Minnesota Parent Support Outreach Program Evaluation

Final Report

Prepared for
The Minnesota Department of Human Services

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Preface and Acknowledgements

In 2001 Minnesota began a 20-county pilot project to test the benefits of the differential response approach in child welfare. Under this approach, called Alternative Response, most reports of child abuse and neglect were handled through a non-accusatory approach to families—a family assessment. One of the outcomes was that families were reported to Child Protection Services (CPS) less frequently after receiving family assessments. Another was that services addressing basic poverty-related needs of families increased under the new approach and that this was one of the reasons why families returned to CPS less frequently. A third was that family engagement, a natural consequence of the family-friendly and participatory approach, was also implicated in the slowdown of returns to the system.

The Minnesota Parent Support Outreach Program (PSOP), the subject of this report, originated in this context. The designers of the differential response program thought that a similar approach could be used with families that were reported to CPS with reports determined to be inappropriate for a CPS response—reports that were *screened out*. By 2005, 38 Minnesota counties had agreed to participate in the program. The hope was that subsequent reports of child maltreatment might be reduced or averted by assisting families in advance to deal with stressful life situations that often underlie child maltreatment. This report will examine whether families were engaged, whether services were offered, what kinds of services were utilized and whether they indeed produced beneficial results, particularly averting returns of families and children to CPS caseloads.

The PSOP evaluation would not have been possible without the generous efforts of PSOP workers in providing case-level data on the characteristics of families and the services they provided them. They did this extra work for three years running. Anyone reading PSOP case notes cannot help but be impressed with the shear hard work and dedication of PSOP workers and their supervisors to families in need of assistance. This report is dedicated to them.

Of no less importance was the work of the PSOP designers and implementers at the Minnesota Department of Human Services, including David Thompson, Carole Johnson and Brenda Lockwood, who were supported in their efforts by the Director of the Agency, Erin Sullivan Sutton, and all the local county staff responsible for the operation of their programs. Finally, PSOP would not have been possible without the financial support of the McKnight Foundation.

Executive Summary

The Minnesota Parent Support Outreach Program (PSOP) was designed to provide voluntary supportive services to families reported for child abuse and neglect (CA/N) whose reports *were not accepted* for further response (screened out) by Child Protection Services (CPS) and with a child five years old or younger. Program criteria were later expanded to include families with a child under 10 and referrals from other agencies. PSOP was funded through a grant from the McKnight Foundation.

- PSOP began in October 2005 in 38 Minnesota counties. These included the two largest counties in the state (Hennepin and Ramsey), various Minneapolis-St. Paul metro counties and other outlying and rural counties.

- By November 2008, workers had made 8,830 offers of services, of which 4,125 resulted in PSOP cases. Removing duplicate counts of families that participated more than one time, offers were made to 7,753 families, of which 3,841 accepted services at least one time. This represented an acceptance rate of 49.5 percent.

- The acceptance rate increased during 2007 and 2008 after program criteria had been expanded.

Implementation

Organization of PSOP. Counties organized PSOP in different ways. There were three general types or models:

1. *Contracted Private Workers,* in which case-management was contracted out to one or more community agencies

2. *Dedicated Public Workers*, in which case-management was handled by one or more county social workers that were solely dedicated to PSOP

3. *Divided Public Workers,* in which case-management was split among county workers who also handled other child-welfare or child-protection cases

Outreach strategies varied at the start of PSOP, involving combinations of letters, telephone calls and home visits. By the conclusion of the program, most counties telephoned families first while the remaining sent a letter or brochure and followed-up by telephone if no response was received. Two counties conducted unannounced home

visits. Workers and supervisors strongly agreed that speaking directly to potential participants was more likely to result in acceptance than sending written material first.

Engaging Families. Families that were screened out of CPS did not know that they had been reported. Workers developed various strategies to contact them. In general, they found that terms such as "report" and "abuse and neglect" needed to be softened to terms such as "concerns" regarding "well-being." Families from other referral sources, like the Minnesota Family Investment Program (MFIP) or community agencies, were easier to engage because the program had already been explained to them and they had tentatively committed to it before the initial PSOP contact. Many families had had previous contacts with CPS through past accepted reports or open cases. Workers perceived these families as more difficult to engage. However, they were successful with about half to two-thirds of such families, depending on the model.

The ability of PSOP workers to pay for basic services that families needed was an important incentive to participation. Workers felt that this sometimes gave them entrée to families, after which they could begin working on other "deeper" issues.

Case Intensity. County staff noted that the work exceeded original expectations, since most families that agreed to PSOP had multiple needs, including basic poverty-related needs. They estimated that most needed at least three to four months of case management to reach their minimum goals. Staff were strained to conduct case management at this level for all PSOP cases.

Characteristics and Needs of Families

- *Decliners and Accepters.* Most families approached by PSOP had had previous experience with public service systems, including CPS: 55 percent of those declining to participate in PSOP and 65 percent of those agreeing to participate. Among those that declined, 28 percent had had a previous CPS investigation compared to 35 percent of those that accepted PSOP services. PSOP accepters were on average higher-risk families than PSOP decliners. Counties that contracted with private agencies for PSOP were more successful in engaging families with previous CPS experience.

- *Racial and ethnic identity of families approached through PSOP:* 73 percent of total families were Caucasian, while 16 percent were African American, 7 percent were American Indian, 3 percent were Southeast Asian, and 1 percent were Other Asian or Pacific Islander. Nine of ten of African American families came from metro counties. American Indian families were more widely dispersed among metro counties and counties with reservations. Southeast Asian families resided mainly in two metro counties. Southeast Asian and African American families accepted PSOP in greater proportions that other racial groups.

- *Family Structure.* Families averaged 2.4 children each. A mother was present in 93 percent of households that participated in PSOP and in 44 percent no other

adult was present. About one-fifth of caregivers were married and living with their spouse. Another fifth of mothers reported a male companion (most often the father the children) living in the household.

- *Education.* About 16 percent of caregivers had not finished high school, 36 percent had a high school diploma or GED and 48 percent had some college or a college degree.

- *Income and Employment.* Only 28 percent of families had a caregiver employed full-time, while 51 percent were unemployed and 21 percent worked part-time. Incomes were low with 61 percent reporting an income of less than 15,000 in the previous 12 months and only 14 percent reporting incomes of $30,000 or more.

- *Social Support and Isolation.* Based on scaled responses, it was determined that 20 percent of families were very isolated from emotional and financial support by others. On average, caregivers indicated occasional social support from friends and family.

- *Stress.* Among several sources of stress, caregivers reported the greatest stress about their financial situation. Those that were more socially isolated reported greater overall stress in their lives.

- *Family Needs and Strengths.* The Minnesota SDM Family Needs and Strengths instrument showed that the majority of families had problematic needs in three or more areas; 28 percent had five or more areas of needs. Many of these needs were described as severe or chronic. Workers judged that nearly 60 percent of families to have inadequate income and 28 percent to have an adult with a chronic emotional problem. About 18 percent of families had an adult with a substance abuse problem.

- *Similarities to FAR Families.* Minnesota's differential response program, Family Assessment Response (FAR), was for families screened in to CPS that were provided with a family assessment rather than an investigation. Analyses indicated that PSOP families, all of whom had been screened-out of CPS were demographically similar to FAR families but had lower incomes and were more likely to be unemployed.

Services Made Available

Many types of services were made available to families during cases that lasted, on average, several months.

- *Length of Cases*. Some 30 percent of PSOP cases were less than 90 days duration and 33 percent lasted 200 days or longer with the other third in the 90 to 200 days range. The average was 141 days or slightly less than five month, confirming the

estimates of workers and supervisors. However, average case lengths varied greatly from county to county.

- *Contacts.* The median number of contacts made with or on behalf of families was 16, including face-to-face, telephone, letter, email and collateral. Four or more face-to-face contacts were made with 54 percent of families and 11 or more with 18 percent of families. Four or more collateral contacts were made with 37 percent of families and 11 or more with 18 percent.

- *Quality of services.* Quality of services was measured through family responses. Of all families, 95 percent indicated that were very satisfied or generally satisfied with their PSOP worker and 74 percent felt their worker very much tried to understand their family's situation and needs. These proportions were comparable to CPS family responses in the earlier evaluation of Minnesota's Alternative Response pilot.

- *Community Referrals.* Approximately 87 percent of families were referred by their workers to at least one community provider. Mental health, childcare and emergency food were the top three categories of referrals. Differences were found in community referrals by racial groups that seemed to correspond to differences in identified needs among those groups: African American and American Indian families were referred more often to emergency food, employment and training and community action agencies. American Indian caregivers were referred more often to alcohol and drug rehabilitation. Caucasian families were referred more often to mental health providers. Programs utilizing contracted community providers referred to other community agencies at greater rates.

- *Worker Reports of Services Offered.* The largest categories of services provided by PSOP workers concerned basic needs: household needs, transportation, rent and house payments, emergency food, and housing but also included child care, respite care, mental health and parenting. Services were already in place for some families at the time of first contact with PSOP workers in most categories examined. The largest of these were welfare, medical/dental, child care, mental health and employment. Southeast Asian families received more services in the categories of basic household needs, emergency food, transportation and employment. Caucasian and American Indian families received more services in the categories of respite care, counseling and mental health. American Indian and African American families received services more frequently in categories of emergency shelter, basic HH needs, emergency food, transportation, employment and recreational services.

- *Family Reports of Services Received.* The largest categories reported by families were, in order of frequency: emergency food, counseling, rent money, mental health, other financial help, utilities, car repair or transportation and child care assistance. Concerning contacts with other agencies on behalf of families, 37

percent of caregivers reported that their worker contacted another agency or source of assistance for them, 37 percent said they were not sure and 26 percent said their worker had not contacted another agency. A little less than half of responding caregivers (47 percent) said that they had learned of a service organization that they did not know about before.

- *Direct Help by Workers.* Half of responding caregivers stated that the worker provided direct assistance to help their family. The most frequently cited categories were: transportation, financial assistance or concrete items, such as gift cards, food, clothing, diapers, and household goods, furniture and rent security, gas cards and car repair and assistance in locating and securing housing.

Service Utilization

A significant array of services were made available to families. The evaluation considered whether the assistance provided corresponded to the needs of families and how often families took advantage of offered services.

- *Match of Services to Needs.* About half of workers (49 percent), when responding concerning specific families, felt that services were *well matched* to needs while 47 percent indicated they were *adequately matched*, for a total of 96 percent. Family caregivers were asked whether the services they received were the kind they generally needed. While 14 percent indicated that they did not receive services, of the remaining families, 92 percent answered *yes*.

- *Effectiveness of Services.* Again concerning specific families, 34 percent of workers said services were *very effective* and 52 percent said they were *somewhat effective*, for a total of 85 percent Family caregivers responses were similar. When asked whether services were generally enough to really help them, 81 percent of those receiving services responded *yes*.

- *Services Wanted or Needed but not Received?* A little more than one-fourth of families (28 percent) answered *yes* to this question. Basic financially-related services were mentioned most often: housing, rent, house payments, house repairs, utilities, furniture, clothing, car purchase or repair, transportation assistance, medical and dental. Other less frequently cited needs were daycare assistance, respite care, mental health services and legal services.

- *Barriers to Services.* The following reasons were offered by workers, responding concerning specific cases, for why needed services were not received: did not offer the service to the family (3 percent), insufficient funds (5 percent), service was not accessible by this family (5 percent), service was not available for this family or in this area (10 percent), service was offered to but not accepted by the family (56 percent). The rest (20 percent) were unspecified.

- *Service Participation and Utilization.* The highest levels of participation were in services related to basic needs, such as welfare payments, rent and house payments, basic household needs, medical or dental care, emergency food, transportation, child care and housing. Lower participation occurred as a rule for more therapeutic and instructional services such as counseling, parenting classes, alcohol abuse treatment, support groups and domestic violence services, which usually required multiple meetings and continued commitment, and therefore were more subject to barriers to services.

Outcomes

- *Instrumental and Immediate Outcomes.* Some outcomes were immediate and tangible. Some of these, in turn, were instrumental to longer term outcomes. Such outcomes included:

  1. PSOP Workers entered the lives of families in need and in the majority of cases had multiple direct contacts with them and with others on their behalf.
  2. The large majority of families responded positively to the PSOP intervention, indicating that they were satisfied with the worker and the intervention and felt that their worker understood their needs.
  3. Workers and families generally agreed that the assistance received fit the needs of the family and that it was effective.
  4. Referrals to community agencies of various kinds occurred for 87 percent of PSOP families.
  5. Services were provided by workers and through community referrals, and for most types, this represented a substantial increase over services already in place before PSOP.
  6. A sizeable proportion of families (47 percent) learned of services that they did not know about before PSOP.
  7. Half of responding caregivers indicated that they received direct assistance from their PSOP worker in the form of transportation, financial assistance, help with housing and the like.
  8. The level of participation or utilization of services, as judged by workers, was moderate to high.
  9. There were various barriers to services and for this reason over a quarter of families (28 percent) said they did not receive some form of help that they wanted.

- *Family Views of the Impact of PSOP on Their Lives.* Family caregivers were asked after their case was completed: *Do you feel more or less able to care for your child(ren) than you did a year ago?* On the positive side, 35 percent said

much more and 24 percent said *somewhat more* for a total of 59 percent positive. Another 35 percent answered *about the same*. On the negative side, 4 percent said *somewhat less* and 3 percent said *much less* for a total of 6 percent negative. Positive responses were correlated with caregiver's reports of adequacy and effectiveness of services.

- *Impacts of PSOP Identified by Workers.* Workers indicated that the financial situation of families was addressed in about 63 percent of families and that marked improvement was observed in about 25 percent. Looking across all the issue, when something was addressed, the proportion of families with a marked improvement averaged about 36 percent. Thus, while workers indicated they worked with many families on a range of issues, on average they felt that noticeable improvements occurred in only a little over a third of the time for any particular issue. However, it was also the case that for 62 percent of families at least one issue or problem from this list had improved markedly in the view of workers. Thus, improvements were observed in at least one area of family functioning in about six of ten families served.

- *Reduced Subsequent CA/N Reports among Families in Poverty.* Analyses indicated that serious-or-chronic-basic-needs families did as well as families with fewer needs when services addressing those needs were utilized and did significantly worse when such services were not made available or were not utilized. The latter had significantly more subsequent CA/N reports screened-in to CPS and the reports were received sooner.

    - *Similar Analysis Utilizing Information from Families.* Similar findings were obtained when the analysis controlled for family isolation, neighborhood quality and family satisfaction with the PSOP worker. In this case families earning less than $10,000 annually that received no or few poverty-related services did significantly more poorly.

- *Employment and Employment Related Services.* A related finding was that families that were under-employed or unemployed that received welfare and employment and training services fared better (had fewer subsequent reports screened into CPS) than similar families for whom such services were not made available or were not utilized.

- *Substance Abuse and Substance Abuse Treatment Services.* Analysis were conducted of families with moderate or serious alcohol or drug problems. These kinds of families had fewer subsequent reports screened into CPS when substance abuse treatment services were utilized at high levels compared to lower levels and cases in which no treatment was available or used.

- *Racial Difference in Family Perceptions of Service Impact.* No statistically significant difference was found in ratings of caregivers of different racial/ethnic groups concerning whether their family better off or worse off because of PSOP.

- *Impact of PSOP on the Flow of Accepted Child Abuse and Neglect Reports.* Analyses indicated that counties that served relatively large numbers of families through PSOP in relation to their CPS caseload experienced a greater reduction in accepted reports of child abuse and neglect during the 2006 to 2008 period. It was concluded that PSOP was likely to have had an impact by reducing the flow of new reports to CPS.

- *Conclusions Concerning Outcomes*. A great deal of evidence was proffered of positive instrumental and immediate outcomes of PSOP. The large majority of families felt they had been helped by PSOP. Workers indicated that there were discernable improvements in the majority (at least six in ten) of families they worked with in at least one of the family functioning areas studied. There was also evidence based on the outcome measure of number of reduced subsequent accepted (screened-in) reports to CPS that at least some of the treatment approaches produced a difference when utilized by families that needed the service. No differences were found in some areas, where this type of analysis was most difficult. Finally, the potential impact of PSOP on the flow of new reports is of importance and illustrates the value of preventive services in child welfare.

1.
Introduction

The Minnesota Parent Support Outreach Program (PSOP) was designed to provide voluntary supportive services to families reported for child abuse and neglect (CA/N) whose reports *were not accepted* for further response by Child Protection Services (CPS). The original program criteria also required that a child five years of age or younger be in the family. This was an attempt to target the program to assist younger and lower risk families and avert future CA/N reports. Normally, unaccepted reports are quickly expunged from the reporting system. Under PSOP, intake workers were able to refer reports that met program criteria to PSOP workers, who contacted families to offer assistance. The PSOP was set up in 38 Minnesota counties but was organized in different ways that are described in the next chapter. In some counties a public agency worker from the local CPS or Child Welfare office approached the family while in others contact was made by private agency workers working with the public agency.

After the program had been operating for some months it was apparent that original referral criteria were not yielding enough families to permit counties to meet their planned service quotas. The criteria were broadened to permit referral of families whose youngest children were in school. In addition, other referral sources were allowed, including MFIP (Minnesota Family Investment Program, i.e., TANF), and community-based agencies. This increased the number of families referred to PSOP as well as the number that agreed to participate in services.

PSOP was funded in part through a grant from the McKnight Foundation. The grant supported the agencies that operated the program and provided local resources for purchasing services, particularly those addressing basic family needs.

1.1 Differential Response and PSOP

PSOP was conceived as a natural extension of Minnesota's Family Assessment Response (FAR) program.[1] The FAR program is directed to families reported to CPS

[1] FAR is Minnesota's version of *differential response*, which has come to be used as an umbrella term to refer to child welfare reform programs that have established one or more alternative responses to traditional investigations of CA/N reports. Originally piloted in 20 Minnesota counties beginning in 2001 under the name Alternative Response (AR), the program was implemented statewide in 2004 and 2005 and renamed as Family Assessment Response (FAR). The final 2004 evaluation report of the Minnesota Alternative Response Pilot can be found at: http://www.iarstl.org/papers/FinalFRAReport.pdf.

whose reports were *accepted for further action* by CPS. Historically, this has meant a CPS investigation. Under FAR, accepted reports are assigned to one of two tracks: an *investigation* or a *family assessment*. Investigations are reserved for more dangerous and clearly criminal kinds of CA/N allegations and those in which imminent risk of serious injury is alleged. In the Minnesota system this is a minority of reports. Most child maltreatment reports now receive a family assessment. Family assessments, unlike investigations, are non-adversarial family encounters that do not result in designations of victims and perpetrators nor in determinations or substantiations of CA/N. Family assessments are concerned with child safety and family needs. Family participation in decision making is emphasized. If children are determined to be safe further participation by families becomes voluntary.

Because the FAR approach was shown in the 2001 to 2004 evaluation to have positive and preventive effects, planners thought a similar approach might be beneficial to families whose reports were screened out, that is, *not accepted for further action* by CPS. These families are often encountered at some later point in time with reports that *are accepted* by CPS. By offering voluntary services to such families, it was believed that some of the risk conditions that lead to child abuse and neglect might be improved and later CA/N prevented. PSOP was designed as a pilot project to test this hypothesis.

1.2 Implementation

The PSOP began officially in October 2005, although a few counties had already begun accepting clients earlier in the year. It operated in 38 Minnesota counties.[2] The map in Figure 1.1 shows the participating counties and the relative size of their populations. Counties included those of the Twin Cities (Hennepin and Ramsey), the most populace counties in the state, as well as several of the surrounding suburban counties. Olmsted a smaller urban county (where the city of Rochester is located) also participated. The remaining counties ranged from those with small cities to very rural areas.

Local offices organized their programs in different ways. Some operated using public agency workers in the local child protection or child welfare offices while others utilizing the staff of external, community based agencies. Types of organization are described in Chapter 2.

Families referred to PSOP were approached and asked whether they desired to participate in the program. From the start of the program a certain proportion of families declined to participate. By November 2008, workers had made 8,830 offers of services, of which 4,125 had resulted in PSOP service cases. Over a thousand families were offered PSOP services more than one time and about a third of them accepted. Thus, the number of PSOP cases exceeded the number of families. Removing duplicate counts, 7,753 families were offered services of which 3,841 accepted services at least one time.

[2] Two small counties effectively dropped out very early in the project but their cases are included.

This represented an acceptance rate of 49.5 percent of individual families over the entire course of the program.

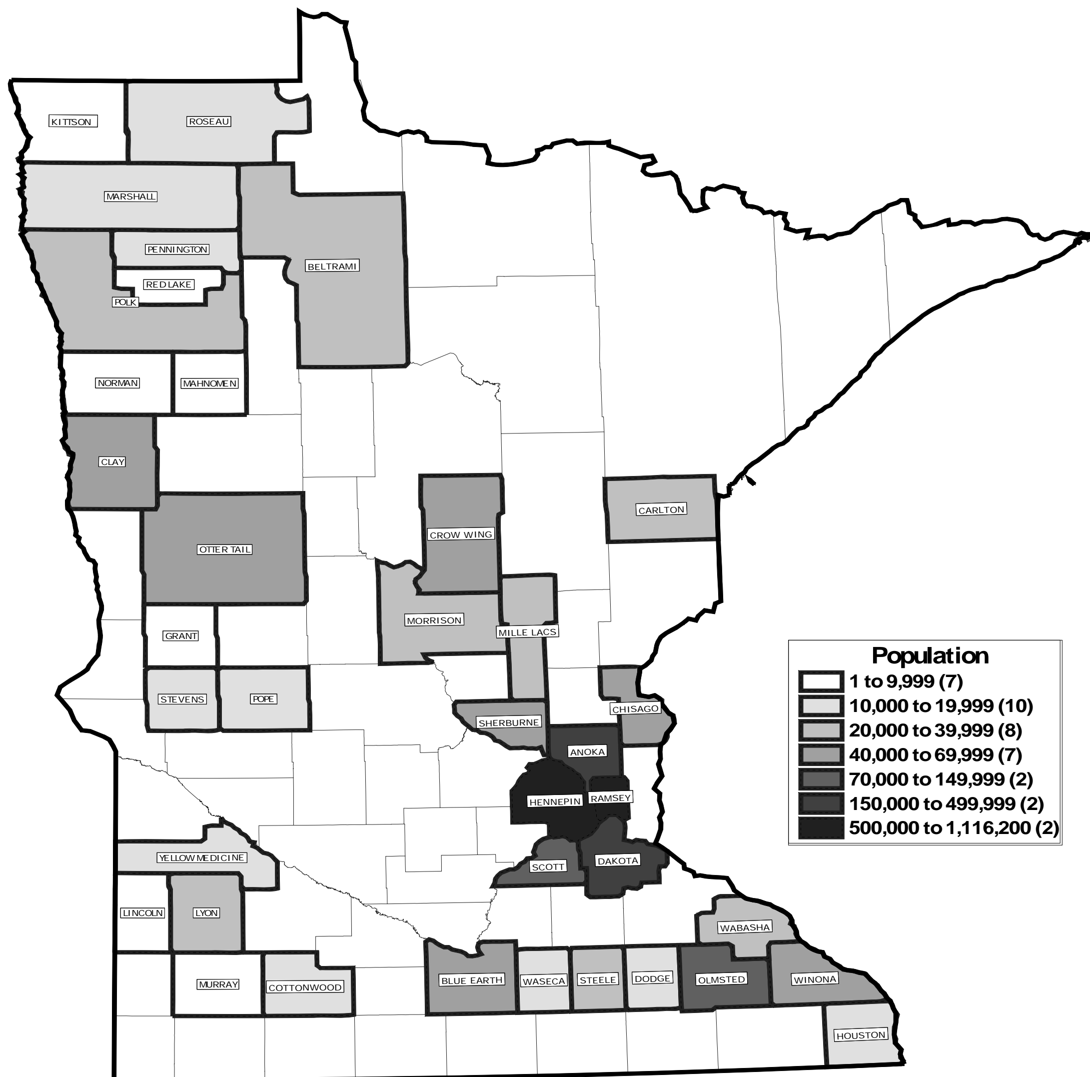

Figure 1.1 PSOP Counties by Size of General Population

A breakdown of the number of families that accepted services versus those that declined in each county is shown in Figure 1.2. The 18 smallest counties approached less than 100 families during the entire program. Counties accepting the largest number of clients were usually found in urban areas although will serve to show that this was not always the case. Ramsey, Anoka, Scott, Chisago, Dakota and Olmsted are large and moderate sized urban areas, but the largest urban center in the state, Hennepin County, is lower in the list and ninth in order of the number of families accepting services (the basis of the order in the chart). On the other hand, Mille Lacs, Otter Tail and Crow Wing, which have much smaller populations, approached nearly as many families as some

larger counties. As will be seen, this had to do with the number of personnel assigned to the project and to other structural features of programs.

