orientation	61	77.0			
Visitation	198	64.5	1013	51.9	

Table 3-2: Categories of Use (Utilization Scores)

Proportion of Services With Which Parent Fully Complied	SC n	SC %	CWR n	CWR %
1 None	37	16.4	488	36.9
2 01% - 49%	44	19.6	175	13.2
3 49%-99%	55	24.4	153	11.6
4 All	77	34.2	428	32.4
Missing	12	5.3	79	6.0
	225	99.9	1323	100.1

Vugia, H., Osterling, K. L., & D'Andrade, A. (2009). *The relationship between reunification services, service utilization, and successful reunification.* Berkeley: University of California at Berkeley, California Social Work Education Center.

Table 3-3: SC: Average Utilization Score by Parental Characteristic

	SC		CWR	
	n	Mean	#	Mean
Gender (CWR***)				
Mother	133	2.87	800	2.51
Father	80	2.70	444	2.25
Language (CWR**)				
English	186	2.78	1161	2.39
Spanish/Other	21	3.10	77	2.83
Custodial Status (CWR***)				
Yes	165	2.88	1021	2.49
No	48	2.54	213	2.05
Ethnicity				
African American	15	2.47	217	2.23
Asian/Pacific Islander			91	2.42 (and Native American)
Hispanic/Latino	113	2.79	253	2.46
Native American				
White	65	2.92	615	2.48
Substance Abuse Problem (SC*; CWR***)				
Yes	138	2.69	694	2.22
No	75	3.03	550	2.67
Domestic Violence Problem (SC**)				
Yes	66	2.49	251	2.42
No	146	2.95	993	2.42
Mental Health Problem				
Yes	41	3.02	159	2.50
No	171	2.75	1085	2.41
Neglect (CWR**)				
Yes	79	2.96	805	2.33
No	134	2.72	439	2.58
Physical Abuse (CWR***)				
Yes	23	2.83	156	2.76
No	192	2.80	1088	2.37
Emotional Maltreatment				
Yes	19	2.58	370	2.47
No	196	2.83	874	2.40
Failure to Protect				
Yes	41	3.02	(not available	
No	174	2.75	in dataset)	

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

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Table 3-4: Average Parental Age by Utilization Score

Utilization score	SC**	CWR
1	30.49	29.66
2	29.09	30.61
3	31.93	30.54
4	35.62	30.72

**ANOVA F 5.091, p<.002; Bonferroni for 2-4 p<.002

Table 3-5: Average Utilization Score by Successful Reunification

	SC		CWR	
	#	Mean Score	#	Mean Score
Reunification (SC***; CWR***)				
Yes	81	3.70	524	3.29
No	132	2.26	720	1.78

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

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Table 4-1: Survival Analysis of Successful Reunification (SC Interaction Model)

Model	HR	p-value
Parent age	1.02	.310
Custody	1.41	.410
Mental health problem	0.88	.730
Domestic violence problem*		0.018
Did not fully utilize services	0.30	
Fully utilized services	2.40	
Substance abuse problem***		<.001
Did not fully utilize SA services	0.43	
Fully utilized SA services	18.00	
Full utilization parenting services	1.66	.180
Full utilization individual counseling***		<.001
Has substance abuse problem	1.02	
No substance abuse problem	12.12	
Full utilization DV services**		0.018
Has domestic violence problem	3.60	
No domestic violence problem	0.46	
Full utilization SA services***		<.001
Has substance abuse problem	20.50	
No substance abuse problem	0.47	

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