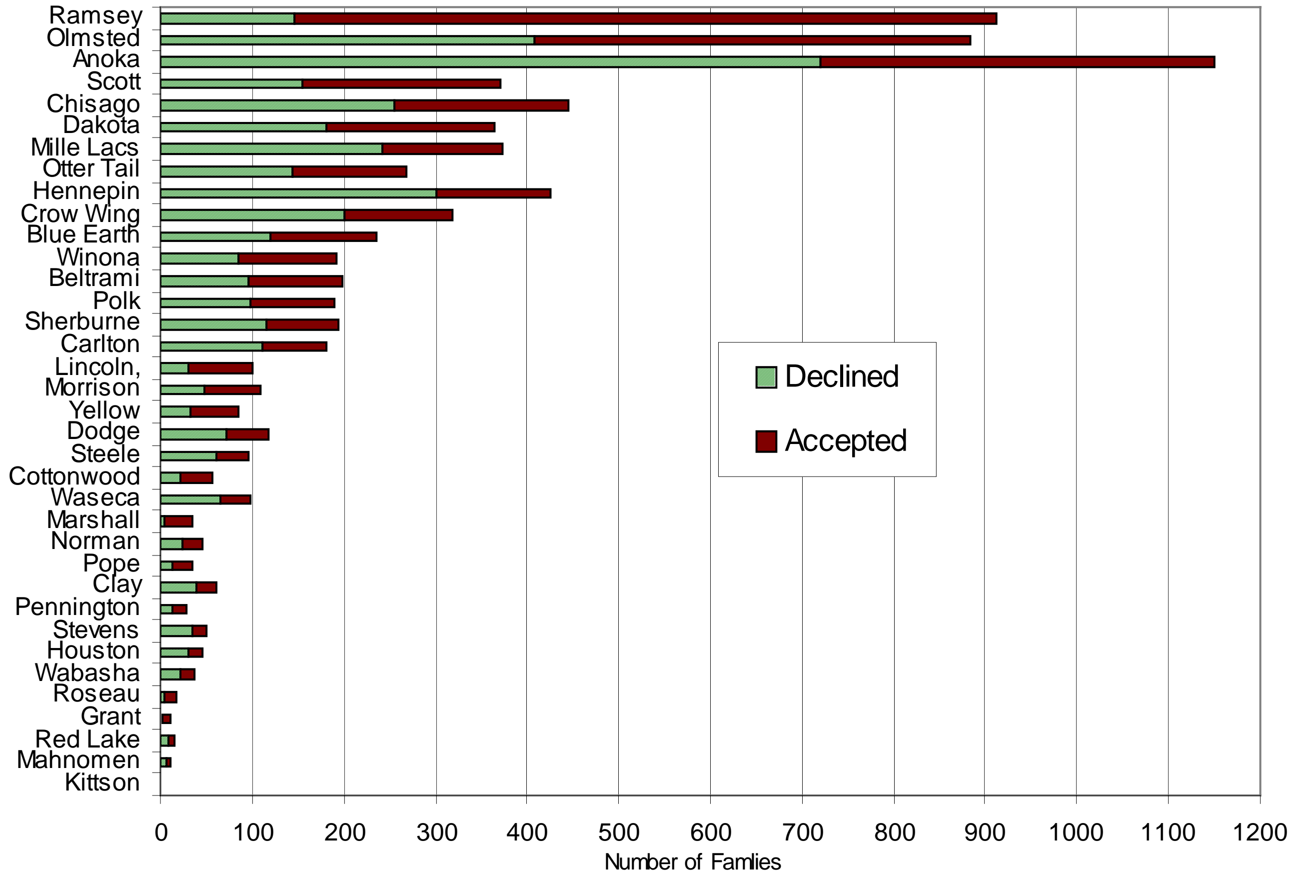

Figure 1.2 Number of Families by County that Accepted or Declined PSOP Services (2005-2008) (Ordered by the Number of Families Accepting Services)

The rate of acceptance increased over the three-plus years of the program. During 2005 and 2006 the rate was approximately 40 percent (Figure 1.3). During 2007 and 2008 it was between 55 and 60 percent resulting in a final program acceptance rate for the entire period of the evaluation of 49.5 percent. The increase in PSOP acceptance reflected, at least in part, the mid-2006 changes in criteria for the program. Originally families offered PSOP had to have at least one child under six years of age. In April 2006, some six months after the program began, this was changed to at least one child under ten years of age. The original criteria restricted families to those that had received a screened-out report of child maltreatment. In June 2006, self referrals and referrals from community agencies and MFIP were permitted and by the end of the program the

best estimate of the proportion of families that were referred from other sources and entered PSOP was 45.4 percent.[3]

Counts of families accepting services were determined primarily through identification of formal child welfare case openings in the Minnesota Social Service Information System (SSIS). This was not always a good indicator since some family caregivers that had at first agreed later changed their minds. In these cases counts were adjusted based on feedback from PSOP workers. In addition, even the adjusted counts do not reflect full cases. In some instances, family participation fell off quickly and little assistance or services were ultimately provided. The issue of participation and actual reception of assistance is considered in Chapter 5.

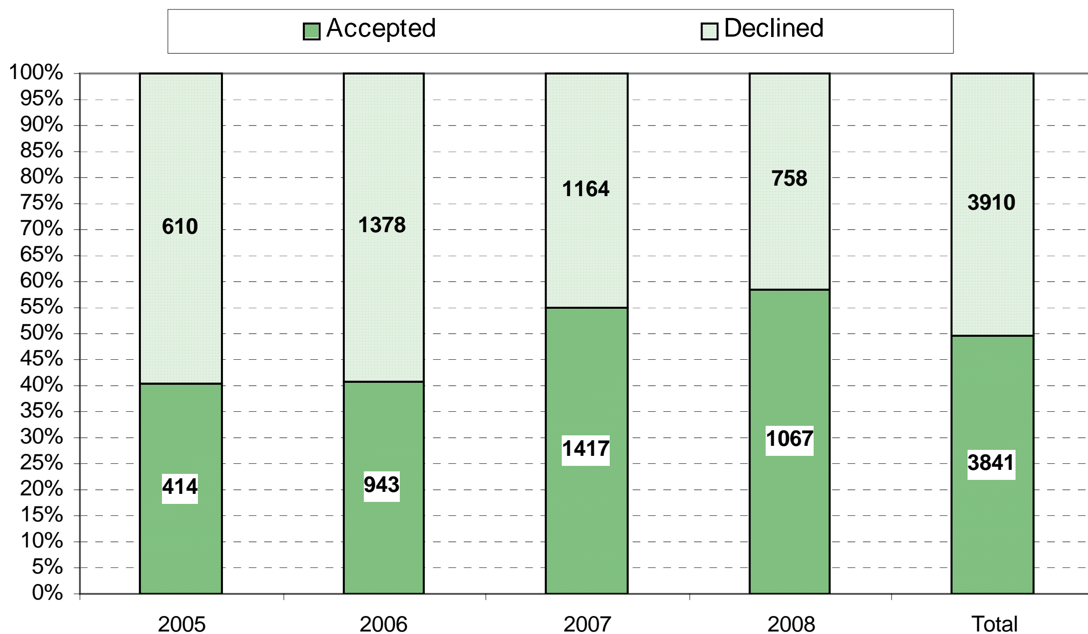

Figure 1.3 Number of Families Accepting or Declining PSOP Services by Year (2005-2008)

1.3 The Evaluation

Data collection for the evaluation began in October 2005 and continued through the end of November 2008. The unique structure of the PSOP made assignment of families to a control group impossible. The program involved approaching families, describing the program and asking whether they needed and would accept services. At this point assignment of accepting families to a control group in which service would not

[3] When the evaluation was designed it was assumed that the source of all PSOP referrals would be "screened out" reports. A content analysis of intake narratives after March 2006 revealed that 45.4 percent entered PSOP through self-referral or referrals from other sources and that the remaining 54.6 percent had had screened-out reports to CPS. (See Appendix 1 for details of this analysis.)

be offered or delivered was effectively impossible and, in any event, would have been unethical. For this reason, the evaluation employed a one-group design.

To assess PSOP within this restricted model, it was necessary to collect detailed information from workers, families and state data systems describing what actually occurred in families served. This led to relatively rich information on family strengths and needs, services delivered and service participation.

A primary model utilized for outcome analyses, we have termed the *dosage model*. This model is described in greater detail in Chapter 6 where it guides a portion of the outcome analyses. Essentially it is built on the assumption that in a program of the magnitude of PSOP, families with similar sets of needs can be found that for different reasons receive variable levels of services addressing those needs. If the services are effective then families that received and utilized more (higher doses) might be expected to have better outcomes than families with less or none. However, this model can only be used in an evaluation that collects services information from workers and families in sufficient detail. In addition, the views of workers and family caregivers concerning the benefits and detriments of PSOP can be and were treated as statements of outcome, as well.

Another analytical method that was used involved a dual follow-up with families. Families were contacted immediately following case closure and information was obtained on their perceptions of the program and services. This resulted in a fairly representative sub-sample of the entire sample of PSOP accepters. A second follow-up was conducted later in the evaluation to obtain family and child welfare information directly from families.

1.3.2 Evaluation Data Sources

Minnesota Social Services Information System (SSIS). SSIS is Minnesota's SACWIS (state automated child welfare information system). Monthly extractions were received from the system that contained all Child Protection System (CPS) records. PSOP information was not stored in the CPS portion of SSIS but in the larger Child Welfare system. This system contained records of child welfare work with families. Evaluators received only the child welfare records of families approached through PSOP, not the entire child welfare database. However, other records for these families within SSIS, such as substance abuse treatment services, childcare, developmental disabilities and others were made available. Each month SSIS data were converted and information used in the evaluation was extracted. This information was the central core of the comprehensive research database.

Structured Decision Making Family Needs and Strengths Assessment (FNS). PSOP program designers made the decision to use this assessment tool. It was made available to evaluators and was used in analyses of family characteristics and program outcomes. An FNS assessment was conducted of each family that agreed to PSOP

services. In most cases the tool was entered directly into SSIS and was received by evaluators as a part of the monthly data extraction. The evaluators created an online mirror version of the tool for workers to enter who for one reason or another had not entered the information into SSIS.

Child Well-Being Assessment. PSOP designers also required the use of this tool. While evaluators received the information, the tool turned out not to be useful for evaluation purposes.

Extended Family Assessment (EFA). This instrument was designed to provide fuller information on families than could be obtained through SSIS or standard clinical assessment forms like the SDM FNS. When PSOP cases were completed workers logged on to the evaluator's website and completed the questions in this instrument. The EFA asked workers questions about family responses to the program, family problems, agency referrals they had made, and services delivered. These data were linked with FNS and SSIS data in the research database. After setting aside cases that were too truncated for the EFA to be completed and EFAs that were completed on families that accepted PSOP services a second time, 2,614 cases remained on which EFA, FNS and SSIS data were available.

Family Surveys. Feedback was obtained from family caregivers as soon as possible after the PSOP case was closed. Usable responses were received from 608 families. In addition, a follow-up family survey was conducted near the end of the evaluation.[4]

Phone Interviews and Site Visits. Qualitative information regarding program organization and process was gathered through interviews with workers and supervisors in county offices and with staff of contracted community providers. Early site visits were made to 15 counties in late 2006 and early 2007. Additional visits were made in October 2007 to Anoka, Carlton, Dakota and Scott counties. Semi-structured phone interviews were conducted with 27 counties during the spring and summer of 2008 to obtain an understanding of program implementation for all operating projects. Finally, in-depth interviews regarding engagement strategies were conducted on site in September 2008 with Chisago, Crow Wing, Hennepin, Mille Lacs, Ramsey and Sherburne counties.

1.4 Structure of the Report

Chapter 2 summarizes information about the structure and implementation of PSOP obtained through on-site and telephone interviews of workers, supervisors and program managers. In Chapter 3, the characteristics of PSOP families and caregivers are described including their social and economic situation and strengths and needs. Chapter 4 considers referrals and services provided to families under PSOP including direct services by workers and services from many other sources. The intensity of worker activity and contacts are described. The chapter focuses on offered rather than utilized

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[4] Data collection instruments are available by special request from IAR. Email your request to laloman@iarstl.org or contact@iarstl.org.

services. In Chapter 5, the description of services is continued by considering those that were needed but not received, levels of participation and utilization of services and barriers to service reception. Service constellations are described. Chapter 6 is a consideration of outcomes and impacts of services received under PSOP. Finally, Appendix 1 contains various methodological notes and analyses along with technical details of analyses presented in Chapters 3 through 6.

2.
PSOP Implementation and Operation

The 38 counties each followed the same general guidelines in designing their local implementation of the Parent Support Outreach Program. While there were substantial differences in the structure of local programs, all consisted broadly of outreach to families and case-management for those that agreed to services. Each county developed a process for referring such reports to workers who would then attempt to contact families and engage them in voluntary, preventative services. Workers conducted a family assessment of families that agreed to participate in PSOP and created a case plan for short-term case management to connect the family with needed resources. Parents completed an application for social services to confirm their consent to services, after which a formal child welfare case (a case-management workgroup) was opened in SSIS. Counties were allocated $1,000 per family up to the targeted number of families specified in their agreement with the state agency, making it possible for counties to purchase services for families. Casework continued until the county and the family agreed to end involvement.

2.1 Referrals to PSOP and Service Targets

As part of their PSOP plan, each county agency set a target number of families to be served annually. Funding to cover the cost of services and staff time or contracts with private agencies was allocated to counties based on targets. Counties set their annual targets based on the number of screened out maltreatment reports typically received in a year and the number of families with children less than six years of age. During the first two years, most counties found it difficult to meet the original service target. Between October 2005 and March 2006, only eight of the 38 counties were able to offer the program to the number of families they had originally projected. Thirty-six counties were unable to meet 50 percent of their enrollment target (families that accepted services), and only six counties enrolled more than 40 percent. Reasons for this varied. Some county agencies experience delays in organizing the program or had trouble beginning the program with a contracted agency. Some counties found that the PSOP families were very high need (see Chapter 3) and the program overextended the staff assigned. Almost all county agencies had far fewer screened-out reports that involved families with children of preschool age than anticipated and found it more difficult than expected to convince these families to participate.

These challenges prompted statewide changes to the original eligibility policy. By mid-2006, the state made two changes to the program to try to increase participation levels. The first was to expand the minimum age of children to ten years of age and the second was to allow workers in other institutions and other community programs, such as public health, MFIP, and schools, to refer families directly to PSOP without making an official child protection report. Counties found that both of these changes increased the pool of potential participants considerably and boosted the overall acceptance rate (see Figure 1.3). County staff reported that families identified through internal referrals or those that were referred from other agencies, especially from financial workers or public health, were easier to engage than those that came into the program from screened out maltreatment reports. In cases referred from other agencies, parents had already discussed the program with social workers and agreed to have their names submitted to PSOP or had initiated contact themselves.

By 2008, the last year of the project, every county had expanded their pool of participants and increased referrals from other agencies. All active programs, except Hennepin County[5], were accepting children up to the age of 9, and most were encouraging voluntary referrals from other professionals and families. Some counties were more active in advertising the program to other county departments and community agencies, and therefore had a greater number of outside referrals. At least 11 county programs had the majority of their referrals come from sources other than screened-out maltreatment reports. Even with the increase in participants, however, most counties reported that they did not need to control the volume of cases served (for example, by prioritizing referrals) and some counties continued having trouble meeting annual targets. Staffing levels also influenced the flow of cases into programs. For example, three counties reported limiting the number of outreach calls they made due to reduced staff capacity.

Counties that did need to limit the number served focused on families with multiple risks or severe individual risks, such as homelessness or major mental health issues. A small minority of counties also emphasized particular circumstances affecting families, such as domestic violence or families that had a prior history with child protection or DHS.[6] Olmsted County was unique in serving a large number of prenatal cases.

2.2 Program Models

Counties had been permitted to adapt the program to local needs and available resources. Intake was similar in all counties. Reports or referrals were typically received by telephone through the central intake unit. Potentially appropriate reports were then

[5] Hennepin housed and staffed their program in the Early Childhood Department and continued to focus only on children less than six years of age.
[6] The Minnesota Department of Human Services. DHS is used in this chapter primarily to refer to the local programs, such as Child Protection Services, Child Welfare Services, Mental Health, etc. that are administered at the local level and supervised and partially funded by the state agency.

referred to a main PSOP coordinator or supervisor to be considered for inclusion in the program. The structure of programs diverged at this point. There were three primary models of case-management:[7]

1. **Contracted Private Workers.** Case-management was contracted out to one or more community agencies.

2. **Dedicated Public Workers.** Case-management was handled by one or more county social workers that were solely dedicated to PSOP.

3. **Divided Public Workers.** Case-management was given to county workers who also handled other child-welfare or child-protection cases.

2.2.1 Contracted Services Model. In this model, employed by 12 counties for a part or all of the project period, the county contracted with selected community service providers to carry out the case-management for PSO. These were typically agencies with a strong historical relationship with county child welfare prior to the start of the pilot project and had other current counseling or mental health service contracts with the county.

There were two modes of referral. Contracted agencies either 1) took the referral directly from the county and initiated the first contact with the family or 2) the case was transferred to the contracted agency after a county worker conducted outreach with the family and secured an agreement to open a case. In both methods the agencies handled all of ongoing contacts and service brokering. Of the 12 counties that operated PSOP through contract providers, six—Blue Earth, Chisago, Crow Wing, Dodge, Steele and Waseca—arranged to have all PSOP referrals sent directly to the contracted agency with no prior contact by a county worker. In Anoka, Ramsey, Morrison, Winona, Wabasha and Houston, a county worker made the outreach call to the family to offer services and then, if the family accepted assistance, transferred the case to the community based provider.

The majority of counties that utilized the contracted services model had only one agency that was contracted to take PSOP cases. Exceptions to this rule were Ramsey and Anoka counties (both larger urban counties). Ramsey (St. Paul) worked with multiple agencies permitting families to choose among 15 service providers.[8] These included agencies that specialized in Latino and Hmong populations and agencies that focused on particular geographic areas of the Twin Cities. County staff felt that the variety of service providers let families select the "best fit" to their needs. Anoka County contracted with three providers and allowed families to choose among them. Staff in both counties agreed that giving families a choice about their case management provider strengthened their programs.

[7] Diagrams of different organizational approaches can be found in Appendix 2.
[8] Ramsey also utilized this model during the AR (differential response) pilot.

Nine of the 12 counties that initially began PSOP using the contracted provider model maintained this program structure until the end of the pilot period. Dodge, Steele and Waseca originally proposed to conduct their program as a consortium and contracted with the same agency for case-management service. They chose to end their contract with this organization in October 2007 because of logistical problems. All three counties opted to move the PSOP case-management back into their respective child protection units and operated the program separately. Winona, Wabasha and Houston had a similar goal of running the program through a common community provider. In this instance, the three counties were very satisfied with work of the contracted agency and continued their contract through the end of the pilot period.

2.2.2 County Worker with Dedicated Caseload Model. Five counties—Dakota, Carlton, Sherburne, Olmsted, and Hennepin—adopted a program design that utilized county staff to conduct initial outreach and manage PSOP service cases. PSOP was their main priority, although they were occasionally assigned to child protection cases and sometimes received assistance from other non-PSOP workers. Olmsted assigned four workers and two overflow workers to the program while the other offices each assigned one full-time worker. Hennepin utilized a worker in the Early Childhood Department. Other offices assigned workers from their child welfare or child protection teams. Staff in these counties felt that by focusing exclusively on PSOP they were able to more fully address the family needs.

2.2.3 County Worker with Divided Caseload Model. In most counties workers with other responsibilities also handled PSOP outreach and case management, including Beltrami, Cottonwood, Grant, the Lincoln-Lyon-Murray coalition, Mahnomen, Marshall, Norman, Pennington, Polk, Pope, Roseau, Scott, Stevens, Yellow Medicine, Red Lake and Kittson. Workers were from child welfare (voluntary services), child protection or had another role in the county, such as home-based parent educator. In some instances the approach changed during the project period. For example, one county initially assigned a dedicated worker but changed to a divided model.

Many counties preferred the divided worker option because it absorbed PSOP into the existing staff structure, minimized personnel expenses, and allowed the program funding to be used more directly for family needs. On the other hand, this model presented challenges in that many of the families had significant barriers or family dysfunctions that required considerable human resources to address (see Chapters 3, 4 and 5). In order to intervene most effectively in these cases, many supervisors admitted that full-time, dedicated PSOP workers were probably needed.

2.3 Family Engagement

A critical feature of the Minnesota Family Assessment Response is its family-friendly and non-adversarial orientation. Analyses conducted as part of the original AR evaluation demonstrated that part of the positive effects of this program stemmed from

improved engagement and participation of families.[9] It was hoped that these benefits would be carried over to PSOP.

2.3.1 Outreach Strategies. Workers stated that the initial contact with the family was the most critical step in successfully enrolling participants. Initial outreach to prospective participant families was done in three ways: 1) placing a telephone call to the last known phone number of the parent, 2) making an unannounced home visit to the last known address, 3) mailing a letter or brochure to the family or dropping them off at the family's residence. Combinations of the three were used when one alone was not successful.

Many workers responsible for outreach reported that the strategy of providing letters and brochures by itself only rarely moved families to inquire further about the program. Several counties began their program with this as their preferred contact method, but eventually changed the approach and began calling families at the outset instead of or in addition to sending written material. By the last year of the project, 23 counties (of 36 that were active at this point) telephoned as the primary form of initial contact. Thirteen counties sent a letter and brochure first and followed up with a phone call if no response was received from the parent.

During interviews, workers and supervisors strongly agreed that speaking directly to potential participants was much more likely to result in acceptance than sending written material first. Phone conversations were preferred, but in several counties the outreach worker indicated better results from drop-in home visits. In 14 counties, workers dropped by families' homes when they were unable to make contact or get a response through phone or mail. Two counties preferred to conduct unannounced home visits as the primary form of attempted contact.

Regardless of the initial outreach method, respondents reported that two or more attempts were usually necessary to reach families. The number of additional attempts to contact families was limited in some locations by the staff size and availability but also by the presence of risk factors known to be present in families, such as domestic violence. In some cases of this kind a drop-by visit was the first contact strategy.

When families were reached, workers described the outreach program and then, for interested families, arranged for first home visits and family assessments. Caregivers that agreed to services and signed the social service application were considered to have accepted PSOP services.

While counties varied in the amount of time staff devoted to the outreach process, the entire process from reception of the referral to the point of a signature on a county application was estimated to take up to 30 days.

[9] Shown in the final 2004 AR evaluation report. The combined effects of the orientation to families (that is, the non-adversarial, helping approach) and services were demonstrated more robustly in the 2006 follow-up report of the Minnesota AR evaluation: http://www.iarstl.org/papers/FinalMNFARReport.pdf (see Chapter 2 of that report).

2.3.2 Challenges of Referrals of Families Screened Out of CPS. Screened-out reports are expunged and families are not notified about them. Thus, families approached by PSOP workers were unaware that CA/N reports had been made until workers contacted them. Because of the association with child protection, PSOP may have been less threatening to families when it was not associated with a maltreatment report made to the county about a child. When families were referred to PSOP by a collateral agency or different county department, workers perceived that families tended to be less resistant to outreach. This was confirmed by the increase in acceptance of PSOP after referral sources were broadened (see Figure 1.3).

2.3.3 Families with Previous CPS Contacts. Workers believed that calls or visits by county workers sometimes raised defenses among families that had had previous experience with CPS. Yet, families with previous experience with public services, including CPS, were not less likely but *more likely* to accept PSOP services (see Figure 3.1). PSOP accepters were substantially more likely to have had past CPS reports and/or cases (34.7 percent of accepters versus 27.7 percent of decliners). Some families with previous experience with CPS no doubt found it a barrier to accepting PSOP services. But if it was a barrier for most families of this kind we would expect the rates of acceptance to be reversed, that is, many *fewer* families with previous CPS report engaged to accepted PSOP.

On the other hand, community-based agency workers in counties with the *contracted* model had greater success in engaging families with a previous CPS history. More families (64.3 percent) previously reported to CPS accepted PSOP in counties that relied on workers from community agencies, than similar families in counties with dedicated county workers (49.7 percent) or those that used county workers with divided responsibilities (49.5 percent), as is shown in Chapter 3. Community agency workers were substantially more successful in engaging such families, but public agency workers were also successful with about half of such families. Nonetheless, counties were successful overall in engaging half to two-thirds of such families.

2.3.4 The Explanation and Offer of PSOP. When parents of screened-out maltreatment reports were approached they were hearing about PSOP for the first time. In these cases, workers regarded the first meeting and method of presentation of the program as critical to family receptivity. Initial outreach methods were less important to successful enrollment of families that had previously discussed PSOP with another professional, such as their MFIP worker. In these cases, the parent was usually expecting a call from the county or community provider regarding the program and had already made a preliminary decision to participate. Some parents referred themselves to the program and were by that fact motivated and ready to accept when the program was offered. For these types of referrals, outreach workers noted that there was little resistance to the idea of PSOP services.

According to workers and supervisors, two things most influenced the success of outreach to "screened-out" families. The first was the language that was used by the

worker to inform the family about how the county obtained their name. The second was whether the outreach worker was a county employee or staff of a community-based provider.

Concerning the latter, workers stated that parents were more hesitant to agree to services when a county employee presented the offer rather than a community-based social work provider. One worker described this as stemming from a "consistent fear of county involvement." Staff members from community service providers also noted that families were not as skeptical of community-based agencies, especially those that had a strong local reputation for serving families. Some workers from community agencies used this fact to their advantage during the engagement process, making sure to mention that they were "not from the county." Despite this tendency, however, outreach staff agreed that <u>the engagement skills of the worker were more critical than an individual's professional affiliation with the county or particular agency.</u>

The precise language that was used to let a parent know why they were being contacted and what was being offered seemed to impact how the parent responded. Many staff that conducted outreach throughout the project stated that parents often reacted poorly to being informed that a report had been made regarding their family. In response, workers adapted the way they introduced the program and generally tried to avoid using the word "report" or discussing the content of the report during the initial phone conversation. If possible, workers would instead let the parent know that "concerns" had been brought to the attention of the county. One very experienced county child welfare worker said that she typically used the phrase "a call or concern was made regarding your family's well being." A worker from a community agency explained:

> *When I address families for the first time, I usually don't get into the report a whole lot. In my initial phone call, I just let them know we are offering this new program to families, to assist them in getting the things they need. The program is about you being able to decide what you need.*

Sometimes workers attempted to skirt the issue of the report altogether and suggested to the family that they had been selected for the opportunity to receive services through a pilot project. Only if the parent questioned the worker further would the worker discuss that a hotline report had been received. In some counties (for example, Hennepin) the county had an internal policy requiring that families be informed of the CA/N report.

Workers skilled in outreach and engagement described how they took cues from the family to shape their communication with parents. If the family raised an issue, like trouble with a broken down car, workers would build on this to show the family how the program could help them address the issue. Experienced workers varied their approach according to the type of report or referral. If the report concerned a dirty home, for example, the worker would focus on issues that were likely to be relevant to that problem. Other strategies included asking multiple questions about the family, but limiting the amount of time that the program itself was discussed during the initial call.

Successful engagement styles were non-judgmental and pro-family, conveying the belief in the family's ability to change and the value of PSOP in helping them. A seasoned county child welfare worker explained:

I approach the family knowing that they are going to be afraid of social services. I really focus on building a human connection, understanding where they are coming from, but also having ideas in mind about what resources might be helpful for them, to make it practical for them to become involved.

A community based agency worker that dealt primarily with "screened-out families" summarized her outreach approach:

I try to go out to the home first, [because there is a] better chance of engaging them face-to-face. I would be more likely to frame [the child protection report] in terms of a "concern", or a "referral," rather than a "CP report". If there was a police report attached, I might say "I heard you had some problems with the police", because they are obviously going to know that. I might just say, "I heard that you might benefit from our services." You can sense when you meet with them what they are hearing, how much they can take in at one time, how quickly you need to come back to set up the assessment. [You are] making some really quick decisions about the course to take with the family. If the client is an MFIP client, the phone call does mention that there was a referral made from the county worker that the individual may benefit from services. [You] have to judge their anxiety level.

Another worker from the same community agency describes it this way:

A common theme with the families is poverty, and trying to figure out how to get through the county system. One of the things that we [the workers] would say regardless of the situation would be that we are able to help them [the parent] navigate through the county system and can help them stay in compliance with MFIP. Also, another common theme is that we always acknowledge that parenting can be difficult, and that we can offer support. We stress that even if the family has good friends and [extended] family it can be helpful to have a neutral person that can [offer] support during times of stress. We also emphasize that we are <u>not</u> the county. That in itself can ease tension. Some have had numerous bad experiences with the county and we can take some of those defenses down by saying that is not who we are. It helps to go into it knowing things about the family, such as the kids' names, and using that to show an interest in the situation and the family unit. We try to be flexible and reduce the demands on the family.

2.4 Motivation to Participate in PSOP

2.4.1 Financial Incentives and Initial Engagement. PSOP was a flexible funding program. Each pilot county received funding of $1,000 per family up to its targeted number of families. Counties were given wide discretion in how these funds

would be spent to address the needs of families, including traditional counseling and therapeutic services but also services to address basic poverty-related needs. This feature of the program was a key incentive for families because most were near or below the poverty level (see Chapter 3). In at least 12 counties, staff said that workers routinely mentioned the availability of financial help during outreach calls as a way to increase parent's interest in the program. Several counties indicated that this strategy was "critical" to getting people to agree to service. A county child welfare worker stated:

> *Suggesting or stating outright to the parent that "we have money to help your family" is an engagement strategy that all of us use.*

In this worker's county and several others, flexible funding defined PSOP. Workers that managed other types of child welfare cases asked which families on their caseloads might benefit from flexible funding. Workers approached newly referred cases with the question, *How can we use the funding to help the family?* In these counties, being able to do something tangible for families also appeared to be a motivation for workers.

The explicit and up-front approach was not universal, however. Staff in one community-based agency stated that they usually did not mention flexible funding until the client brought up a need. They did not announce to the family that the county had money to spend. A worker in this agency explained:

> *The reality is that if we came to the family announcing we had a $50 grocery card and said, 'Do you want to come work with me?,' we would not see real motivation to move forward. Are you going to have a really engaged client? It is not [the agency's] way to emphasize that we have anything to give anyone.*

How funding was allocated in the county may have influenced how readily it was offered to families. In counties that allocated the funding entirely for services or concrete items for families, staff felt more freedom to offer it openly. In counties that allocated most of the funds to contracts or staff time, there was less to offer families and workers were more guarded. Ramsey County, for example, used most of the money to fund contract providers and limited the amount the providers could spend on each family to $200. In Chisago County, all the PSOP funds were allocated to the contract agency for case-management services and virtually none were available for extra spending on families. Staff members in counties such as these had limited financial flexibility and had to be more creative in meeting family needs. Workers in Chisago, for example, depended a great deal on community agencies, thrift stores, churches and food banks, and used engagement strategies other than an offer of financial assistance to secure participation.

2.4.2 Internal Motivation to Improve Parenting Skills. Parents participated in PSOP for many reasons. In some cases the motivation was simple and straightforward, such as the need to have utilities restored. In others it was complex, like the hope of reducing domestic violence. PSOP was intended to prevent incidences of abuse and

neglect by offering whatever assistance parents needed but a basic goal was to strengthen their parenting skills. This was often not a primary priority for parents who viewed other problems as more important than their relationships with their children. Parents in difficult circumstances often do not recognize how circumstances affect their children's behavior or their own ability to interact positively with their child. Parents often did not immediately perceive that there was any safety risk to their child, even in cases initiated because of a child protection report. As one worker described:

> *Sometimes [parents'] are not even perceiving it. [They are] so into survival, and not in tune with their children. [Parents] have trouble recognizing their own behavior.*

Another worker stated:

> *Many times it is the way they were raised, and they don't recognize that what they are doing could harm their children. Parents are more likely to minimize or deny risk—most think they are good parents—or explain it away. It is what they have learned. Even if families have had prior experience with CPS, they tend to explain it away. By the end of the relationship [casework], they are definitely more likely to recognize that there are alternative ways to deal with their children. Most will acknowledge that they have learned some things.*

During interviews, workers reflected on what they believed were most often the initial motivations for accepting services and how this motivation impacted a parent's willingness and ability to work on parenting issues. They observed that parents commonly entered the program with a mixture of external and internal motivations. At the time of the outreach contact, parents were primarily moved to accept services because of the possibility of removing or alleviating external stressors. As noted above and in later chapters, these stressors were usually related to their struggles to meet basic needs, such as housing, food, medical care and household needs, or with navigating the benefits systems, as with MFIP sanctions. Workers emphasized the need to first address the external stress and, as services continued, the families would begin to actively participate. In this process an internal motivation to change would develop. Workers believe that only when internal motivation was present could they then begin to address things like domestic relationships and parenting. Similarly, other sensitive personal issues, such as drug abuse, did not typically emerge until weeks or months into service. Another worker stated:

> *Often there is external pressure, such as MFIP sanctions that bring a client to us, or the need for employment, but deep down most parents want to improve their situation. Sometimes they don't have the capacity to do that on their own. They may be pushed by someone else, but that's where key engagement comes in. It also depends on how they see the service. Sometimes they just want to get one thing done, other times they see the potential of the service.*

In order to begin to work with parents on barriers to healthy parenting, experienced workers said it would not be productive to bring up relationships with their children right away, but instead to focus on the parent and what is going on in their lives. Parents quickly defend their current parenting strategy. It was better to bring up parenting issues after caregivers felt more comfortable. Pushing parenting strategies too early would raise defenses, as workers acknowledged during interviews:

> *For some, it is a generational thing and there is a certain sense of normalcy around how the family is run. It is difficult to tell parents that there is a "better" way to do things, when that's the way it was always done.*
>
> *No one wants to be told how to parent, so just to build that trust takes months. To address all the barriers and build that relationship, that takes 7 to 8 months. Then the participants might say "Yeah now I can trust you to tell me that my child needs to dress differently in the winter." The mom may change that pattern [of parenting] because she trusts her worker. I mean, you can address parenting early in the relationship, but the minute you walk out the door, they are going to say "Yeah, whatever,…are you a mom? What do you know? Your kid is probably perfect.*

Pressure to address external needs and the length of time necessary for parents to reach a comfort level with workers made addressing parenting issues difficult. It was an important goal of PSOP but was not the need most frequently addressed nor the service most often delivered (see Figure 4.3).

2.5 Case Intensity and Family Change

Most workers and supervisors stated that the needs of PSOP families and the time required to work with them exceeded original expectations (see the discussion of Figures 3.8 and 3.9 below). Counties that had planned for short-term services and consequently had not allocated adequate staff resources to case management found that the needs of families sometimes overwhelmed staff. This also explains, in part, the focus on concrete case goals and basic services (such as, finding housing), which are time-limited. Workers could work on underlying issues only when circumstances permitted them to work longer with parents and to establish a deeper rapport.

Workers reported that the work they did with PSOP families was challenging and that it took a long time to achieve change. They noted that building the kinds of relationships with families necessary to address core issues disrupting family life took weeks or months. Supervisors and workers believed that most PSOP families needed at least 3 or 4 months of case management to reach their minimum goals. County representatives indicated that cases were typically open for three to six months but in some cases extended to eight months or more. This varied from county to county, of course, depending on the program's definition of the PSOP worker's role and available

resources. In general, analyses of case-specific data backed up these reports (see Chapter 4, Section 4.1).

In programs that encouraged more intensive services and responses to new needs as they arose, workers could choose to keep cases open until families had stabilized in most life areas. Case examples provided later in this report show how demanding and time-consuming this approach can be, especially with families that experience continuing successions of crises. Such cases are difficult to close. Some workers reported that many PSOP families needed services for as long as the county was willing to keep the case open. Workers said they had to gauge the progress of the family and how hard the family was willing to work in order to determine when cases should be ended.

They also noted that how much families could accomplish depended greatly on whether the family was ready to change. Fostering change often simply involved being a support and a guide for a family until the caregiver developed greater self-confidence and a sense of self-efficacy. Workers said that much of what they did was to try to get families to work on making better decisions and become more independent:

> *It is a really sensitive issue to challenge the way that families are doing things. We don't go in as experts. People in general just want to be validated and just want to be heard. A lot of these families know that something is missing or that something isn't right. But we need to judge if they are just looking for information or are the looking for direct support. We want them to feel respected and valued, because we want them to reach out to us again.*

> *Although we are unable to address everything by the time we close cases, most workers can document at least 3 or 4 things that they were able to accomplish. So although there are not huge strides, there are always little things that have gotten on track.*

2.6 Worker Views of Successful Outcomes

Workers and supervisors were asked during interviews to comment on what they believed were the benefits of PSOP. Because most families entered PSOP with concrete barriers to self-sufficiency and significant obstacles to appropriate parenting, workers were modest in their statements about what they believed the immediate and long-term results to be. Staff in both county and community agencies believed that success needed to be defined individually for families since each family has different abilities and needs. Any step that the family made to reach their goals was seen as positive progress, especially when the family had many things stacked against them. As one county worker stated:

> *We definitely define success differently for each family. Success could be when the risk for CA/N has gone down. Or if they have met some of their goals and have achieved some stability. If they are involved in other community resources*

and have strengthened their social network. A lot of our families are socially isolated, so knowing that they have support is part of being successful. It can also be when stress is reduced in the household, or when school performance has improved. Or simply when parents are responsive and call back. Or if a parent initiates a call to the worker. Or when you walk in the house, and it's not chaos—when the house begins to have a schedule and is more organized.

A similar sentiment is found with a community based workers:

We [workers] are happy with any type of progress. We have no attachment to any specific outcome. Things like safety, seeing a child start developing the way he or she should, are what we look for. Realizing personal responsibility. A parent becoming invested in their own life. Reflecting on what they are doing. Increasing positive interaction between parent and child. It's a lifetime process.

Success is when parents do things on their own, or increase their knowledge of resources. You have to start small. Success is when the family comes to a certain awareness, or comes to a deeper ability to love their child, or changes their attitude toward their situation. But it also can be things like making a deposit or fixing a car. In one case it was just getting a dad to a counseling session, after working on that issue for several months. Tiny things can be big deals for these families.

Another common theme that emerged among workers was parents gaining knowledge about how to better seek help in the future. The education that families received on how to seek and secure community resources was viewed as one of the program's main positive results (see Chapter 4, Section 4.4.3 for the response of families concerning their knowledge of service availability). When a family seeks services on their own it is an indicator that the family can prevent potential future crises. Workers emphasized that they strove to make sure that families were connected to available services in the community and became aware enough of their own safety and risk levels to contact someone if future assistance was needed. In this way, subsequent contacts with the county did not necessarily mean that things were going poorly for the family, but that the family was trying to avoid falling into bad patterns or situation. The vast majority of supervisors and workers agreed that this was a positive step for families and that PSO thus diverted families from the child protection system. The issue of diversion from the system is one of the themes of Chapter Six (see Section 6.4).

Many staff also stated that they believed that PSOP helped to reduce the fear families may have about working with the county agency. When families have an opportunity to interact with the agency voluntarily, it can strengthen the trust that families have that the county will empower them and not threaten them. If families have an awareness of what type of assistance they can receive and begin to call social services for help before things get out of control, they begin to accumulate more positive experiences with the county.

2.6.1 Client Mobility and Case Transfer. Unstable residence is a barrier to working with families and thus to successful outcomes. Families selected for PSOP often had unstable housing arrangements and might have to move at any time, with no forwarding address. Outreach cannot occur to families that cannot be located. This was more of a problem in counties with contracted services where a case transfer occurred after initial engagement and there was a delay before outreach occurred. Some potential clients were lost in this way. In addition, families were more likely to accept services when the contracted agency could immediately begin working with the parent. In Anoka County, for example, delays sometimes occurred between first contact by the county and transfer to the contracted service provider. When delays of many days occurred, contracted workers had to reengage the family. In some instances, the parent had changed her mind or the family's living circumstances had changed in a way that made services impractical.[10]

2.6.2 When PSOP Works Best. Because PSOP allowed the county child welfare agencies to quickly respond to concrete financial needs and connect families to services in the community, workers and supervisors believed that the program was successful at keeping children from entering the child protection system. Some county staff stated that they have observed the number of CA/N reports to have gone down over the course of the pilot project and at least in part attribute this to preventing acute crisis through the PSO program.

Providing a small amount of assistance up front can help maintain a family's stability and allow parents to work on deeper things. Workers stated that families who did better in the program overall were those that had immediate basic needs that could be directly addressed. The program model lends itself well to those with short term needs who just need a small amount of help to keep them from a serious crisis. A county worker likened these families to "simmering pots that sometimes boil over." However, workers also stated that families that seemed to accomplish the most in the program were those that recognized and acknowledged that they had parenting or mental health issues at the start of service. Parents that agreed to parenting services or other support in addition to case-management made the most gains. In general, families that "needed an extra push" and were cooperative tended to have better outcomes. Parents appreciated having the choice to participate, the ability to set the goals they want to work on and the opportunity to end service when they wanted to.

[10] This was also found in IAR's study of differential response in Missouri. One of the positive outcomes was avoidance of the delays between initial contacts with families and the entrance of a service worker into their lives. To read about this go to www.iarstl.org, and click on the *papers and reports* tab and under Child Welfare in Missouri click on *Missouri Family Assessment and Response Demonstration Evaluation Report, November, 1997* and then on *full report.* The relevant sections can be found on pages 49-51 and 107-114. In general, family flight was reduced by initiating services at the time of the first visit with families.

2.7 Similarity to Alternative Response (FAR) Families

Although a large portion of the PSOP population was screened out from formal child protection responses, supervisors and workers believed that PSOP families were very similar to families served through FAR (see Chapter 3, Section 3.3). Many PSOP parents had prior contact with the CPS system (see Chapter 3, Section 3.1), either with their own children or with their family of origin. The primary difference identified by staff between the PSOP client population and the FAR client population was the presence of an immediate safety threat. At the time of the report, FAR families have safety issues that are critical. County staff otherwise perceived that the circumstances for both sets of families were largely the same. Workers believed that each program worked with the same population, but that PSOP often caught families right before the situation became unmanageable. Because PSOP was not directly focused on resolving a safety threat, there was an opportunity to get to know the parent and to provide them with more general help and encouragement. One worker gave this example:

> *I really had a strong relationship with one mother. It was clear that what she was missing was having someone to call and chat with, have someone to take interest her. There was some DV going on; she was the mother of five children. But one visit all I did was look through her design portfolio. I didn't get any folder out or talk about anything. All we did was look through her art. [The mother] had said to me many times that that was the best thing that anyone had done for her for a long time. Just appreciate her and encourage her to continue to reach for that goal. The connection made that case a success. She just needed that support and she was then very empowered to make some decisions and utilize some resources that were provided.*

According to most county workers interviewed, services for PSOP and FAR families were similar, focusing on addressing basic needs, crisis management and parenting skills. FAR families may receive more interventions directed towards trying to prevent the recurrence of abuse or neglect, and according to workers in some counties, these families may receive more in-home parenting support as part of their case plan. PSOP families may have had a larger and more flexible contingency fund available through the program than FAR families, although most workers felt that they also had sufficient access to financial resources to meet the concrete needs of FAR families.

2.8 Conclusions

PSOP was a voluntary program that families were completely free to accept or reject. For this reason, greater organizational freedom was also possible than is the case for programs designed to approach families whose reports are screened-in to CPS. Participating counties organized the program in different ways, with initial contact and case management conducted completely by public workers in some instances and in others by private workers and various public-private combinations. While there were some advantages in permitting private agency workers to make initial contacts, the

program operated successfully in each of the three general structures that we have outlined. There was no evidence that PSOP failed because of where the program resided or the types of workers utilized. Most respondents felt that the most important factor in successfully engaging families was the skills of workers rather than their originating agencies.

PSOP is a case example of successful program adaptation. Criteria for admittance to the program were broadened. Workers and supervisors adapted and revised methods of presenting the program to families. Both these changes were instrumental in increasing the proportions of approached families that were willing to participate in the program during the final two years of the evaluation.

3.
Characteristics and Needs of PSOP Families

In order to understand the PSOP process and its effects on families, this chapter examined the characteristics of families involved in the program. It considers the background of families in relation to public agencies, the size and structure of families, their income and employment situation, the connectedness to other family members and the community, the types of neighborhoods in which they lived and special problems or needs that were identified by workers.

An assumption that program planners made during the design of PSOP was that the families initially targeted for an approach would be younger parents with minimal previous contacts with child protection and with fewer needs than the population of families for whom reports had been accepted for a response within CPS. Workers that approached families generally did not find this to be the case. Families that accepted PSOP services often had multiple needs and in many cases had experienced or were in the midst of various crises.

3.1 Families Declining Compared to those Accepting PSOP Services

Information was compiled on previous contacts that families referred to PSOP had with each of the service systems tracked through SSIS. This information was compiled to permit comparisons of families that accepted assistance with those that declined. The service systems included:

1. **Assessments and cases within the Child Protection System (CPS).** In Minnesota these included two kinds of cases: those that began with a traditional investigation and others that began with a non-adversarial family assessment.

2. **Child welfare assessments and cases.** Minnesota also has a parallel system for approaching families in need of child welfare service outside of CPS.

3. **Childcare services.** Publicly funded childcare is made available to qualifying families in Minnesota through a regional system of information and referral agencies and private providers of services.

4. **Chemical dependency services.** Alcohol and drug treatment services.

5. **Developmental disabilities and mental health-related services.** Under this category we included: Children's Mental Health, Developmental Disabilities services and Early Intervention for DD or High Risk Infants and Toddlers.

6. **Adult Services.** Under this rubric we included Adult Mental Health, Adult Services, Community Alternative Care for adults, Community Alternative Care for disabled individuals, the waiver programs for the elderly and adult traumatic brain injury.

7. **Placement Related Services to Children and Families.** These included Adolescent Independent Living Skills, Minor Parent services, child protection facilities, the alternative care waiver and adoption and guardianship programs.

The service backgrounds of families accepting or declining PSOP services are compared in Figure 3.1. This figure is based on counts of *any* services within each category. Families with any contact with child welfare, for example, are counted as equivalent although some had only one and others had multiple previous contacts. However, families with multiple previous contact *in several different service categories* were a small minority of all cases.

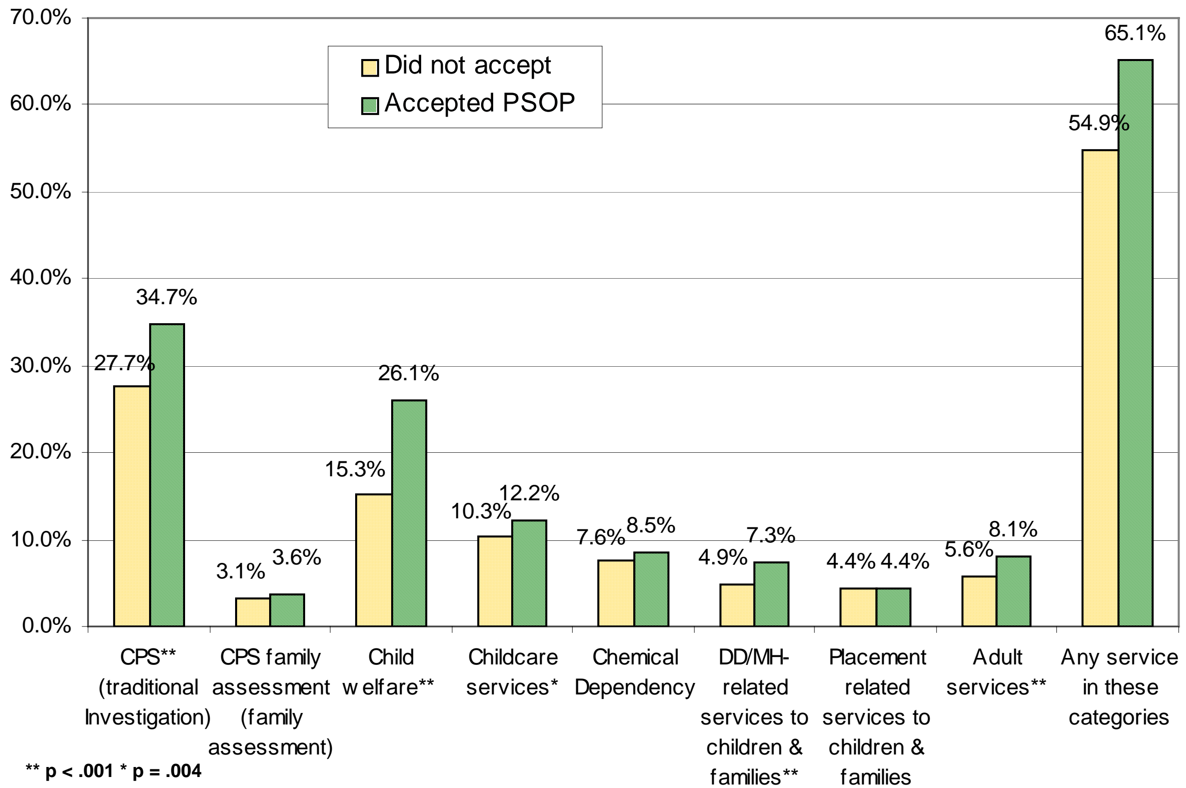


Figure 3.1 Previous Experience in Public Agency Cases of Families that Accepted and Declined PSOP Services

Families that accepted services had significantly greater contacts in several categories. Over one-third (34.7 percent) of PSOP accepters had at least one previous report accepted by CPS for an investigation. This is significantly greater than the rate for PSOP decliners. These did not always develop into a formal CPS case, but represent one step beyond the kind of response to reports that brought families into the PSOP. A similar result can be seen for child welfare cases, for developmental disabilities and mental health, and adult services. In addition, they were more likely to have utilized

childcare services in the past. No differences were found for past reports accepted for family assessments, past chemical dependency services or placement-related services. Finally, 54.9 percent of decliners and 65.1 percent of accepters had a case in at least one of these categories.

This analysis demonstrates two things. First, a majority of all families approached by PSOP workers had a previous case within one of these problem or service categories. Second, a greater proportion of families that agreed to participate in PSOP—nearly two-thirds—had such a previous involvement. On the assumption that service history is a predictor of future needs, these findings support the statements of workers and supervisors that PSOP families had greater service needs than originally anticipated.

3.1.1 Level of Acceptance in Counties with Different Models of PSOP. Three models of PSOP were described in Chapter 2: 1) Contracted: case-management was contracted out to one or more community agencies, 2) Dedicated: case-management was handled by one or more county social workers that are solely dedicated to PSOP, 3) Divided: case-management was split among county workers that also handled other child-welfare or child-protection cases. The highest level of acceptance of PSOP services was found in counties with contracted providers at 53.2 percent. Counties with a dedicated worker had an acceptance rate of 48.1 percent. Counties with the divided model demonstrated a rate of 45.5 percent. These were statistically significant differences ($p < .001$), although the levels of difference were modest.

The difference is attributable in part to greater success under the contracted model with families that had previous experience with traditional CPS. More families (64.3 percent) previously reported to CPS accepted PSOP in counties that used *contracted* providers, than similar families in *dedicated* counties (49.7 percent) or in *divided* counties (49.5 percent). This was not the case for most other types of previous service contacts.

3.1.2 Race of Decliners and Accepters. Characteristics of racial groups will be considered further below. Some differences of the entire population of families are noted here. The racial distribution of families approached by PSOP was uneven in several ways. First, most of the counties that participated were non-metro counties that had predominantly Caucasian populations, and therefore, 72.6 percent of total families were Caucasian, while 16.0 percent were African American, 7.0 percent were American Indian, 3.2 percent were Southeast Asian, and 1.2 percent were Other Asian or Pacific Islander.

The distribution of racial groups across the participating counties was uneven. Caucasian families were the largest group of families approached for PSOP and were found in all participating counties. Nine of every ten African American families were located in metro counties with Anoka, Dakota, Hennepin, Ramsey and Scott accounting for 78.9 percent and Olmsted another 10.7 percent. American Indian families were located in counties where tribes resided with Beltrami, Carlton, Mille Lacs and Polk accounting for 51.4 percent and another 30.3 percent in the metro counties of Anoka, Dakota, Hennepin, Ramsey and Scott. Southeast Asians were in metro areas but mainly

in two counties, Ramsey, with 77.6 percent and Olmsted, with 8.1 percent. Other Asians were also in metro counties.

Southeast Asians were the most accepting group of families encountered by PSOP workers with 84.8 percent agreeing to participate in PSOP. These were followed by African American families at 61.8 percent. American Indian and Caucasian families accepted at lower rates of 52.0 percent and 48.3 percent, respectively. Finally, the lowest rate of acceptance was found among the smaller group of other Asian and Pacific Islander families at 38.8 percent.

The distribution of previous cases by race revealed that African American and American Indian families were more likely to have had previous CPS involvement in the form of a traditional investigation. They were not more likely to have had previous child welfare cases, however, and African American families were slightly less likely to have had childcare services in the past. The pattern of higher rates of previous service contacts among families that agreed to PSOP services held true for all the racial groups.

3.2 Characteristic and Needs of Families that Agreed to Services

Detailed information underlying the following analyses were available only for families that *accepted* the PSOP services.

3.2.1 Types of Households and Families. PSOP workers indicated the types of adults in households. These are summarized in Figure 3.2. In a little over one-third of families (34.5 percent) the father of the children was present and a male companion was present in another 6.7 percent. Grandfathers, grandmothers, uncles, aunts and other adults were present in small numbers of families but these often were overlapping counts, that is, there were multiple other adults in the household. The mother was present in 92.6 percent of accepter households and in 43.6 percent no other adult was reported present in the household.

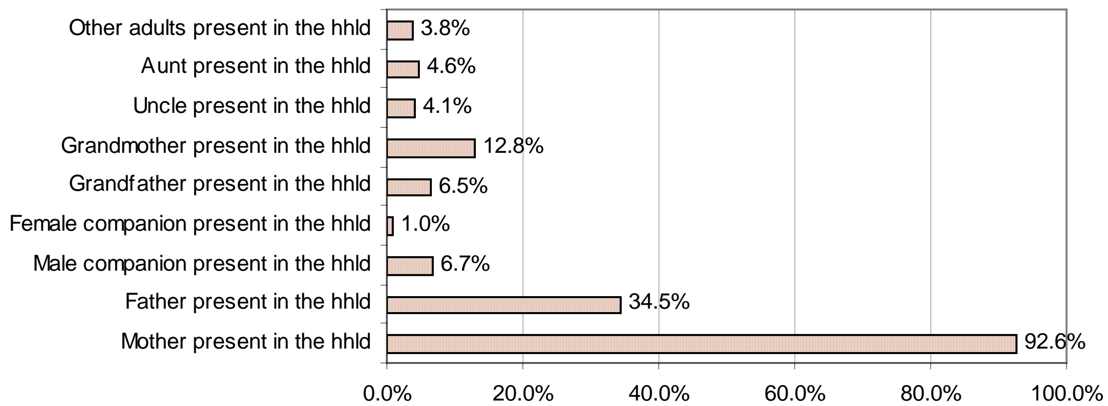


Figure 3.2 Household Membership of PSOP Accepters

Families averaged 2.4 children each. The numbers of children were: one child in 30.8 percent of families, two children in 32.6 percent, three children in 19.4 percent and more than three children in 17.2 percent of families. In 35.4 percent, at least one child was present from more than one relationship or marriage and custody disputes were going on in 15.0 percent of families. The average of 2.4 children is substantially larger than the average for all families: 1.93 children for Minnesota families with children in the 2000 Census.

Racial differences in the average number of children were found, but were small for families that accepted PSOP services and not statistically significant: Caucasian: 2.34; African American: 2.66 and American Indian: 2.66.

In the initial family survey, caregivers indicated the number of children in their family and the ages of their children. These are summarized in Figure 3.3. Over half of the PSOP families had one or more preschool children in their families, and about half of these were infants and toddlers under three years of age. Large family size and younger children make employment more difficult, particularly in mother-only families.

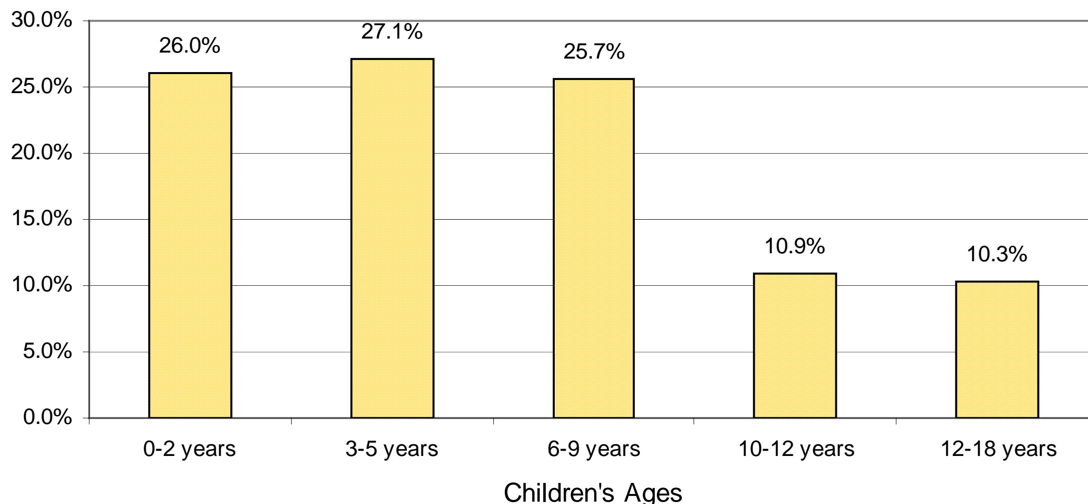


Figure 3.3. Proportions of Families with Children in Five Age Groups

The marital status of families is shown in Table 3.1. Roughly a fifth of caregivers were married, and family feedback data indicated that about the same proportion were living with their spouse. However, another fifth (20.3 percent) reported a male companion (most often the father of the children) living in the household. Racial differences were found in marital status in the *never married* category: Caucasian: 43.3 percent; African American: 69.7 percent; American Indian: 50.0 percent.

Table 3.1 Martial Status

	Percent		Percent
Married	20.7%	Widowed	0.8%
Separated	11.2%	Never married	47.2%
Divorced	20.1%		

3.2.2 Education. Only a small proportion of caregivers had not completed high school (16.4 percent), while 35.8 percent had a high school diploma or GED (Figure 3.4). A relatively large proportion (42.6 percent) had some college or had completed a two year program and 5.1 percent had a college degree. Racial differences in education were small among PSOP accepters, with African American caregivers having a lower proportion with a high school education or GED (30.3 percent compared to 36.5 percent for Caucasians and 35.1 percent for American Indians) and slightly higher proportions with less than a high school education among both African American and American Indian families.

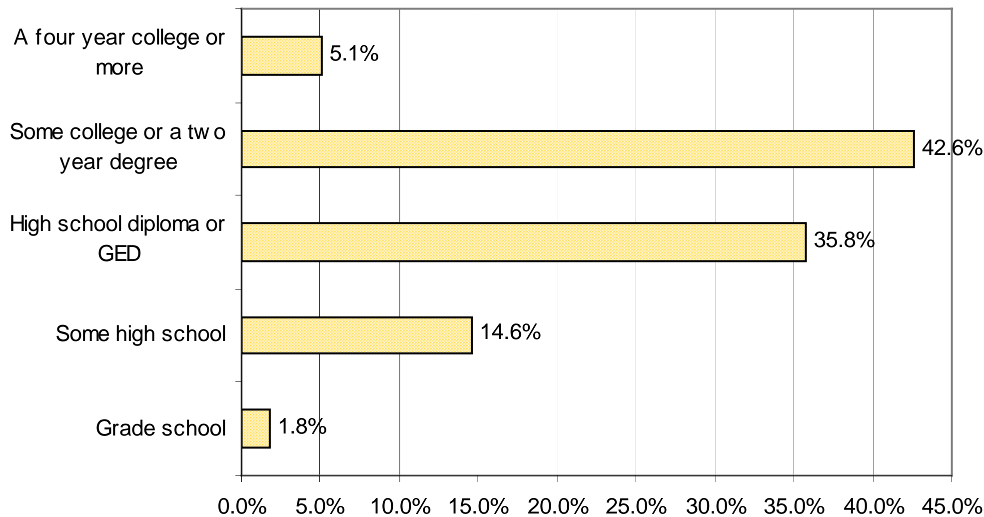


Figure 3.4 Educational Level of PSOP Caregivers.

3.2.3 Poverty and Income. Only 27.6 percent of respondents to the family survey indicated that they were employed full-time, while another 21.1 percent were working only part-time (Figure 3.5). Another 48.2 percent were unemployed and 3.1 percent were doing volunteer work. Of those that were employed, 41.5 percent were working less than 30 hours per week, as can be calculated from Table 3.2. This table shows that some who said they were working full time were working less than 40 hours per week.

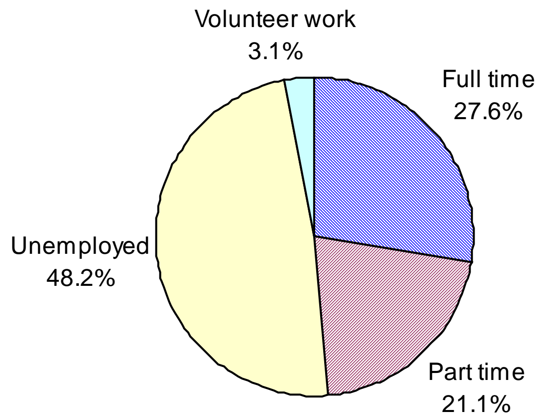


Figure 3.5 Employment of PSOP Caregivers

Table 3.2 Hours Worked per Week

	Percent
Less than 20 hours	21.4%
20 to 29 hours	20.1%
30 to 39 hours	25.6%
40 hours or more	32.9%

There were sometimes adults other than the survey respondent who were working. Of all PSOP caregivers, 41.1 percent reported that they were currently living with a partner, and of these, 55.5 percent reported that their partner was employed full-time and another 14.0 percent indicated part-time employment.

Reported annual incomes of PSOP families were low. In Table 3.3 it can be seen that total income over the previous 12 months was below the poverty level for the majority of families. This can be judged from the proportion (61.4 percent) who earned less than $15,000. This income places families with two children below the poverty level, and the average for this population was 2.4 children per family. Less than 10 percent had incomes near or at the middle class level ($30,000 or more). Most PSOP families were in poverty and a substantial minority (42.5 percent) with incomes of less than $10,000 over 12 months could be said to be in deep poverty.

Table 3.3 Household Income during the Past 12 Months

	Percent	Cumulative Percent
Less than $5,000	20.0%	20.0%
$5,000-$9,999	22.5%	42.5%
$10000>$14,999	18.9%	61.4%
$15000>$19,999	11.4%	72.8%
$20,000>$29,999	13.4%	86.2%
$30,000>$39,999	7.5%	93.7%
$40,000>$49,999	3.4%	97.1%
$50,000 or more	2.9%	100.0%

Racial differences were found in income levels. Virtually all the families with incomes above $30,000 were Caucasian. Correspondingly higher proportions of African American and American Indian families were found in the lowest categories. For

example the percentages earning less than $10,000 per year were: Caucasian: 40.8 percent; African American: 56.5 percent; American Indian: 51.3 percent.

Caregivers were asked whether their current income had changed "since this time last year." Most were steady or on a downward slope during this period: 40.6 percent said *decreased*, 25.6 percent said *no change* and 33.8 percent said *increased*.

Low income status is also supported by the proportions receiving cash and non-cash welfare support. The categories are shown in Figure 3.6. Nearly two-thirds were receiving food stamps. The large proportion receiving WIC corresponds to the many families with very young children. It should be remembered that this survey was conducted *after* the final contact with the PSOP worker. Thus, in some cases enrollment in these programs was the *result* of assistance provided through PSOP.

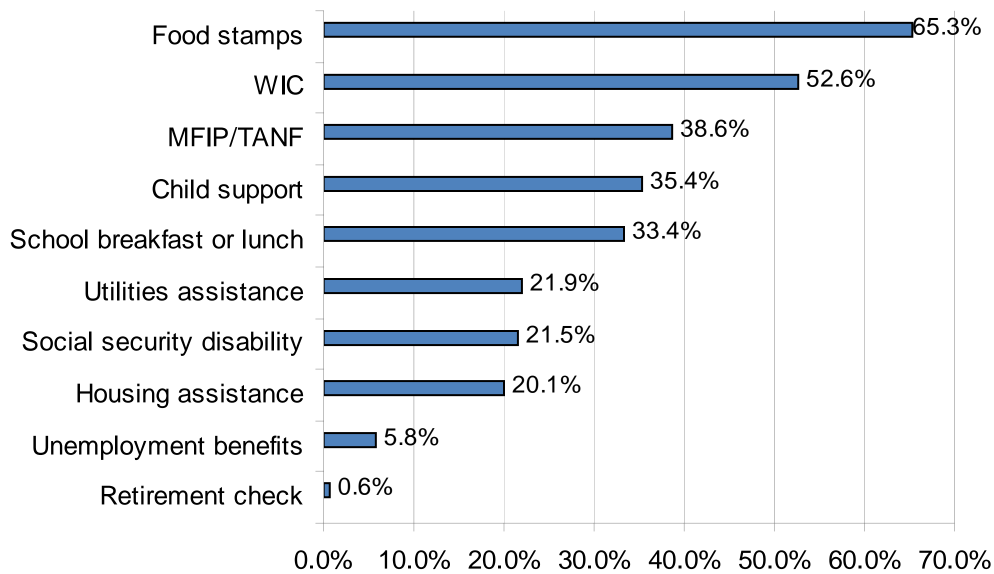


Figure 3.6 Other Sources of Support

3.2.4 Social Support and Isolation. Families were asked a series of questions about sources of emotional and financial support in their lives. The questions and caregivers' responses are shown in Figure 3.7. The questions are arranged in order with those indicating greater support at the top and those indicating less support, and thus greater isolation, at the bottom of the chart. Those with the most positive ratings referred to emotional support (a person to talk to or turn to in times of stress). Again, these questions were answered after the end of the PSOP case during which some linkages might have been made and after the worker had had contacts (extensive in many cases as is shown in the following chapter) with the caregiver and family members. The responses may in some instances reflect improved family relationships achieved under PSOP. It is even possible that the *anyone* referred to in the question was the PSOP worker.

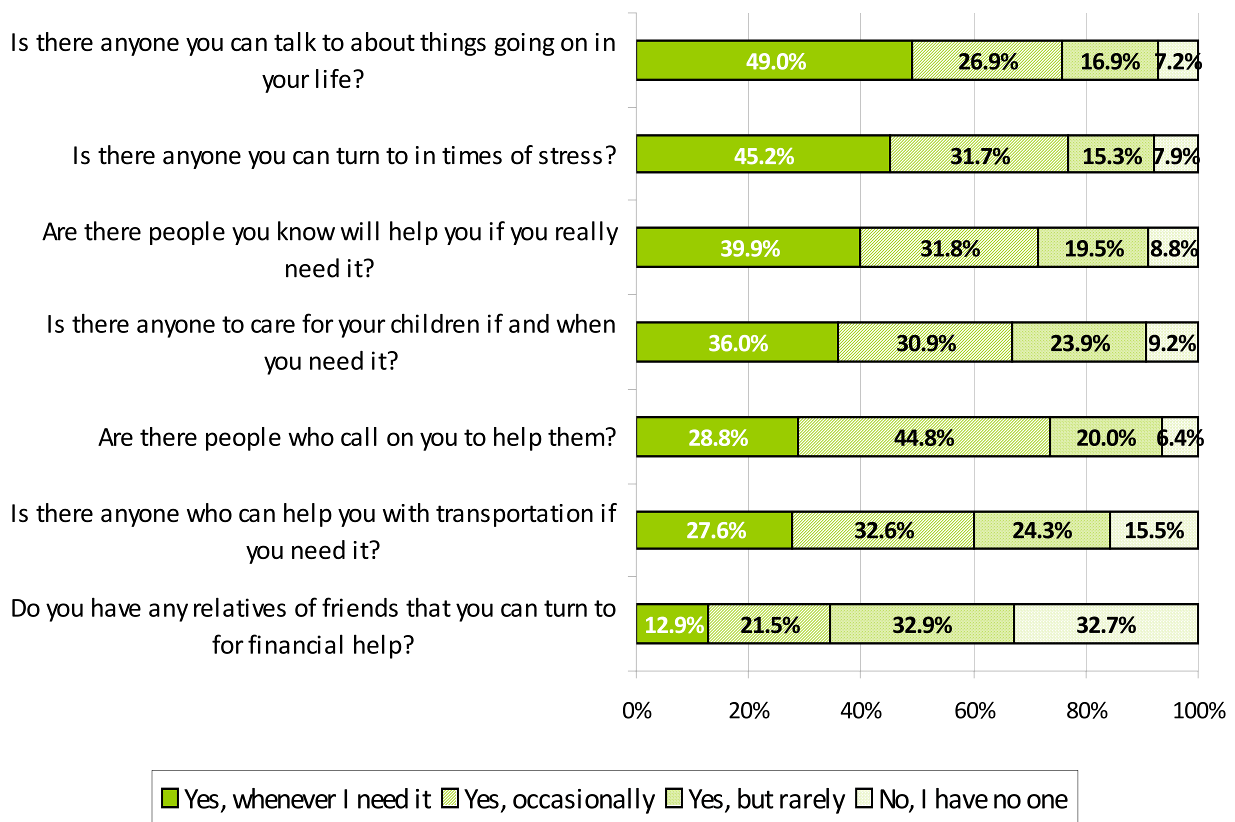


Figure 3.7 Items Indicating Social Support or Isolation

A general social isolation score was generated by scoring the responses on the questions and summing them. Social isolation scores ranged from 7 (score of one on each of the seven questions) to 28 (a score of 4 on each of the questions).[11] Families with scores of 20 or higher (20.4 percent of all responding families) could be characterized as very isolated. The average for all families was 14.8, which might be thought to correspond overall to the second response item: *yes, occasionally*.

Families with the two lowest categories of income in Table 3.3 (less than $10,000 per year) also had the highest social isolation scores, and generally those with greater incomes showed more social connection and reduced isolation ($p = .048$). The differences in scores were not great, however, because some of the questions were less concerned with financial support and more with social support.

Some variations were found in social isolation by race, but the differences were small and were not statistically significant. The level of emotional (and financial) support from friends and family, therefore, was generally consistent across families of different races and ethnic backgrounds.

[11] The range of scores and internal consistency are described in Appendix 1.

3.2.5 Description of Neighborhoods of PSOP Families. There was apparent variability in the residential neighborhoods of families. This is reflected in the answers to questions directed to families about the area (or neighborhood) in which they lived (Table 3.4). In each case a minority ranging from 8.9 to 48.3 percent described their neighborhoods in a negative fashion (the two negative categories). The more negative categories were related to social relationships in neighborhoods: help from other people, others to be counted on, and safety.

Table 3.4 Neighborhood Characteristics Reported by Families

*Description of the Area or Neighborhood where You Live?**	Very much	Some-what	Very little	Not at all
People here help each other out	15.9%	35.8%	26.4%	21.9%
Buildings/yards are well maintained	47.7%	39.1%	8.2%	5.0%
People here watch out for other peoples' children	26.9%	38.6%	18.0%	16.5%
It is safe	26.9%	38.5%	18.2%	16.4%
It is good place to bring up children	53.5%	37.7%	5.8%	3.1%
There are people I can count on	22.9%	31.4%	24.4%	21.2%
There are people here who might be a bad influence on my children	13.9%	22.1%	32.1%	31.9%
There is a lot of drug abuse in this neighborhood	10.3%	13.7%	24.5%	51.6%

* Last two items are reversed.

These items were also found consistent enough to be combined into a summated scale.[12] In this case, lower scores mean poorer neighborhoods. The average for all families was 18.1 which shows that ratings were overall near the *somewhat* category. Again, difference by race were slight (within one point on the scale) and were not statistically significant. Like social isolation, therefore, PSOP families of different races regarded their neighborhoods in similar ways.

3.2.6 Caregiver Stress. Several questions were addressed to families concerning stress they were currently feeling in their lives (Table 3.5). The greatest stress among PSOP families appeared to be related to their financial situation (82.4 percent answering *some* or *a lot*) and their job prospects (55.4 percent answering *some* or *a lot*). The majority expressed little or no stress regarding relationships. These items were also formed into a summated scale.[13] Small but insignificant differences were found in overall ratings of stress among families of different races.

The general measure of life stress correlated with social isolation ($r = .38$, $p < .001$). Caregivers who described their situation as lacking in social and financial support were more likely to describe their lives as stressful.

[12] See Appendix 1.
[13] See Appendix 1.

Table 3.5 Caregiver Stress

How much stress do you feel about the following:	A lot	Some	A little	No stress
Financial outlook	45.7%	36.7%	14.0%	3.6%
Job or job prospects	25.3%	30.1%	21.6%	23.1%
Relationship with other adults	12.2%	30.9%	25.6%	30.4%
Relationship with children	8.7%	20.1%	35.9%	35.3%
General well being	11.4%	25.9%	35.3%	27.5%
Overall well being of children	8.9%	17.5%	32.8%	40.9%
Home	16.8%	21.7%	32.8%	28.7%
Life in general	19.2%	34.6%	31.3%	14.9%

3.2.7 Worker Assessments of Family Needs and Strengths. Workers completed the Structured Decision Making Family Need and Strengths (FNS) instrument. Generally, the tool was completed relatively early after the first encounter with the family, although in a minority of cases completion was delayed nearer to the end of cases and in some cases after the last meeting with the family. The FNS was designed to provide workers with a systematic and relatively simple method of rating families on 13 dimensions (Figure 3.8a and 3.8b).

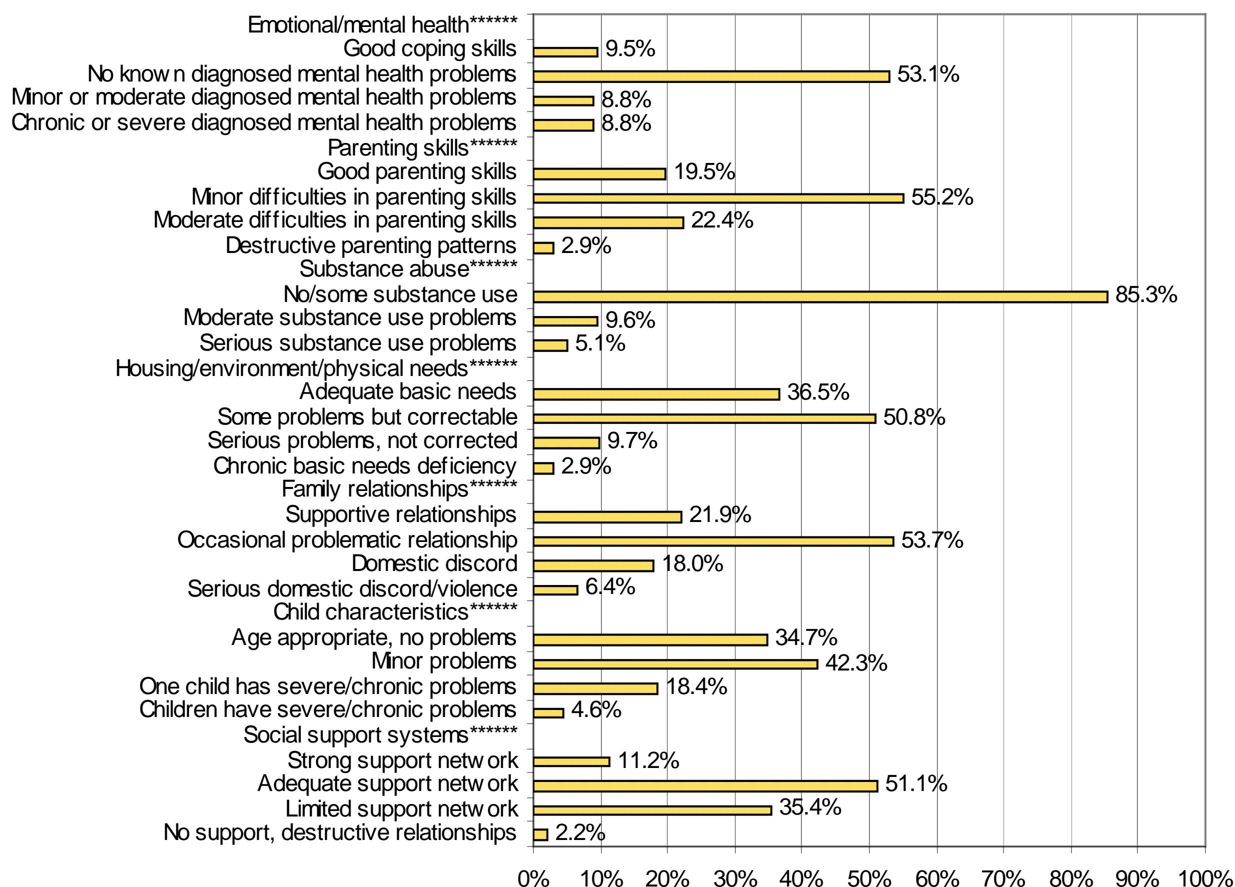


Figure 3.8a Family Needs and Strengths Ratings by PSOP Workers (Part 1)

For most FNS items, ratings indicated strengths or needs in particular areas. For example, the category *Caregiver Life Skills* ranged from *good* through *adequate* and *poor* to *severely deficient*. For some other items, only the need or its absence could be checked. For instance, *Physical Health* ranged from *no adverse problems* to *serious problems or disabilities*.

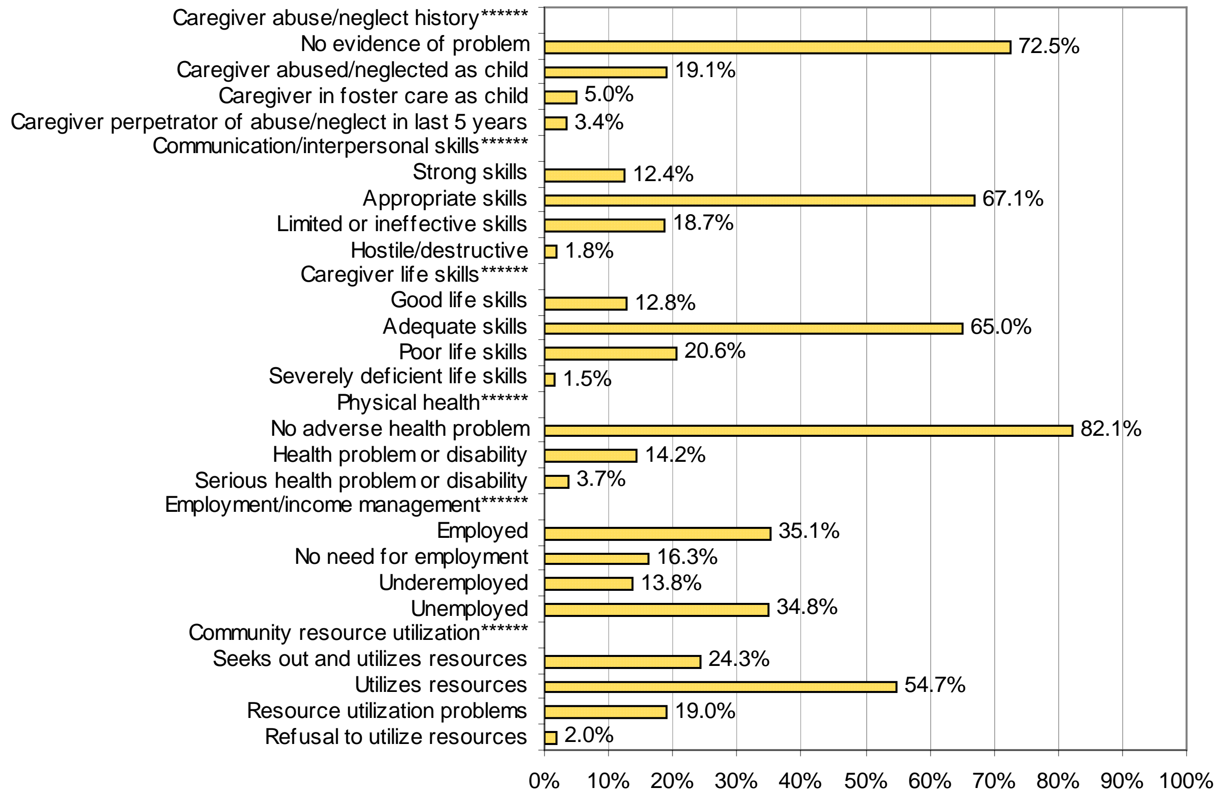


Figure 3.8b Family Needs and Strengths Ratings by PSOP Workers (Part 2)

The general pattern of FNS ratings that workers entered for these families was that the majority showed either strengths in a particular area or only minor problems. However, in each category serious or chronic problems were referenced in a substantial minority of families ranging from roughly 15 to 35 percent. For example, 17.6 percent of families were identified with diagnosed mental health problems, 14.7 percent had substance use problems, and 23.0 percent of families had one or more children with severe or chronic problems.

A question of importance is whether such characteristics were spread across families or were found in a minority of multi-problem families. Analysis indicated that 14.5 percent of families had no items checked as problem areas, that is, all the FNS dimensions were rated either as strengths or as absent problems. Another 14.8 percent had only one problem item and 15.8 percent had two for a total of 45.0 percent. The remaining 55.0 percent of families had 3 or more FNS items rated as problem areas and 27.9 percent of families had five or more in these categories. As can be seen from the

figures, many of these are described as severe or chronic conditions. We can conclude that a substantial minority exhibited such needs in several FNS areas. These families can probably safely be categorized as multi-problem families. As was evident from the service and case background of PSOP accepting families, this population of families as a whole must be viewed as high risk on variables that are related to child welfare deficits and possible child maltreatment.

3.2.8 Other Needs and Problem Conditions. In order to supplement the categories contained in the FNS, workers were asked to rate families on several specific areas. These were problem areas known to be related to family welfare and child maltreatment. Workers were asked to rate the condition, if present, as *moderate* or *severe* (Figure 3.9). The items are ranked from those most often indicated to those least often.

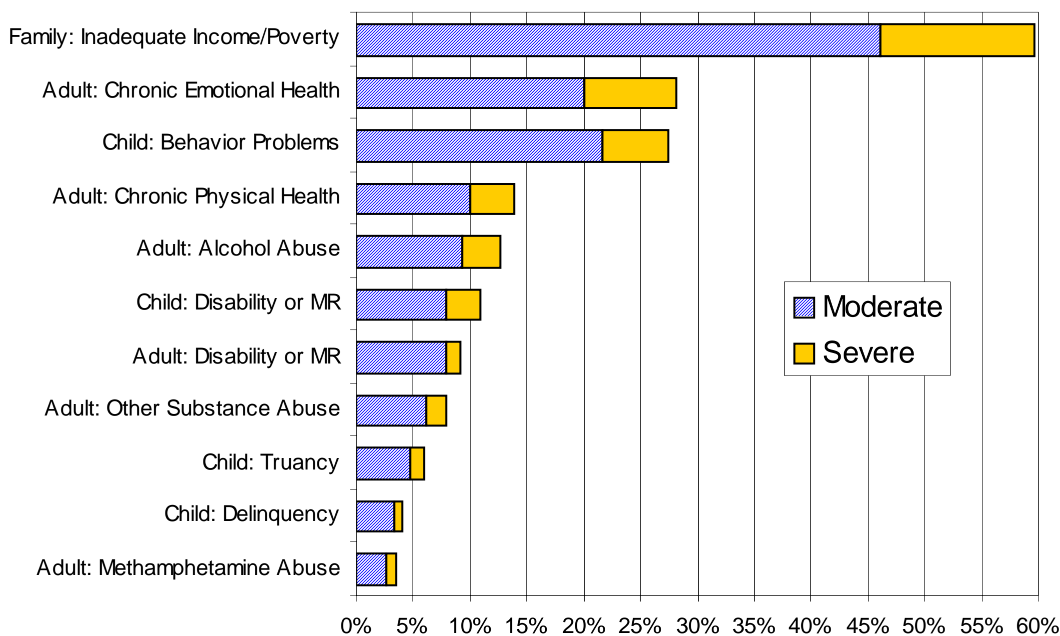


Figure 3.9 Other Problem Conditions and Needs

The most frequently indicated category was inadequate income or poverty. Workers checked this category for 59.7 percent of PSOP families, corresponding roughly to income and welfare use directly reported by families (Table 3.3 and Figure 3.6). In most cases workers rated the problem as moderate but for 13.6 percent of families they considered the problem severe.

The next largest category was chronic emotional health of an adult. This was a more general category in some ways than the corresponding category in the FNS, where the word "diagnosed" was used (see first item in Figure 3.8a). Using "chronic" permitted workers to add families increasing the total to 28.1 percent.

Similarly, by specifying multiple categories of characteristics and behavior problems for children (behavior problems, disability or mental retardation, truancy and

delinquency) the number of families with a child that strained the family in various ways increased as compared to the FNS. Analyses indicated that the four "child" categories were positively mutually associated suggesting that more than one of these problems was often found in the same family. For example, children with behavior problems are often truant or delinquent.

Also unlike the FNS, substance abuse was broken into three specific categories. These also tended to be mutually associated. For example, alcohol abuse was found in families where other substances were being abused. Moderate or serious substance abuse problems were checked for 14.7 percent of PSOP families using the FNS, but in the instrument underlying the present figure at least one of the three categories (alcohol, methamphetamines, other substances) was selected for 17.8 percent of families. This may be due to confusion over the terms "alcohol" and "substance."

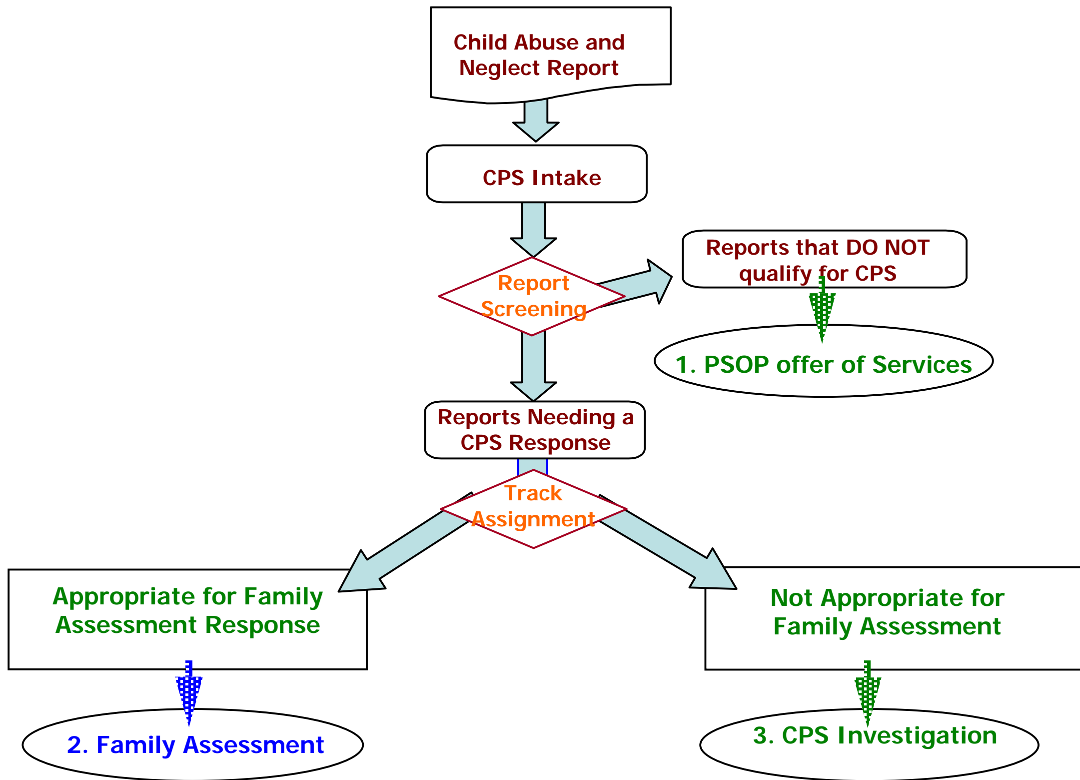
Differences by Race. Several differences in family problems and needs were found among racial groups. The differences cited were not great, but they were large enough to be statistically significant:

1. More Caucasian caregivers with emotional/mental health problems
2. Greater substance abuse for American Indian caregivers and least for African American caregivers
3. More difficulties with housing, environment and basic physical needs among African American and American Indian families
4. More family discord problems in Caucasian and American Indian families and least in African American families
5. More unemployment in African American and American Indian families
6. About half of the small group of Southeast Asian families were multi-problem families including substance abuse issues, poverty, mental health issues and children with behavior problems.

The findings in the list concerning basic needs (3) and employment (5) correspond to findings regarding family poverty (as reported by families) cited above.

3.3 Similarities and Differences of PSOP and FAR Families

Because PSOP was in part inspired by the results of the differential response program (FAR) in Minnesota, we can ask what similarities or differences there were between families that accepted PSOP services and families screened as appropriate for FAR. The following diagram shows where PSOP and FAR families are encountered in relation to CPS. The three ovals in the diagram show the three responses: 1) PSOP services, 2) FAR family assessment and 3) traditional investigation.



Families in all three groups were reported to CPS, but the reports of PSOP families were not accepted for further action. Normally, these reports would be expunged from the system and there would be no contact with the family. For this reason, little has been known about these families. We have seen that they have multiple needs. In this section, the income, employment and education level of PSOP families that accepted services are compared to families that were determined to be appropriate for a family assessment (category 2) during the Minnesota AR evaluation of 2001 to 2004.

In Figures 3.10 and 3.11 yearly income and employment are compared. Families that accepted PSOP services were more often in the poorest group (less than $15,000 per year) and unemployed.

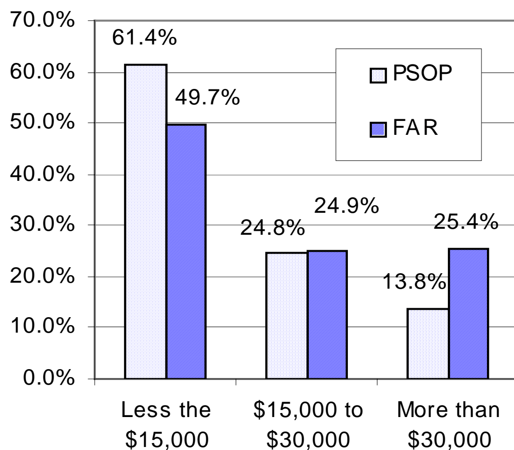


Figure 3.10 Yearly Income of FAR and PSOP Accepting Families

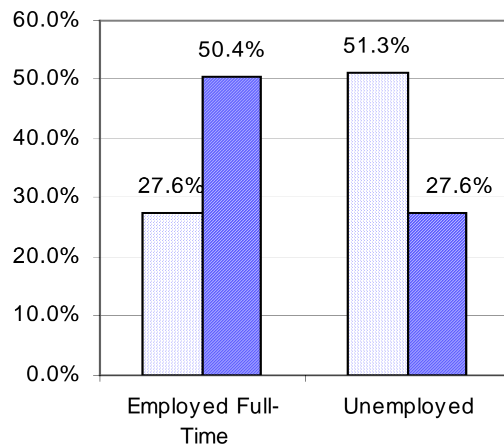


Figure 3.11 Employment of FAR and PSOP Accepting Caregivers

The education levels of PSOP caregivers were also lower than FAR families. FAR caregivers were more likely to be college educated. PSOP caregivers were more likely to have only a high school diploma or GED, although there were slightly more dropouts among FAR families.

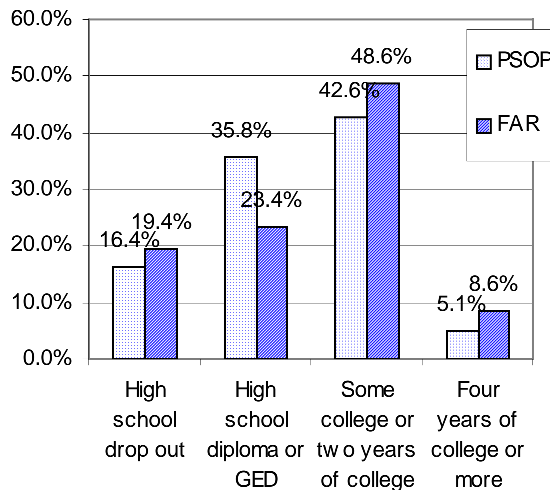


Figure 3.12 Education Levels of FAR and PSOP Accepting Caregivers

These three demographic indicators show that the socioeconomic status of PSOP families was lower on average than families whose reports were accepted and assigned to the family assessment track. Thus, rather than being less needy families than those often encountered by CPS workers, PSOP families that accepted services were more needy.

There were certain similarities between the approach utilized in PSOP and FAR. Both were non-adversarial, and while child safety was a central concern of both approaches, they also focused on a broader set of family needs than occurred during traditional CPS investigations. Families reactions within FAR and PSOP are compared in the following chapter.

3.4 Conclusions

Families that accepted PSOP services were on average near or below poverty levels, unemployed or employed only part time. Like the CPS population a substantial proportion of families were mother-only. These characteristics are usually associated with needs for basic poverty-related services. Analyses of family strengths and needs indicated that most families had multiple problems and needs beyond those associated with their low-incomes status.

Demographically, PSOP families were not dissimilar to families whose reports had been screened into CPS, and determined to be appropriate for a differential response family assessment. In some ways, PSOP families were more needy than FAR families. They often had had previous experience with CPS and with other public services.

These findings supported the reports of local staff that the families they encountered usually required much more assistance or longer cases than originally anticipated.

4.
Services Provided under PSOP

The Parent Support Outreach Program was established to deliver preventive services to families. Several general questions are addressed in this chapter. Were services and other assistance made available to families? What kinds were made available? What were the sources of services offered? To how many families were offers made?

4.1 Worker Contacts with Families

In this section the length of cases and worker contacts with families are examined quantitatively. A basic question that this analysis seeks to answer is whether most cases for families that agreed to PSOP services were summary and simple or whether they involved more intensive and longer-term activities.

4.1.1 Length of Cases. Some PSOP service cases were relatively short in duration while others lasted for several months. About three in every ten cases (30.3 percent) lasted less than 90 days. About an equal proportion (32.7 percent) stretched for 200 days or longer. The average (median) length of a case from the beginning of the assessment process until the service case was closed was 141 days or slightly less than five months. This period may in some cases reflect delays in formally closing cases in the data system, and we can safely assume that the final contact with families occurred, on average, slightly sooner than case closure. However, discussions with workers and supervisors in local offices confirmed that PSOP cases in most counties were indeed open from three to five months on average.

Table 4.1 shows the median length of cases along with minimum and maximum case length and the number of cases included in this analysis for each PSOP county. The number of cases in the table is 2,300—the total number of cases for which accurate or final closing dates were available by the end of data collection for 2,614 cases. Some counties, typically those with PSOP workers within the public agency, handled cases relatively quickly (for example, Olmsted). Others, particularly those for which a separate community agency served PSOP families, kept cases open for much longer periods (for example, Blue Earth).

Table 4.1 Average (Median) Length of PSOP Service Cases

County	Median	Max	Min*	N	County	Median	Max	Min	N
Anoka	164	734	0	259	Murray	27	85	5	5
Beltrami	95	402	5	74	Norman	189.5	344	86	8
Blue Earth	357.5	1086	0	78	Olmsted	52	1119	0	336
Carlton	234.5	498	31	40	Otter Tail	149	520	22	81
Chisago	93	345	14	115	Pennington	106	154	58	2
Clay	136.5	267	12	10	Polk	147	576	29	74
Cottonwood	140	343	17	25	Pope	73.5	250	15	20
Crow Wing	223	783	34	65	Ramsey	314	1012	53	271
Dakota	105	774	8	146	Red Lake	514	514	514	1
Dodge	84	522	18	11	Roseau	146	450	80	5
Grant	189	366	29	7	Scott	76	685	1	151
Hennepin	184	656	30	105	Sherburne	181	435	50	64
Houston	210	260	161	4	Steele	92	701	39	17
Lincoln	475	498	239	5	Stevens	122	433	9	11
Lyon	174	728	20	35	Wabasha	77	143	53	5
Mahnomen	51	51	51	1	Waseca	143	623	35	27
Marshall	382	610	34	19	Winona	159	322	38	45
Mille Lacs	95	858	2	100	Yellow Medicine	114	441	30	47
Morrison	130	327	24	31	Morrison	130	327	24	31
					Total	**141**			**2300**

* 0 case length indicates a case open for one day.

4.1.2 Types of Worker Contacts with PSOP Families. Contacts with families, which included both public and private agency workers, varied from case to case. Slightly less than half (45.4 percent) had three or fewer face-to-face meetings with families (Table 4.2). Thus, over half had four or more face-to-face contacts. The largest category (11 or more face-to-face contacts) included a number of cases with 20 or more contacts. Telephone communication was heavily utilized with PSOP families. PSOP workers conducted an average (median) of six telephone calls per family. Email and letters were also utilized but much less frequently, although in some counties the initial contact with families was made by letter during the first year of the program.

Collateral contacts include work on behalf of families such as communication with public and private service providers, informational contacts to find out about possible services or methods of qualifying for services and advocacy activities. As will be evident from examples presented in this chapter and later, this sometimes involved contacts regarding MFIP (Minnesota Family Investment Program—the employment program under TANF), mental health providers, other social and financial support providers, treatment (for example, substance abuse) programs and other formal and informal sources of assistance to families.

Table 4.2 Frequencies of Four Types of Contacts with PSOP Families: Face-to-face, Telephone, Email/letters and Collateral

Type of Contact	*Frequency*	*Percent*	*Type of Contact*	*Frequency*	*Percent*
Face to Face			Emails/letters		
None	46	1.8%	None	1099	42.0%
1-3	1167	44.6%	1	601	23.0%
4-5	410	15.7%	2	461	17.6%
6-10	533	20.4%	3 or more	453	17.3%
11 or more	458	17.5%	Collateral		
Telephone			None	821	31.4%
None	309	11.8%	1-3	574	22.0%
1-5	944	36.1%	4-10	762	29.2%
5-10	661	25.3%	11 or more	457	17.5%
11 or more	700	26.8%	**Total Families**	**2614**	**100.0%**

The overall picture of contacts indicates considerable work with and for families that agreed to PSOP services. The majority of face-to-face contacts involved travel, usually to the client family's home, for example, and a period of time for meeting and discussing issues. In some instances, such trips may have involved transporting the caregiver or other family members to a service provider. PSOP workers engaged in an average (median) of 16 total contacts with or for families. The mean number of contacts was 25.2, reflecting the subset of families that received more extensive assistance, with scores of contacts over several months.

Thus, in answer to the initial question of this section, both kinds of cases, simple/summary and intensive/long-term, were found on PSOP caseloads. However, the analysis indicates that case activities leaned toward intensive and long-term in this program. This may show the possibilities for a preventive service program outside the normal CPS context where workers have greater freedom to maintain social work practice with families in need. Within CPS, the daily influx of newly accepted reports of child maltreatment generates pressure to close cases, sometimes earlier than workers would otherwise prefer.

4.2 Family Satisfaction with PSOP Workers

The previous section was about the quantity of worker contacts with families. The present section speaks to the quality of contacts. After PSOP cases were concluded and contacts between workers and families had ceased, caregivers were asked a series of questions designed to gauge their reactions to PSOP workers and the experience generally. As can be seen in Figure 4.1, the large majority of families (93.3 percent) were *generally or very satisfied* with the way they were treated by PSOP workers. The figure also shows the reactions of experimental and control families in the Minnesota

Alternative Response (AR) Project Evaluation.[14] Experimental families in the AR project received an intervention similar to that employed in PSOP, although unlike PSOP families, the child maltreatment reports of AR families had been accepted as appropriate for a CPS response. PSOP caregivers reacted slightly but not significantly more positively, on average, than AR families to the intervention by workers.

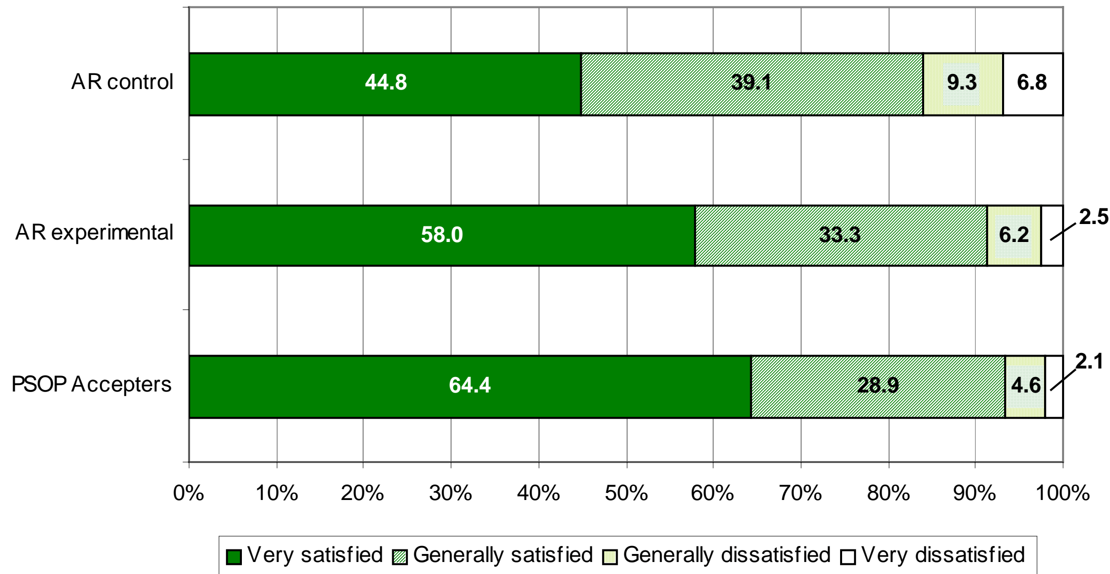


Figure 4.1 Comparison of AR and PSOP Family Caregiver Responses to the Question: How Satisfied are you with the Way You and Your Family were Treated by the PSO (AR) Worker?

PSOP families accepting services also reacted positively to PSOP workers' efforts to understand their needs. In response to the question, "Did the worker or workers who met with you try to understand your family's situation and needs?" nearly three-fourths (73.7 percent) answered *very much* and another 16.1 percent answered *somewhat*. About one in ten responded much less positively or negatively to this question: *a little* (7.4 percent) and *not at all* (2.8 percent). PSOP workers were generally perceived as engaging and helpful.

[14] The Minnesota Alternative Response (AR) Project was the state's original *differential response* pilot project. AR took place in 20 counties from 2001 through 2004. The data for this figure were collected from families in the 14 counties that permitted random assignment to experimental and control groups. AR, now referred to as Family Assessment Response or FAR, was Minnesota's version of the differential response approach to families screened into CPS. Control families were provided with a traditional CPS investigation while experimental families were given a family assessment. Family assessments, in contrast to investigations, were non-adversarial, involved a broader family-centered assessment process and did not attempt to determine victims or perpetrators or to substantiate child maltreatment. The final 2004 evaluation report (see footnote 2) can also be found by visiting the IAR's website: www.iarstl.org and selecting the 'papers and reports' tab. The discussion of family satisfaction begins on page 31 of that report.

Families were also satisfied with PSOP assistance. When asked whether they were satisfied with the help offered or received, 54.2 percent answered *very satisfied* and another 35.6 percent answered *generally satisfied*. Among the remaining families, 3.9 percent said *generally dissatisfied*, 2.3 percent said *very dissatisfied*, and 3.9 percent indicated that *no help was offered*. Further caregivers' perceptions of the benefits of assistance were also positive overall but less unanimous than their responses to these three questions. The judgments of caregivers concerning the effectiveness of services offered to their families will be addressed in the next chapter.

These questions—satisfaction with worker, worker's efforts to understand, and assistance received—were examined for families of different races/ethnicities. No differences were found. African American, American Indian, Asian and Caucasian caregiver responses were virtually identical.

4.3 Community Referrals

PSOP workers indicated that they referred families to a variety of service providers (Figure 4.2). The large majority (87.1 percent) of families were referred to at least one provider. Mental health and childcare agencies top the list of agency referrals. However, over a quarter of families were referred to emergency food providers, a finding that might be expected based on the low-income status of PSOP families shown in the previous chapter. School services were in response to issues surrounding children, consistent with the finding that well over a third of the families accepting services had children with serious or chronic behavior problems or with disabilities (Chapter 3).

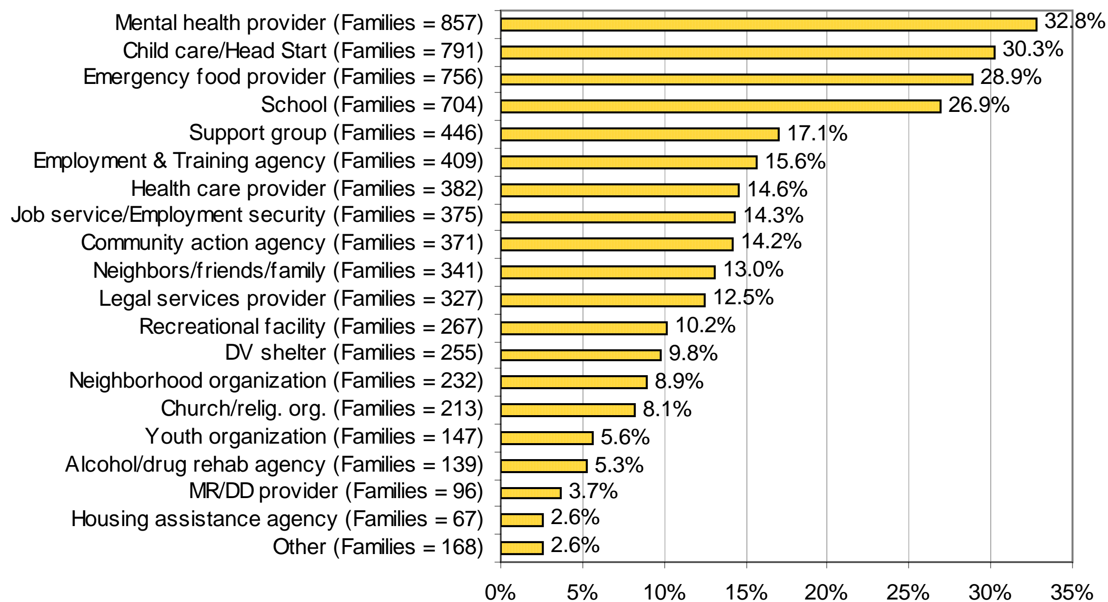


Figure 4.2 Types of Agencies to which PSOP Families were Referred

Some of the agencies, like emergency food or legal services, were related to a specific category of need. Thus, the referral to a domestic violence (DV) shelter is an indication of severe and dangerous family conflicts and the referrals of about one in every 10 PSOP families can be taken as a minimum proportion in which this need was severe enough to require action to keep the mother and children safe. Analogous statements could be made about emergency food providers, alcohol and drug rehabilitation agencies, MR/DD providers, and housing assistance agencies. However, the term *minimum* should be emphasized in deducing needs from referrals, since some services were in place before PSOP cases began and in other instances needs may have existed but for various reasons no referral was made. For example, appropriate services simply may not have been available in some geographic areas. Needs for services that were not provided will be considered in the next chapter.

Specific types of needs cannot be deduced from referrals to other agencies which are themselves responsive to multiple needs. Examples of these are community action agencies, neighborhood organizations and church/religious organizations. For example, emergency food services are sometimes provided by churches but church groups also assist families in other ways.

4.3.1 Differences in Community Referrals by Race/Ethnicity. Many differences were found in the rate of community referrals for families of differing racial and ethnic backgrounds. These seemed to be generally explainable by differences in family and caregiver characteristics (see Chapter 3, Section 3.2.8). Southeast Asian families, as might be assumed by high rates of multiple problems, were referred significantly more often in most of the categories in Figure 4.2. African American and American Indian families, which were shown to have lower incomes and greater unemployment on average, were correspondingly referred more frequently to emergency food providers, employment and training agencies and community action agencies. American Indian caregivers were referred more often to alcohol and drug rehabilitation programs and to domestic violence shelters. Caucasian families, with greater rates of emotional/mental health problems, were referred more often to mental health providers.

4.3.2 Differences in Community Referral among Counties with Different Models of PSOP. Three models of PSOP were discussed in Chapter 2: 1) *Contracted Private Workers* in which case-management was contracted out to one or more community agencies, 2) *Dedicated Public Workers* in which case-management was handled by one or more county social workers that were solely dedicated to PSOP and 3) *Divided Public Workers* in which case-management was split among county workers that also handled other child-welfare or child-protection cases. Referrals to other agencies differed in important ways among these three approaches. In general, dedicated public workers referred to other agencies at lower rates, with divided workers in between and contracted workers highest. For example, contracted and divided programs referred to employment and training agencies, job services, schools at two to three times the rate of dedicated. Contracted programs had higher rates of referrals to emergency food, legal and support groups than the other program models.

4.4 Services Offered or Available to Families

4.4.1 Worker Responses. Workers were asked what types of services were made available to families. In each case they were asked to specify: 1) was the service provided, 2) was information and referral provided, or 3) was the service already in place before PSOP? Any or all of these could be indicated (Figure 4.3).

Each of the three segments within the bars of Figure 4.3 represent a count of families. They are shown as one bar for the sake of clarity and comparison. However, the same families can and do show up on many segments. The entire bar, therefore, cannot be taken as a count of families but rather a count of *service availability*. In this sense they are good general indicators of the *relative emphasis* on different types of services that were available to PSOP families, and indirectly, needs for services. We should also note that Figure 4.3 does not indicate the *level of participation* in the services, which was measured in a different way that will be considered more fully in Chapter 5.

The *services provided* category can be taken to mean that the PSOP worker was directly instrumental in providing or linking to the service. Thus, the relative differences among the first (solid) segment of the bars in the graph is an indication of the areas in which PSOP workers expended the greatest effort. The largest of these were services addressing: basic household needs, transportation, rent and house payments, emergency food, child care, respite care, housing, mental health and parenting. The greatest emphasis was on basic, poverty-related needs of families.

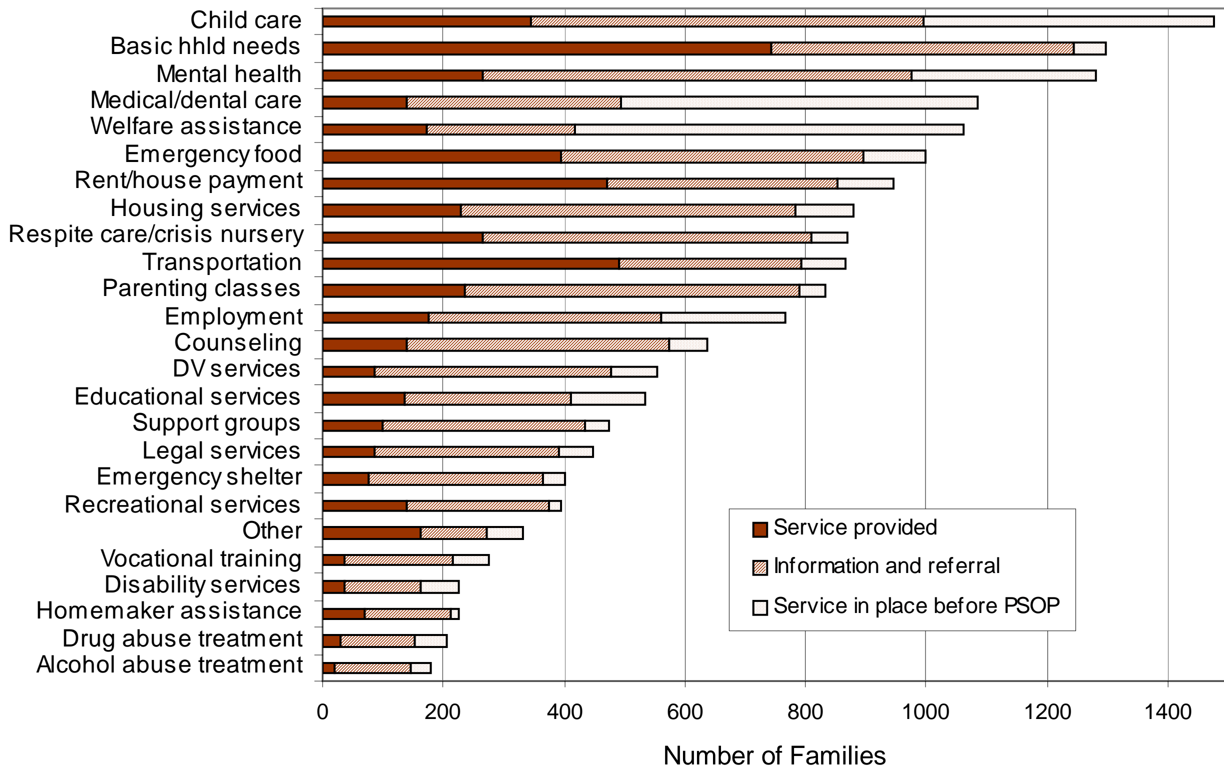


Figure 4.3 Services Made Available to PSOP Families in Three Categories
(Duplicate Families in Bars: Some Families were Served in Two or Three Categories)

Information and referral in many of the categories of Figure 4.3 was provided to more families than the services themselves. Families took advantage of services that they learned of in this way, although the level of assistance provided in helping the family to make contact with the agency varied. In some cases the worker told the family about services and how to access them, such as giving them addresses and directions, telephone numbers and contact persons. In other cases, as can be seen in the examples below, the worker took an active role in assisting the family to take advantage of the services. As was shown above in Table 4.2, workers engaged in collateral contacts for about half the families that accepted services. In some cases the transportation services involved driving a family to an agency and in others making sure the family had access to public transportation to services.

Services of various kinds were also in place before the PSOP case. With the exceptions of welfare, medical and childcare assistance, new services and new service referrals substantially outweighed services already in place.

4.4.2 Differences by Race/Ethnicity. Various differences were also found in the rates of direct service provision by the race of the family, although as discussed in Section 4.3.1, these seemed to correspond to the needs and other characteristics of families in these groupings. Southeast Asian families received at higher rates in several categories, for example basic HH needs, emergency food, transportation, employment and homemaker. Caucasian and American Indian families received more services in the categories of respite care, counseling and mental health. American Indian and African American families received services more frequently in categories of emergency shelter, basic HH needs, emergency food, transportation, employment and recreational services. Some other differences were found and while the differences cited here were statistically significant, they were not large. Emergency food services can be taken as one example: Caucasian: 13.4 percent; African American: 18.8 percent; American Indian: 21.3 percent; Southeast Asian: 22.5 percent.

4.4.3 Family Responses. Family caregivers were also asked about the services they received (Figure 4.4). The categories were similar but not identical to those employed with workers and were in language that would be easier for families to relate to. For example, rather than asking about emergency food services, food assistance was wrapped into questions about provision of food or clothing. However, the order of the services reported by families in Figure 4.4 is roughly similar to that reported by workers, particularly the *service provided* segments of the bars in Figure 4.3. Again, basic services top the list along with mental health.

Referrals to Other Service Resources. Caregivers were asked whether the PSOP workers gave them the names of service agencies or anywhere else where they could get services or help for something they needed. The answer was affirmative in 72.3 percent of cases. Parents had the option of acting on this information, however, and when asked, 77.6 percent of respondents given referrals indicated that they had made contact with the agency or place to which they were referred. These correspond to *information and referrals* segments of the bars in Figure 4.3.

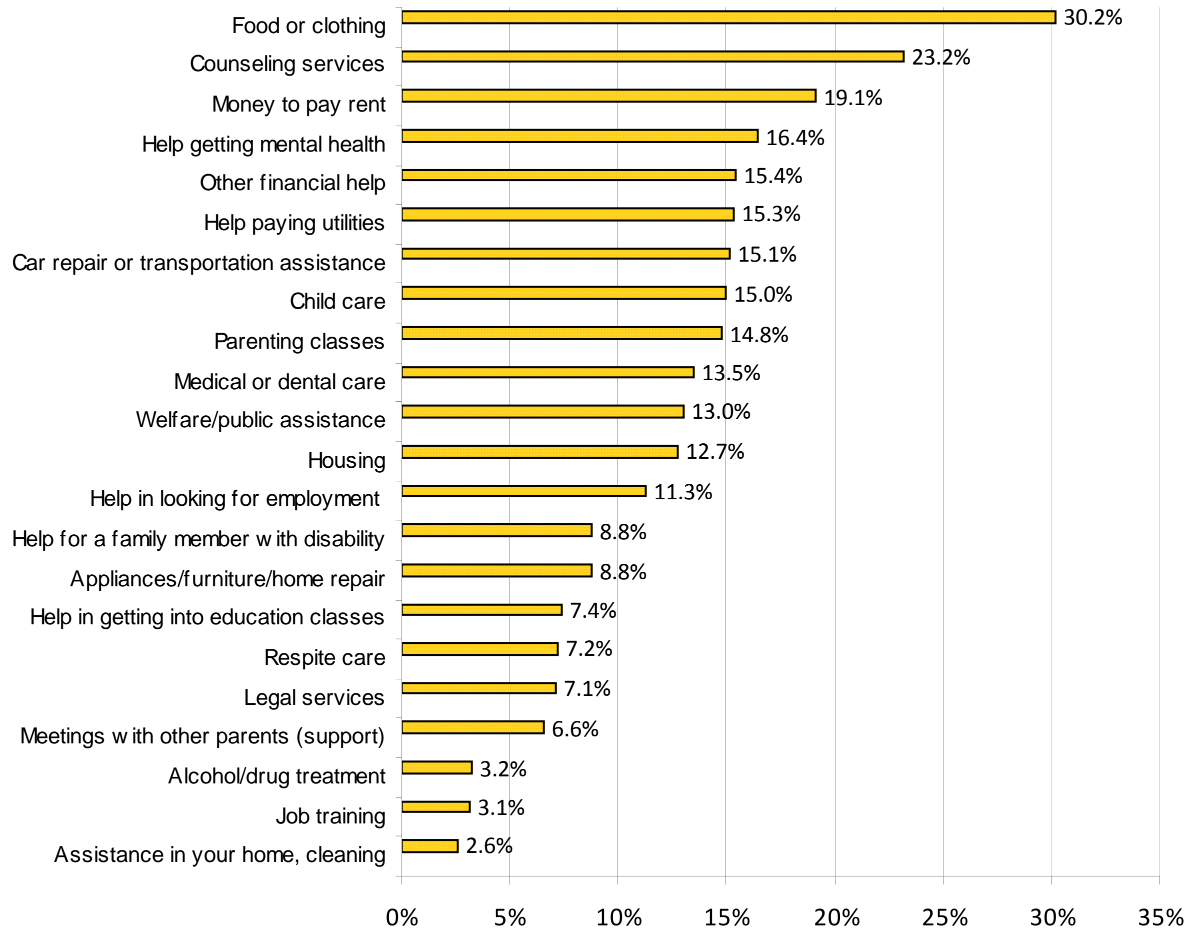


Figure 4.4 Caregiver Responses to the Question: Did the PSO worker(s) help you or another family member get any of the following help or services?

Contacts with other Agencies on Behalf of Families. Caregivers were asked whether PSOP workers made contacts on behalf of their family with service providers. In response, 36.9 percent said the worker contacted another agency or source of assistance for them, 37.3 percent said they were not sure and 25.8 percent said *no*. In over a third of cases, therefore, the caregiver knew that the worker had facilitated other agency contacts, but in the majority of cases either this had not occurred or the caregivers did not know.

Knowledge of Service Availability. It is sometimes assumed that the problem in finding services is not knowing *how* to access them. This is incorrect in many cases where the primary problem is more basic—not knowing that the services exist. One of the clear forms of assistance provided by PSOP, that most likely would not have happened in its absence, is that families were educated about the existence of services. A

little less than half of responding caregivers (46.6 percent) said that they had learned of a service organization that they did not know about before.

Workers were also asked whether particular families became *aware of community resources that they did not know about before*. They were able to provide examples in 55.1 percent of cases. Hundreds of specific agencies and service providers were cited by workers, generally corresponding to the categories in Figure 4.2. The 10 types of agencies most frequently cited were, respectively: mental health provider, emergency food provider, childcare or Head Start, a housing assistance agency, a church or religious organization, a school program, a community action agency, an agency providing help with basic needs, a support group and an agency providing adult education or educational resources.

It seems unlikely that, in the absence of PSOP, families would have discovered these resources on their own. This growth in awareness and knowledge of resources is an outcome of PSOP that represents an immediate impact on the families involved. This finding is reiterated in Chapter 6.

Direct Help by Workers. As a part of this analysis, the evaluators reviewed a sample of case narratives. The most striking thing about these, and one that is reflected in the case examples selected below and in subsequent chapters, is that workers engaged in a wide variety of direct services to families. Half of the respondents to family surveys (50.4 percent) stated that the worker provided direct assistance to help their family. The most frequently cited categories of services that family caregivers said were provided to them by PSOP workers were:

- Transportation
- Financial assistance or concrete items, such as gift cards, food, clothing, diapers, and household goods.
- Furniture and rent security
- Gas cards and car repair
- Assistance locating and securing housing

We collected several hundred comments from families describing the kinds of direct services provides. The following are representative examples:

> *"She helped me with gas money when my son and I were moving."*
>
> *"She drove us to pick up a temporary vehicle and also purchased a small tote-dresser to keep clothes neat."*
>
> *"…transportation to [food pantry] to get food and to college for registration and orientation."*
>
> *"…baby diapers as quickly as my child grew—40 to 50 each time and at least once a month."*

"…offered to pick the kids up herself…"

"…helped pay rent one month."

"…clothing, financial help, working with my job counselor pertaining to the restraining order…"

"…transportation and bus pass. Thanks!"

"…help with co-pays for counseling."

"…a ride to the doctor for my daughter's appointment."

"…payment for a seminar I attended on domestic abuse."

"…rides to stores."

Even more than the previous issue of awareness of community services, these can be viewed as services and immediate benefits to families that would not have occurred had PSOP not been instituted. We return to this in Chapter 6.

4.5 Case Examples of Service Provided

The following case examples illustrates several of the service categories in Figures 4.3 and 4.4, including rent, household needs, parenting, mental health services and homemaker assistance. In addition, the case also illustrates direct counseling and instruction by a PSOP worker.

Case 4.1 Poverty and Mental Health Issues

A referral was made by another agency for a young woman G, who was requesting services. She had worked with the county previously and requested a specific worker, as she felt comfortable with her. G had just had a baby, and was feeling overwhelmed financially and emotionally. She had recently begun working at a local grocery store, but was still relying on MFIP (TANF). In addition, she had been diagnosed with post-traumatic stress disorder, depression and anxiety.

G wanted help with parenting initially, but the PSOP worker primarily intervened to help manage crises that arose. G had trouble maintaining employment and lost a couple of jobs during the case period. She had several barriers to becoming financially independent: no diploma, no license, no vehicle, no child support, and trouble with childcare. PSOP was able to assist with rent, utilities and other basic needs for a month. G's infant son had also been hospitalized twice in the previous month for a medical condition. The worker helped G think about how to manage his condition, as well as work on developing her parenting skills. A monthly budget was developed. G was referred to [a mental health agency] for long term help. Chemical use was also a possible issue, and G was provided some education on substance abuse. A home-based worker was recruited for the case to work more directly on mental health and parenting, and this allowed the PSOP worker to focus more on coordination and case management. During the case, another report was received regarding G's behavior and parenting, but nothing new or substantial was reported. Later, G became pregnant again and began having domestic incidents with her new boyfriend. However, she did secure employment and began to attend individual counseling. The PSOP worker and the home-based worker continued to address the goals of safety, budgeting, and home management. The case was closed by mutual agreement after G felt she had adequate access to other services and was satisfied with her current situation.

The following example is of a two-parent family with four children in some financial difficulty. PSOP paid rent, car payments and car repair. The worker also made several referrals connecting the family with other potential services.

Case 4.2 Family Poverty

A rural county received a written report from the Sheriff's Office regarding a possible domestic/child abuse situation. The alleged victim was B and her four children. The husband, C, was observed pulling his children's hair. C admitted to an officer that he did 'slap his wife around' and she did have a black eye, but stated that the children were not present for the incident. There were four children in the family from preschool age to teens.

The family was difficult to reach and difficult to engage in services, but did eventually accept help. The husband reported that he did not read well but had been employed at [ ] for the several years. The parents stated that they loved their kids, were affectionate with them, and did a lot together as a family. They had been looking for a new house, as their current one had only two bedrooms. The family's main concerns were financial and the PSOP case was opened primarily to help them address some outstanding debts and other needs related to poverty. The family did not express the desire for any other help, but was referred to a domestic resource in case family discord should resurface. Rent assistance was provided during the first two months. The worker connected the family to [a food pantry] and instructed them to use them monthly for food shortages. A car payment was made and a tire was fixed on the family vehicle. The youngest child was referred to Early Childhood Family Education (a Minnesota universal access program) services and Head Start, and C received assistance in seeking out information on obtaining his GED in order to improve his employment opportunities. The family owed $9,000 on their house and the worker gave them referrals for programs that might help them find a more affordable home. A Medical Assistance Application was completed for the wife, as she was not covered by insurance. PSOP funds were also used to pay for clothing for the children. The case was closed by mutual agreement when goals had been met.

Behavior problems of children were common among a large minority of PSOP families accepting services. The following example is an illustration of this and the way in which the PSOP assisted the family. The reference to the children's program at school is an example from within the school referral category shown in Figure 4.2. Like most of the PSOP cases, direct financial aid was provided to the family.

Case 4.3 Child Behavior Issues

A report was made to the county regarding a mother, R, and her two children. The reporter stated that the older of the children (older preschool) was observed pushing the younger one and mother did not intervene. The youngest child (younger preschool) had two unexplained injuries in the past.

When the mother was contacted, she agreed to talk with the social worker and admitted that things had been hard. The older boy had just recently been admitted to the hospital for uncontrollable behavior and aggression towards his sister. He had multiple diagnoses, had a history of ADD, and had previously been assigned a DD worker. Several medications had been prescribed to try to control his mood. The hospital social worker recommended in-home family support and it was noted at discharge that the boy did much better with structure and routine. Both children displayed extremely challenging behaviors in the home. A PSOP case was opened to assist R with exploring the service options for her son, manage stress, and improve family stability. The father of the children had been verbally abusive in the past, had recently separated from mom, and did not have a strong relationship with the children. R had been receiving SSID for [a chronic health condition] but the condition was in remission and the she needed to think about finding work. There was also a concern about mom's occasional alcohol use.

Respite services were arranged for one weekend per month and PCA hours were established. Financial assistance was arranged for a damage deposit, small bills, and day care assistance. An in-home behavioral therapist worked with the mom to improve her responses to and interaction with her son. Both

children received special support at school, and attended after-school programs. The worker assisted with ensuring that the mother had as much financial support as she was eligible for, including completing an application for food stamps. Vendor rent payments were established to avoid eviction. During the case, the mother was sexually assaulted by a stranger and needed additional support to deal with the emotional aftermath. However, R did eventually find a job and arrange daycare to allow her to work. At the close of the case, R continued to face behavior issues with her children, as well as her own health and financial stress, but was now more able to access services on her own. Six months after closing, R was attending a business management course at a local college and seeing fewer behavior problems in her children.

4.6 Conclusions

Taken as a whole, these analyses confirm that valuable assistance was made available to families that accepted PSOP services. Worker activities as measured by contacts and direct services were moderate to intensive for most cases. A wide variety of services were delivered. Topping the list were basic financially-related and mental health services. The variety of types of services and the large number of families to which each type was offered confirms that families generally tended to be offered several types. Families were put in contact with many agencies and community providers and in about half the cases these resources had been unknown to families prior to PSOP. The examples presented and the data on collateral contacts confirm than services and referrals were actively presented to families, that is, with help, instruction and counseling by workers. Nearly all families were satisfied with PSOP workers.

However, despite the efforts of workers, not all families participated fully and not all received needed services. These questions are addressed in the following chapter, where the relationship between needs and services is examined.

5.
Utilization of Services

Families referred to PSOP, rather than being low-risk families with a few needs, were often multi-problem families. This was evidenced in part by high levels of previous participation in public service programs by majorities of both decliners and accepters of PSOP services. Families that agreed to PSOP participation were generally at or near the poverty level, with all the needs attendant to low-income status, and very few had relatives or friends they could turn to for financial support. A substantial majority of caregivers were either unemployed or working only part-time. Significant minorities had mental health issues, child behavior problems, drug or alcohol abuse or serious health problems. PSOP accepters tended to be multi-need families.

PSOP workers nevertheless made available a significant array of services to families and referred many families to other agencies and programs, and workers themselves provided direct assistance to families, as was evident in the preceding chapter. The next questions are whether the assistance provided corresponded to the needs of families and how often families took advantage of offered services.

5.1 Adequacy and Appropriateness of Services

Large majorities of workers and families responded positively to questions of adequacy and appropriateness of services. Families and workers were asked in slightly different ways whether services provided matched the needs of families. Their responses indicated general agreement. Responding concerning specific families, about half of workers (48.2 percent) felt that services were *well matched* while 46.6 percent indicated they were *adequately matched* for a total of 94.8 percent of families (Figure 5.1). Family caregivers were asked whether the services they received were the kind they needed. While 13.6 percent indicated that they did not receive services, of the remaining families, when asked whether the services or assistance they received was generally what they needed, 91.7 percent said *yes*.

Workers were asked whether services provided to families were effective. A large percentage (86.6 percent) said they were either very effective (34.3 percent) or somewhat effective (52.3). Families were asked whether services were generally enough to really help them, 80.6 percent of those receiving services responded *yes*.

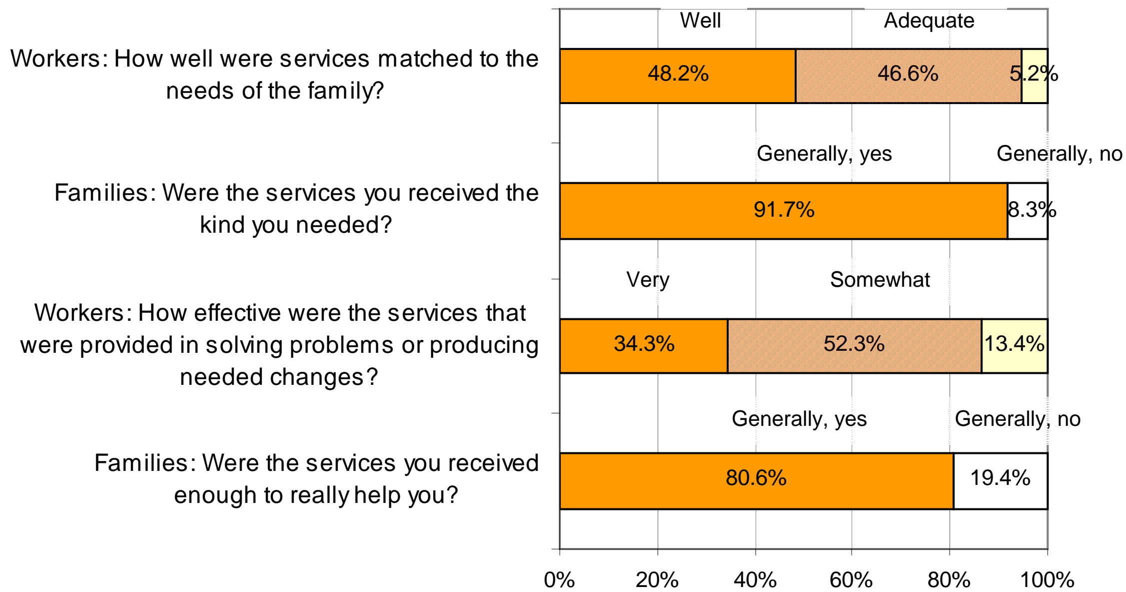


Figure 5.1 Adequacy and Effectiveness of Services
(Reported by Workers and Families)

5.2 Services Wanted or Needed by Not Received

PSOP workers could in some cases provide services directly, but their efforts were limited by time and resources. An examination of the variety of needs of PSOP families listed in Chapter 4 shows that many or most are beyond the direct capabilities of child welfare agencies and organizations. Workers could also aid in linking families to services and assistance from other sources, but this was also limited by time and the participation of families.

Families were asked whether there was any help they wanted or needed but had not received. About 95 percent of responding families answered this question, and of these, over a quarter (27.8 percent) answered *yes*. When asked what these were, basic financially-related services were most often mentioned: housing, rent, house payments, house repairs, utilities, furniture, clothing, car purchase or repair, transportation assistance, medical and dental. Other less frequently cited needs were daycare assistance, respite care, mental health services and legal services. In other words, the needs that families listed were precisely the same needs for which services were most frequently made available under PSOP (see Figure 4.3).

5.2.1 Barriers to Services. To determine why services might not have been provided, workers were also asked to indicate what services families needed but did not receive and why they did not receive them. Corresponding to feedback from families, workers indicated that one or more needs were not met for one-fourth of families (25.3 percent). Their specific responses mirrored those of families listed above with the addition of certain issues that were perhaps too sensitive to be mentioned by families or that may reflect ideas that were salient to workers but not to families: drug treatment,

alcohol treatment, domestic violence services, emergency shelter, support groups, employment assistance and educational and training services. In answer to why they were not provided, the following reasons were given for minorities of services:

The reason mentioned most often by workers was:

1) The service was offered to but not accepted by the family (56.2 percent).

Less often cited reasons were:

2) Did not offer the service to the family (3.1 percent),
3) Insufficient funds (5.1 percent)
4) Service was not accessible for this family (5.3 percent)
5) Service was not available for this family or in this area (9.5 percent).

Finally, for another 20.8 percent of services workers indicated *other* unspecified reasons.

Whether reasons 1 through 5, coupled with unknown reasons within the *other* category, explain the large majority or only some of the needs listed by families cannot be known from this analysis, but would require a detailed analysis of interactions in cases. However, our case reviews (see examples later in this chapter) suggested some of the reasons for the large *offered but not accepted* category. Often parents may feel too overwhelmed to commit to services, or disagree with the worker that a certain service is needed. Other circumstances arise that make it difficult to continue working with families, including arrests, drug abuse relapses, hospitalizations, relocation to other counties or outside the state and many others. In addition, incompatibility of workers and families is sometimes a reason why cases do not continue: 6.7 percent of caregivers, a small but real proportion, were dissatisfied with their PSOP worker (see Figure 4.1).

5.3 Service Participation

A method was introduced to measure the effects of such barriers on service participation. As seen in the previous chapter, families were offered or were referred to a variety of services and in some cases were already receiving services (Figure 4.3). Workers were also asked about family participation. For each of the categories of services in Figure 4.3 they had indicated, workers rated on a scale ranging from 1 = *very little* to 5 = *very much* the level of the family's participation or utilization of the service. Average (mean) ratings are shown in Figure 5.2. The measure combined availability and utilization.[15]

The highest average scores ranged from a low of 2.4 to a high of a little over 4.0, which means that no service type obtained 100% participation. The highest levels of participation were in services related to basic needs, such as welfare payments, rent and house payments, basic household needs, medical or dental care, emergency food,

[15] Total scores ranged from 0 to 5, where 0 indicated that the service was not offered or not available and 1 through 5 measured the level of utilization when the service was available. Thus, the entire measure combined availability and level of utilization.

transportation, child care and housing. Thus, more services of this kinds were offered or in place, and when offered, families more often took advantage of them.

Lower participation occurred as a rule for more therapeutic and instructional services such as counseling, parenting classes, alcohol abuse treatment, support groups and domestic violence services. Generally, these types of services required multiple meetings and continued commitment, and therefore were more subject to barriers to services.

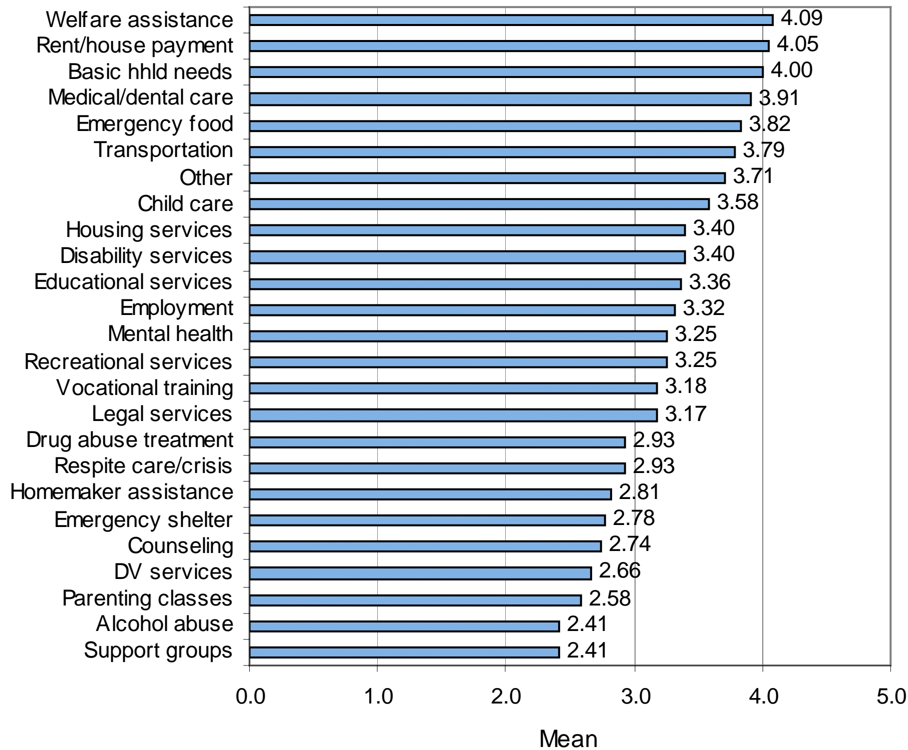


Figure 5.2 Mean Service Utilization and Participation by PSOP Families, as reported by Workers (Scale from 1= Very Little to 5=Very Much)

5.4 Case Examples of Low Utilization, Early Case Closure and Service Failures

The following examples are presented to illustrate some of the barriers to PSOP services experienced by families and their workers. Problems in these cases were not resolved within the context of the PSOP. However, this does not mean that beneficial results were not obtained later. For example, two of the cases entered the CPS system and therefore were not further tracked for this study. The two others were situations where the PSOP worker lost contact with the family.

Case 5.1 Mental Health, Substance Abuse, Loss of Contact

A self-referral was received from Y, a 23 year old mother of two preschool children, who was requesting the help of a social worker. Y stated that she was temporarily living with relatives, and had the following concerns: she was pregnant, was a victim of domestic abuse, needed assistance with her children, needed to obtain transitional housing, had anxiety and panic disorders, and had chronic pain from her domestic abuse and a car accident. The young mother had never had a social worker in the past but had been involved with a transitional housing program previously and was currently on MFIP.

Y's main concern upon entering PSOP was housing. She had poor references due to breaking rules in her former transitional apartment. Y was having difficulty eating and sleeping, had chronic migraines and was on several medications for pain, sleep and anxiety. She had left her former husband, a methamphetamines addict, several months earlier. She had also recently been connected to individual counseling for herself, but was looking for more in-home support.

Within a week, Y checked herself into a hospital for overwhelming feelings of depression, anxiety and stress. Y's family was supportive but could not care for Y's children indefinitely. The worker and Y's family tried to locate affordable housing for her while she was in hospital treatment. Y was turned down for transitional housing because of damage she had done when previously living there. After Y's discharge, she stayed in shelters and then lived with a friend. Daycare for the kids and transportation was difficult, and Y struggled to attend her outpatient mental hospital sessions. There were some concerns that the children were showing learning delays. She was sanctioned from MFIP during this time, and the worker managed all of Y's community supports and resources to ensure they were in place when she completed the outpatient program.

However, Y experienced several barriers to stability, including an accusation of stealing pain pills by the friend with whom Y had been staying. Her father wanted her to attend in-patient treatment for drug abuse, but Y did not believe she needed this help, and instead began associating again with the father of the child she was expecting, a man who also had drug and employment issues. Y had trouble following through with making calls and appointments and had a habit of going to the Emergency Room when she was feeling stressed. At the end of three months, Y's friend, who was providing most of the childcare, moved, and left Y with no place to stay. At this point, the worker and other individuals involved with Y were unable to locate her and the case was forced to close.

Case 5.2 Drug Addiction, Pregnancy, Drug-Exposed Newborn

The county received a call from a young woman, P, who was requesting assistance. She was expecting a child in six months, and although her husband worked full-time, they had been very stressed due to financial worries. P stated that she felt that she needed assistance in locating resources in the community.

Upon completion of the initial home visit, the worker discovered that P had been having severe problems with her back from her pregnancy and was attending a pain clinic for treatment. She was having trouble with transportation and needed some support with food purchases. As the goal was for P to have a healthy pregnancy, the worker agreed to act as a direct support to ensure P attended her appointments and obtained groceries. P stated that the pain was growing worse as the pregnancy progressed but her doctor refused to increase her pain medication dosage, as it might harm the fetus.

P had previously been seeing a psychiatrist, and this doctor recommended she begin Methadone treatment. Upon consultation with the psychiatrist, the worker was told that P had been using alcohol and cocaine. Soon after, P went into the ER for severe pain, but was refused any further medication per her pain doctor. In discussion with the PSOP worker, P stated that she thought she was not ready for the baby and believed that her husband may also need treatment of some kind, but did not admit to his drug abuse openly. Rent and food security were an ongoing issue and P believed that her husband was spending money impulsively. P would not admit to cocaine use at first but did admit to using alcohol. However, P declined an offer by the social worker to have a family group conference to build support for her sobriety.

A couple of weeks later P admitted to relapsing on cocaine, as did her husband. At this point, the county decided to plan for switching the case to child protection. A few weeks later, the child was born premature and addicted, and a Family Assessment (FAR) worker was assigned. Later, after key releases of information were obtained, history was gathered that suggested P's addiction was very deep and spanned the course of many years. P had parents that supported her and paid many of her bills, inadvertently

permitting her to spend what little money she did have on drugs. She had not had any significant period of sobriety for the last 13 years. Domestic violence was an ongoing concern when the couple was using together. P would skip from doctor to doctor to ensure she was prescribed opiates. The county stayed involved to determine the best course of action for safety.

Case 5.3 Child with Behavior Problems/Case Quickly Enters CPS

A referral to PSOP was received from a mother regarding her 14 year old boy, B The woman stated that her son had problems with anger and aggression, and was acting violently towards her and his younger sisters. She initially inquired about Foster Care but also requested help with parenting.

The assessment revealed that B had been struggling both behaviorally and academically at school. At home, B and family members had been fighting both physically and verbally. The mother and current husband (not B's father) were currently seeking marital counseling for frequent arguments. A few family fights had resulted in police intervention. B stated that he was often verbally abused by his mother and step father, and received little or no positive attention from them. He reported that his mother stays in her room all day and his stepfather will hit him on the shoulder at least twice a week. B also admitted to punching and breaking things when he gets mad. The mother was overwhelmed with stress.

The worker tried to establish individual counseling for B and worked with his school to improve his academic performance. His mother was also connected to individual counseling, as well as a home management program. The mother participated in a three-day parenting workshop funded by the county. The mother stated that she learned some things at the workshop, but felt there was too much information. The worker also connected the mother to a driver's education program, since lack of transportation was a barrier to her participation in her children's academic meetings. Funding was also offered for summer camp for the children, but the family declined.

Two months into the service, a new CPS report was accepted and a child protection Family Assessment (FAR) was completed for the family. B continued to struggle in school and have fights with other students. The family situation was deemed too unstable and a FAR case-management workgroup was opened.

Case 5.4 Family in Need of Respite Care and Financial Planning/Loss of Contact

A referral was received from a staff member at Head Start regarding a family with small children that might need some support. The PSOP worker completed an initial home visit, and opened a case. The mother was overwhelmed and stressed: she was working a full time job, raising three children and her husband had a warrant out for his arrest due to a probation violation. The sentence could be up to 15 months, and she was concerned about how she was going to manage without him. The mother was looking for help and time organizing herself and managing stress. She asked for assistance finding and paying for evening day care one night a week to allow her time away from the kids. The worker compiled a list of evening day care providers and discussed the option of paying a relative to watch the children for respite. The mother said she would consider these options, but did not follow up further. The case was closed when the mother no longer responded to worker calls.

5.5 Service Constellations

More than one service was often put in place for families. Co-occurring services may reflect constellations of family needs, such as employment services and transportation or simply related services addressing a particular need, such as domestic violence or emergency shelter. A factor analysis was conducted utilizing the participation scores shown in Figure 5.2. The five constellations that resulted are of the combined measure of service availability/utilization (see Appendix 1 for details of the analysis). The services shown represent the highest factor loadings in order of their

importance. The constellations were named based on their strongest factor loading scores and are called measures, because summated, weighted measures were derived based on the factor analysis.

Measure A. Poverty-Related Services. The first and strongest constellation concerns services that address financial needs of families. They were the kinds of services most frequently offered and used by families in PSOP. They reflect the financial situation of most PSOP families who were living at or near poverty, the orientation of PSOP workers toward meeting these needs and the capability of PSOP to fund such services in many of the PSOP counties. This measure was based on the following service categories:

Rent/house payments
Emergency food
Housing
Basic household needs
Emergency shelter
Transportation
Employment

Measure B. Welfare, Medical Services, Training and Employment. This constellation may partially reflect referrals received from MFIP which is associated with TANF and MFIP work programs, which in turn are related to training, educational and disability services. Because many PSOP caregivers were underemployed or unemployed it may also reflect independent efforts by workers to assistant families in obtaining or maintaining employment and obtaining benefits (e.g., transportation assistance and disability services).[16] This measure is named *Welfare-E&T* in the next chapter. It was composed of the following service categories:

Medical or dental
Educational services
TANF/SSI/FS
Voc/skill training
Recreational services
Transportation
Employment
Parenting classes
Disability services
MH/Psych services

Measure C. Counseling, Domestic Violence Services and Support Groups. Some of the services in this category are related to domestic violence cases, including domestic violence services, emergency shelter, legal and support groups. More generally, it may show cases referred to counseling for other reasons.

Domestic violence services
Marital/family/group counseling

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[16] This measure was weakly correlated with Measure A because of overlapping services, as is discussed in the next chapter.

Support groups
Legal services
MH/Psych services
Emergency shelter
Disability services

Measure D. Substance Abuse Treatment. Drug and alcohol treatment services were clearly related to one another. Illegal substance abuse is often accompanied by alcohol abuse.

Drug Abuse treatment
Alcohol abuse treatment

Measure E. Childcare and Respite Care. Childcare services were utilized by a variety of families of difference kinds. Respite care may be related to family needs associated with child behavior problems and parents who are having difficulty coping with child rearing.

Respite care/crisis Nursery
Childcare/Daycare
Parenting classes
Homemaker/home management

5.6 Conclusions

Families that agreed to PSOP services in large part received services and utilized many of them. Nonetheless, for a variety of reasons, PSOP cases did not always work out. The analyses and case examples in this chapter illustrate the more important of these reasons. Given the kinds of families with multiple needs that will be encountered in a program like PSOP, sufficient worker time and available resources are necessary for continuation of cases. The more successful cases illustrated by the case examples in the preceding and following chapters show that it is possible to productively assist such families in the face of multiple barriers.

6.
Outcomes

Outcome analysis answers the question: *what changes happened in families after they participated in the program?* Some of the immediate changes were considered in the preceding two chapters. These will be summarized and expanded below. However, changes, both positive and negative, occur for many reasons. PSOP interventions were embedded in all the other events that occurred in the lives of families during the time that workers were in contact with families and afterward. For this reason, we can also ask the impact question: *Were any observed positive changes the result of PSOP? Or, put negatively, Would those changes not have occurred had PSOP services not been provided?* However phrased, this is a more difficult question to answer in the present evaluation because the formation of a control group (similar families for whom services were not provided) was not possible.[17] One way to approach this question is to ask families and workers directly whether they were helped by the program. Who would know better than families themselves and the individuals that met and worked with them? Another approach that departs from opinions of workers and families is to use an outcome that can be commonly measured for all families but to limit comparisons to families with similar needs. The version of the method developed for this study is based on what we call the *dosage model*.

6.1 Instrumental and Immediate Outcomes

Instrumental outcomes refer to services and assistance made available through the program that improve life skills and involve learning. Immediate outcomes refer to benefits that accrue to families simply from receiving the service, whether or not their lives subsequently change. These were each considered earlier and are summarized here.

Some may wish to restrict the word outcome to longer-term changes that occur in the lives of families, for example: improved ability to obtain basic necessities, improved child rearing practices, more tranquil and healthy relationships among family members or reduced maltreatment of children. They will object to referring to assistance itself as an outcome. Yet, help from someone else is often a necessary intermediate step in producing changes and the assistance and changes are integral. Drug abuse treatment and subsequent avoidance of drugs might be viewed as an example of this type. Few successfully overcome deep addiction without assistance. Further, providing help to families can not only improve their skills, behavior and long-term welfare, many kinds of

[17] Comparison to families that did not agree to services was considered but collection of sufficient and comprehensive information on families characteristics, in particular needs for services, was not possible.

assistance represent a positive benefit and a change, however transitory, just by being delivered. This is particularly true of basic needs. It is important for families to become able to pay the rent regularly, but immediate help in paying this month's rent also has value and is a positive outcome. Preventive services delivered in programs like PSOP sometimes produce immediate benefits, sometimes assist in initiating longer-term change and sometimes do both.

We can also safely assume that some, perhaps most, of the assistance provided by PSOP workers would not have come to families in the absence of this program, and in this sense instrumental outcomes can be considered program impacts. The level of new assistance cannot, of course, be known but some families simply would not have been referred had PSOP not been in place and families that would have been referred to other programs would not have encountered workers with the extra resources available through PSOP. These outcomes are summarized under the following nine points:

1. PSOP Workers entered the lives of families in need and in the majority of cases had multiple direct contacts with them and with others on their behalf (Section 4.1).
2. The large majority of families responded positively to the PSOP intervention, indicating that they were satisfied with the worker and the intervention and felt that their worker understood their needs (Section 4.2).
3. Workers and families generally agreed that the assistance received fit the needs of the family and that it was effective (Section 5.1).
4. Referrals to community agencies of various kinds occurred for 87 percent of PSOP families (Section 4.3).
5. Services were provided by workers and through community referrals, and for most types, this represented a substantial increase over services already in place before PSOP (Section 4.4).
6. A substantial proportion of families (47 percent) learned of services that they did not know about before PSOP (Section 4.4).
7. Half of responding caregivers indicated that they received direct assistance from their PSOP worker in the form of transportation, financial assistance, help with housing and the like (Section 4.4).
8. The level of participation or utilization of services, as judged by workers, was moderate to high (Section 5.3).
9. There were various barriers to services and for this reason over a quarter of families (28 percent) said they did not receive some form of help that they wanted (Section 5.2).

6.2 Family Views of Impact of PSOP on Their Lives

As noted, the large majority of PSOP family caregivers liked their PSOP worker and were generally satisfied with the services they received (Section 4.2). Caregivers were also asked whether their family was better off or worse off because of the PSOP experience. Their responses are shown in Figure 6.1.

About eight out of ten families (79.4 percent) responded that they were somewhat or much better off because of participation in PSOP. A minority felt that they were somewhat worse off (17.8 percent) or much worse off (1.3 percent) and another 1.3 percent felt that PSOP made no difference to their family.

Family caregivers were also asked after their case was completed: *Do you feel more or less able to care for your child(ren) than you did a year ago?* On the positive side, 35.0 percent said *much more* and 24.0 percent said *somewhat more* for a total of 59.0 percent positive. Another 34.7 percent answered *about the same*. On the negative side, 3.9 percent said *somewhat less* and 2.5 percent said *much less* for a total of 6.4 percent negative.

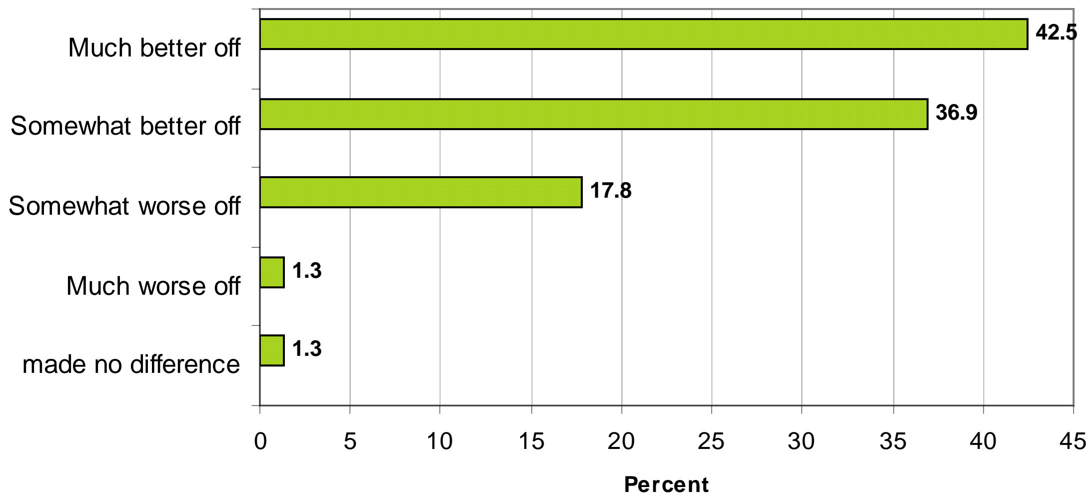


Figure 6.1 Family Responses to the Question: Overall, is your family better off or worse off because of this experience?

As one might expect, there was a close correlations between responses to this question and family satisfaction with workers and the assistance received (Section 4.2 above). For example, 58.4 percent of those who felt much better off were very satisfied with their worker compared to 31.3 percent of those who felt somewhat better off.

However, there was also a relationship between this sense of having been helped and appropriateness and sufficiency of services (see Section 5.1). Concerning whether the services were *the kind your family needed,* 49.4 percent of caregivers that felt *much better off* answered *generally, yes* compared to 39.3 percent of caregivers that felt *somewhat better off* and only 9.5 percent of those that felt *somewhat worse off*. Similarly,

concerning whether the services were *enough to really help*, percentages that answered *generally, yes* for the same three groups were 53.4 percent, 37.5 percent and 7.5 percent.

We can conclude that families that felt better off also tended to feel better and more adequately assisted and served by workers. Another way of thinking about this is that feeling better off meant that families remembered friendly workers, satisfactory help and appropriate and sufficient assistance.

Family caregivers were also asked: *Compared to last year at this time, how confident do you feel about your ability to deal with issues in your life?* Again, 33.7 percent replied *much more* and 29.5 said *somewhat more* for a total positive of 63.2 percent. Another 29.7 percent answered *about the same*. Then, 6.0 percent said *somewhat less* and 1.2 percent said *much less* for a total negative of 7.2 percent.

Caregivers were also asked to compare stress levels now to a year ago regarding the set of topics shown in Table 6.1. For most of the categories the responses resembled those of the two comparative questions just considered, with 60 to 80 percent generally indicating less stress regarding jobs, relationships, well-being, home and life in general. The one exception concerned financial outlook. For this category, more caregivers indicated greater stress (53.6 percent) than less stress (46.4 percent), which may reflect the need for more sustained assistance in improving the financial situation of families that were on average very poor (Table 3.3).

Table 6.1 Current Caregiver Stress Levels compared to a Year Ago

Do you feel any more or less stress than you did a year ago regarding your:	A lot more	Somewhat more	Somewhat less	A lot less
Financial outlook	21.8%	31.8%	31.7%	14.7%
Job or job prospects	15.6%	26.1%	30.9%	27.4%
Relationship with other adults	8.7%	21.6%	37.0%	32.7%
Relationship with children	5.1%	15.4%	39.6%	39.9%
General well being	8.9%	21.9%	38.6%	30.5%
Overall well being of children	5.8%	17.1%	34.3%	42.8%
Home	12.2%	22.8%	32.7%	32.3%
Life in general	14.7%	23.0%	36.5%	25.8%

It cannot be known how families would have rated changes in their abilities and feelings compared to a year earlier if they had not taken part in PSOP, although we might assume that the overall positive responses to the PSOP experience shown in Figure 6.1 were implicated in the positive changes implied in the responses to these questions.

6.3 Impacts of PSOP Identified by PSOP Workers

Workers responded to a set of items regarding family functioning. They were asked whether the family functioning issue was *addressed during the PSOP case* and then to indicate whether they observed *marked improvement while the case was open*. Workers responded to a large number categories of family functioning for *each families served*. They were also asked to respond concerning improvement in each of the categories for each family. These data were systematically collected from each worker for each family over the 2005 to 2008 period. The relatively simple bars shown in the following chart (Figure 6.2) represents summaries of thousands of judgments of individual workers.[18] (Each complete bar in the chart indicates the proportion of families in which the issue was addressed, while the hatched area in each bar indicates the proportion where workers observed marked improvement.)

Figure 6.2 shows that family functioning issues were addressed in relatively large proportions of families but that workers observed marked improvements in less than half the families in each category. The meaning of "marked" was left up to the judgment of the worker. Most understand this term to mean noticeable or obvious, although some might have taken it to mean striking or substantial.

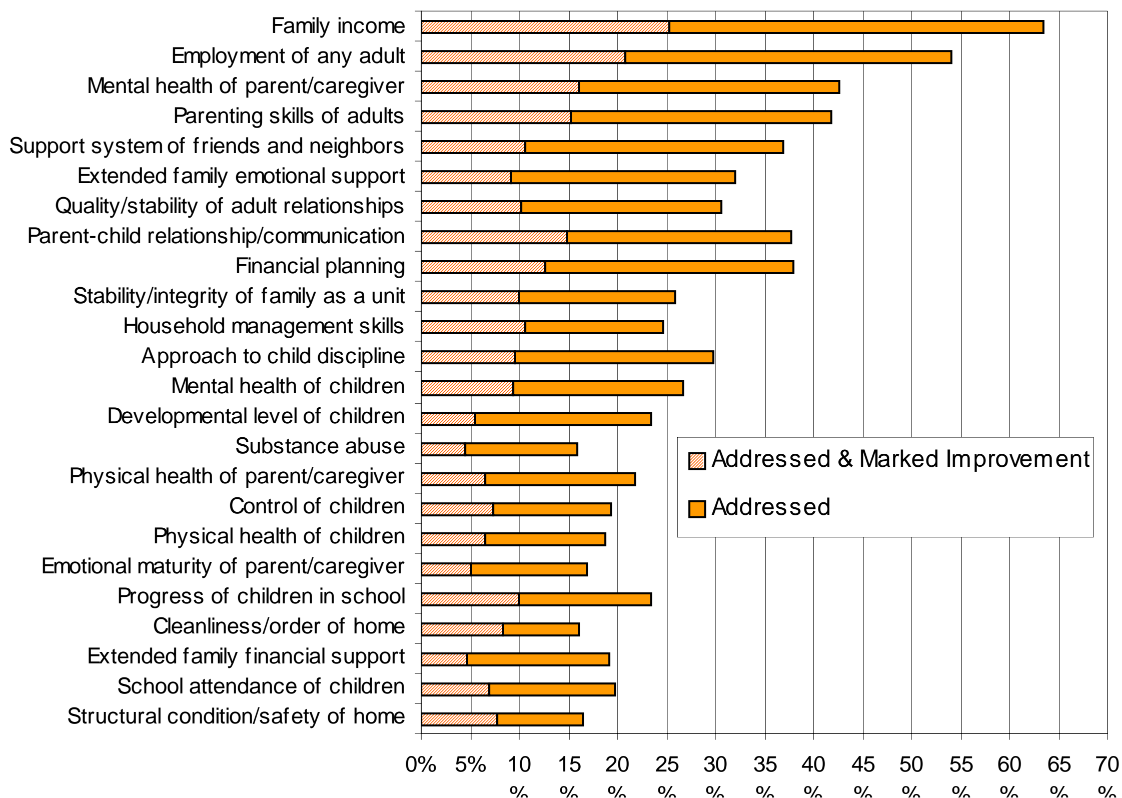


Figure 6.2 Family Functioning Issues Addressed while the PSOP Case was Open and the Proportion in which the Worker Felt there was Marked Improvement

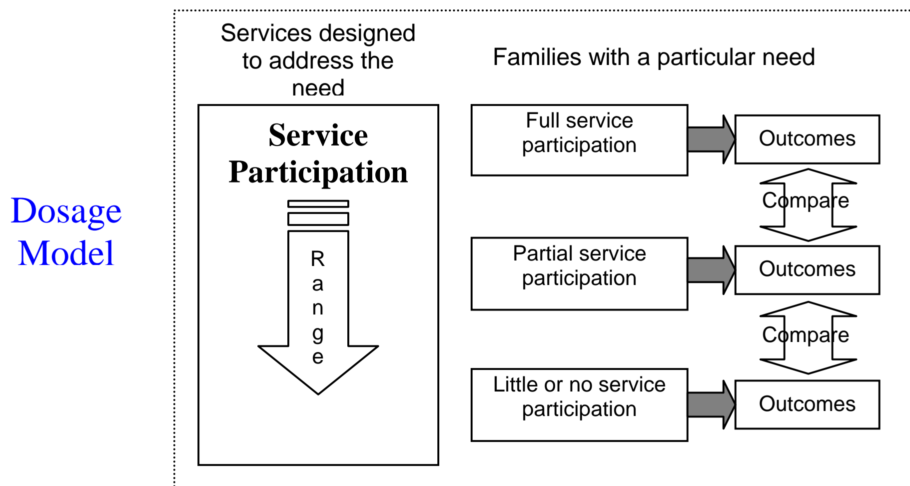
[18] Thus, workers were not asked to respond about their caseloads in general, as is sometimes done, but about each and every family that agreed to services. This method of data collection is more intensive but the results are more robust because the evaluators summarized their responses for over 2,600 families.

Workers indicated that the financial situation of families was addressed in about 63 percent of families and that marked improvement was observed in about 25 percent. Looking across all the issues, when something was addressed, the proportion of families with a marked improvement averaged about 36 percent.[19] Thus, while workers indicated they worked with many families on a range of issues, on average they felt that noticeable improvements occurred in only a little over a third of the time for any particular issue. However, it was also the case that for 62.1 percent of families at least one issue or problem from this list had improved markedly in the view of workers. Thus improvements were observed in at least one area of family functioning in about six of ten families served. This is close to proportions for general improvement that family caregivers themselves provided (Figure 6.1).

If we assume that without PSOP these families would have been ignored or served less intensively then these findings are encouraging. From the standpoint of the total population in need of help, however, they would seem to indicate that more intensive work is needed. And assuming that some of the failures occurred because of the presence of various barriers to services, more work is needed to facilitate services.

6.4 Impact of PSOP on Recurring Reports of Child Maltreatment

In this section, one of the planned sets of outcome analyses is pursued. The research question is whether the level of services and service participation targeted at families with particular needs positively enhances the welfare of children. The PSOP evaluation design did not incorporate a control group. The research strategy outlined here, therefore, was dependent on the possibility of a range of services being delivered to families. How this can be done in an outcome study is shown in the following diagram (simplified from the PSOP research plan). We refer to it as the *dosage* model in the sense that various levels of service reception and participation by families or family members can be conceptualized as different "dosages" of assistance.



[19] Taking the proportion of each category (the length of the bar) as 100 percent, proportion with improvement (the hatched area) average about 36 percent.

The design is based on the assumption that voluntary service programs like the PSOP will naturally result in variability in services received and used by families, as families fail to participate fully for various reason or drop out of the program. While three levels of service participation are shown in the diagram, the number is arbitrary and as few as two could be analyzed as well as many more than three levels and even continuous measures across a range of participation.

The design assumes that families with a specific need can be identified and that identifiable services that directly address that need can also be identified. Some needs and services fit this design well. However, the design may not be useful for other kinds of family problems and situations encountered in child welfare work. Many conditions within families are complex, calling for multiple service approaches and it is not always clear which approach or whether any approach will bring about needed changes or assist family members to cope and grow. In these situations workers may fall back on a assortment of assistance including basic services along with traditional therapeutic and counseling services in hopes that some part of the services package will make a difference. These kinds of problems and services are more difficult to evaluate using the dosage design. In addition, there are specific kinds of services that are useful to many different types of families with a variety of different needs. Childcare is an example of this kind. A final concern is the number of families of a particular kind in the population of families that accepted PSOP services. For example, an analysis of services for the developmentally disabled provided to developmentally disabled caregivers may fit the model but the number of such caregivers in the study may be too small to permit this kind of analysis.

The Significance of Reduced Future Reports of Child Maltreatment. The outcome examined in this section is reduced *reports of child abuse and neglect accepted by CPS* subsequent to PSOP acceptance. Hotline reports of child maltreatment are indicators of risk of future child maltreatment. Put simply, families with several past reports, regardless of whether interventions by child protection workers occurred, are more likely to be reported again than families with fewer or no past reports. And when reported again, the reports are more likely to lead to an intervention by the CPS agency in the family.[20] It is reasonable, therefore, to regard accepted reports of child maltreatment as indicators of problems in families that may affect the safety and the longer-term welfare of children.

Reports of child maltreatment are allegations not facts. In any single case they may or may not be correct. But over large populations of families reported to CPS, reports are associated statistically with a variety of family problems and situations that can harm the welfare and compromise the safety of children. This is what we mean when we say that reports of child maltreatment are *risk indicators.*

[20] The evaluators conducted analyses of several thousand families in the Missouri system showing this. The reports is retrievable at: http://www.iarstl.org/papers/FEfamiliesChronicCAN.pdf. The analyses with academic references can be found on pages 3-8.

As indicators of risk, reports are indirect measures. A report is not the same as the conditions associated with it. Indeed, a variety of different conditions may underlie the same kind of report. For example, a report of a dirty home may reflect conditions such as a depressed caregiver, other mental illnesses in the family, chronic illness of the caregiver, caregiver drug or alcohol abuse, low income, unemployment and domestic violence—to name only a few. The report is not proof that any of these exist. But it turns out that many reports of this kind made about many different families *point to* such underlying problems. This is the justification for using new reports of child maltreatment as a dependent variable in outcome analyses of child welfare. Reduction of new reports among families provided with child and family welfare interventions is a positive finding—an indirect indicator of improved child welfare.

One other consideration needs to be mentioned. Avoidance of new child maltreatment reports is indeed an indirect indicator of improved child welfare but the occurrence of a subsequent report does not mean that preventive services programs like the PSOP had no beneficial effects for the reported family. It is possible that service interventions may have led to the same or greater benefits in families that are re-reported but that old problems nonetheless recurred or entirely new problems arose that stressed family relationships.

Decreased reporting also has the added positive benefit of *relative reduction* of service activities and expenses associated with CPS interventions in families.

In these analyses, families were limited to those that accepted PSOP services from October 1, 2005 through May 30, 2008. Data collection on families for the present analysis, including tracking of subsequent reports, was concluded on November 30, 2008. This provided a minimum tracking period of six months and a maximum tracking period of 38 months. There were 1,791 such families for which full SSIS information was available along with completion of the SDM Family Needs and Strengths tool and the Extended Family Assessment by workers. In addition, a subset of 480 families was available for analysis for which the first family follow-up survey was also completed.

Measurement of Services. It would be a simple world if needs and services corresponded exactly—every need was addressed by a unique service and every service met one and only one distinct need. That is not the case. As already noted, needs may require multiple services. For example, to keep a job an individual may need help with transportation, childcare, training, etc. On the other hand, a single services may address multiple needs such as childcare services facilitating work, school, respite, etc. Occasionally, needs and services can be closely matched, like hunger and feeding. For example, as will be seen below, substance abuse indicates a singular need for substance abuse treatment services.

This evaluation included measures of problems and needs of families as well as service offerings and service participation for each PSOP family. Combined measures of services, like those shown at the end of the preceding chapter were used in the following analyses. In three critical areas, needs and services were considered and matched: 1)

serious basic needs deficiencies and poverty-related services, 2) under-employment/unemployment and assistance with welfare and employment and training, 3) substance abuse and substance abuse treatment. Another section is devoted to summarizing other areas of needs and services where such an analysis was not possible.

Case Descriptions for Deeper Understanding. The outcomes analyses in this section are primarily statistical in nature. In some cases they show relatively convincingly, given the limitations of the evaluation design, that the PSOP had beneficial effects. That is the strength of statistical analyses. Their weakness lies in their generality. They always leave us wondering, what was it exactly about these particular services that led to the differences observed? One aspect of this question centers on variations in service delivery. To what extent were the benefits due to the service itself, the ongoing support, coordination and other assistance provided by the worker or some combination of these. One way of addressing these questions is through a presentation of casework details in case descriptions. As in previous chapters, several case examples are presented below for this purpose.

6.4.1 Family Poverty and Poverty-Related Services

Poverty-related services reflected availability *and participation* in several categories that were discussed in Chapter 5 (Section 5.5, Measure A) As indicated, the analyses in this section are based on determinations of needs and services by workers for 1,791 PSOP families. The services in the following list are the primary services included in this services measure.[21] These are only the strongest contributors to the measure. As noted, the measure is a reflection of multiple services to families, that is, many PSOP families that received one of the services in this list also received one or more other services in the list. This is logical since the needs associated with the service are highly interrelated, reflecting inability to access resources, and arise in part from low income and unemployment.

Rent/house payments	Emergency food	Housing
Basic household needs	Transportation	Employment
Emergency shelter	TANF/SSI/FS	

Evaluators decided to use this measure because the component services were offered to more PSOP clients than any other kinds of services. Families with high scores on this measure participated in several of these services. Families with lower scores participated in fewer or none of these services. The emphasis is primarily on *participation in* services, which, of course, can only occur after *provision of* services. There were families that were offered many services in this list but that had lower scores on this measure because they used the services at low levels or not at all. This is an important distinction in this and the following sections: *only families that utilized services at high levels had high scores on the services measures.* The focus is on something *actually* delivered to and utilized by a family that might produce a change.

[21] Further details this measure are described in Appendix 1.

The four top categories in the measure are clearly related to poverty: food, rent, housing and household needs (e.g., appliances, furniture, home repair, etc.). The remainder (and others not shown) address needs that are somewhat broader in nature but are nonetheless more acute in low income families, and as was clear in Chapter 3, the majority of families accepting PSOP services were in poverty and a subset of these were deeply in poverty. There are, however, various mitigating factors. For example, families may have low incomes but some financial support from their extended families or families may receive support from various non-cash programs. The important consideration for this analysis is not poverty per se, but *need* for the kinds of services in the preceding list of services. Thus, we decided to use the measure of needs for basic services that workers completed in the SDM Family Needs and Strengths Assessment (see Figure 3.8a: Housing, Environment and Basic Physical Needs). Workers completed four response categories: adequate, some problems, serious problems and chronic deficiencies. For this analysis, the first two and the last two were each collapsed into a single category. There were 1,541 families (86.0 percent) in the *adequate or some problems* category and 250 families (14.0 percent) in the *serious/chronic basic needs deficiency* category.[22]

For simplicity of presentation, the basic services measure was also dichotomized into *none or low* versus *moderate or high* services participation. This permitted a straightforward analysis along the lines suggested in the dosage model diagram. The initial results are shown in Figure 6.3.

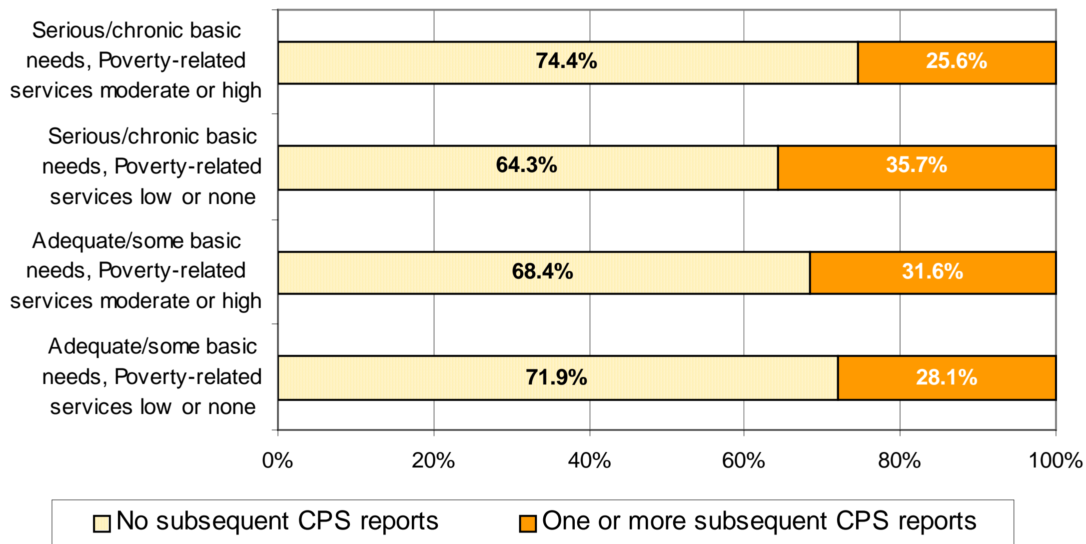


Figure 6.3 Proportion of Families in Four Categories of Basic Needs and and Poverty-Related Services with a Subsequent Report of Child Maltreatment

The differences in Figure 6.3 suggest that families with serious or chronic basic needs that are offered and participate in services that address those needs are assisted

[22] Percentages vary slightly from those in Figure 3.8 because this analysis was conducted on a smaller proportion of the entire population of PSOP accepters, as described at the beginning of this section.

most in comparison to similar families that did not participate. The proportion of new reports on such families is comparable to and slightly lower (25.6 percent) than that of families in the adequate/some basic needs category that received no services of this kind (28.1 percent). However, the differences shown were not statistically significant for the cross-tabulation that underlies this figure (p = .173).

The follow-up time varied greatly for the families in this study. Families that began and ended their original case in 2005 had nearly three years of follow-up while those that began in late 2007 would have had only a few months. For this reason, a more appropriate and stronger analysis was utilized. The following figure (Figure 6.4) illustrates the differences in the same four groups arising in a survival analysis (Proportional Hazards). The lines represent the survival patterns (cumulative survival for each of the four groups in Figure 6.3 over the entire follow-up period (a maximum of approximately 1,150 days). Survival in this case indicates the proportion of families remaining without a new CPS report. Thus, <u>the higher the line the better the outcome</u>. The difference of interest in this diagram is that between the bottom line representing the group of families with *serious/chronic basic needs with no (or low) basic services* and the other three groups. In this more powerful analysis, the difference was statistically significant, as is shown by the variable listing near the bottom of the figure in which the difference between the last variable (the bottom line in the graph) and the other variables is statically significant (p = .05). The analysis indicates that serious or chronic basic needs families did as well as families with fewer needs <u>when services addressing those needs were utilized</u> and did significantly worse <u>when such services were not made available or were not utilized</u>. The latter had significantly more subsequent CA/N reports screened-in to CPS and the reports were received sooner.

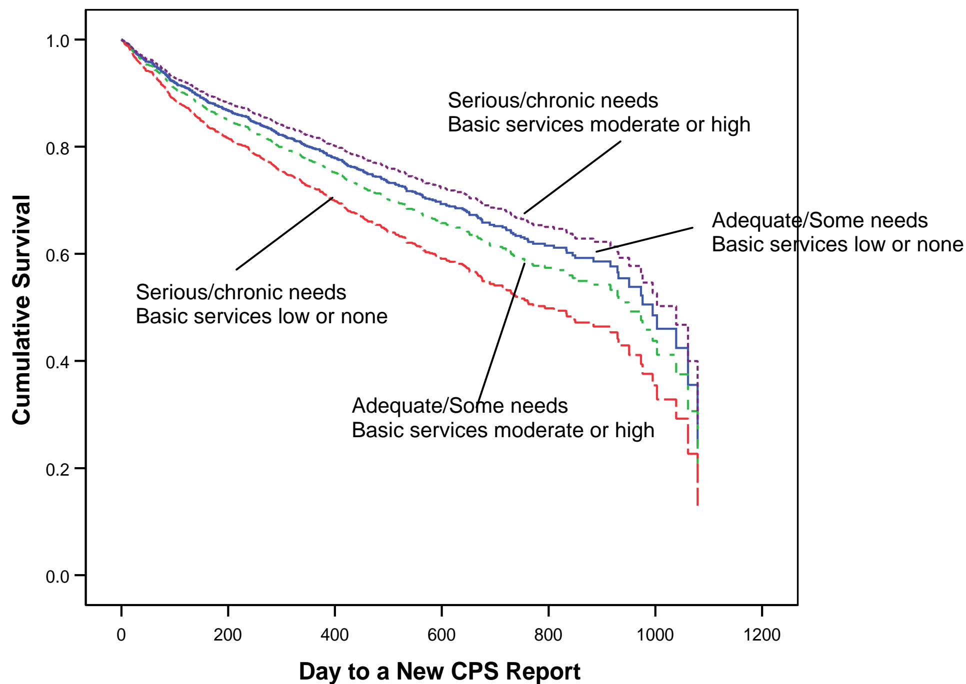


Figure 6.4 Survival Analysis (Proportional Hazards) Low and High Basic Needs by Low and High Poverty-Related Services

We would be remiss not to point out an alternative or supplemental explanation to these findings. Families were not randomly assigned to the four groups in this analysis. Dividing the PSOP families into those with adequate or some basic needs versus those with serious or chronic basic needs certainly has an empirical basis in the judgments of workers that visited and assisted the families. However, within each of these groups the division into service groups of low or none versus moderate or high was based in part on the choice of families to accept and utilize such services and in part on barriers to services beyond their control. It is possible that their willingness and their capacities to overcome barriers reflected other characteristics of families (e.g., attitudes, skills, social support, environmental) that explain to some extent the differences observed. Although not stated, similar provisos apply to the following two sections as well.

Nonetheless, this is an important finding that rings true at an intuitive level. The intense activities of PSOP workers in assisting impoverished families with basic services improved the safety of children and by implication the long-term welfare of families. The results of this analysis resonate with the findings of the Minnesota Alternative Response Evaluation of families, in which an experimental design was utilized. That analysis demonstrated that basic services increased for experimental families as compared to control families and that the increase led to positive benefits for families.[23]

6.4.1.1 Poverty and Poverty-Related Services: Analysis based on Family Reponses. More complete information was available directly from families. Families were contacted after the final visit with their PSOP worker and were asked to respond to a series of questions. In this section, an analysis similar to the one immediately above is described. There were 480 families that fit the conditions outlined above (accepted PSOP between 10/1/05 and 5/30/08 allowing follow-up) with full SSIS, worker and family data on the variables of interest.

In looking at the relationship of poverty-related services to subsequent CPS reports using data from SSIS and workers it was not possible to control for differences in the groups being compared. However, with the addition of family data it was possible to take into account certain other family and environmental characteristics. These were social support/isolation (see Figure 3.7), neighborhood characteristics (see Table 3.4) and caregiver satisfaction with the PSOP worker (see Figure 4.1). By introducing these variables into the analysis, it can be argued that some extraneous differences among the four groups were controlled.

For this analysis, families were split into two categories based on their reported income during the previous 12 months: less than $10,000 (43.0 percent) versus $10,000 or more (57.0 percent). As mentioned before, poverty is a risk factor for subsequent CA/N reports to CPS. The frequency of subsequent accepted reports for the lower-income group was 36.4 percent while the frequency for the “higher” income group was

[23] This report is retrievable at: http://www.iarstl.org/papers/FinalMNFARReport.pdf. See especially Chapter 2, pp 24ff.

28.1 percent. This difference of 8.3 percent was statistically significant (p = .03), confirming the importance of the income variable.

Families were further divided into those with low or no poverty-related services and those that received moderate or high poverty related services on the same basis as the division described above. This yielded the four groups that can be seen in Figure 6.5.

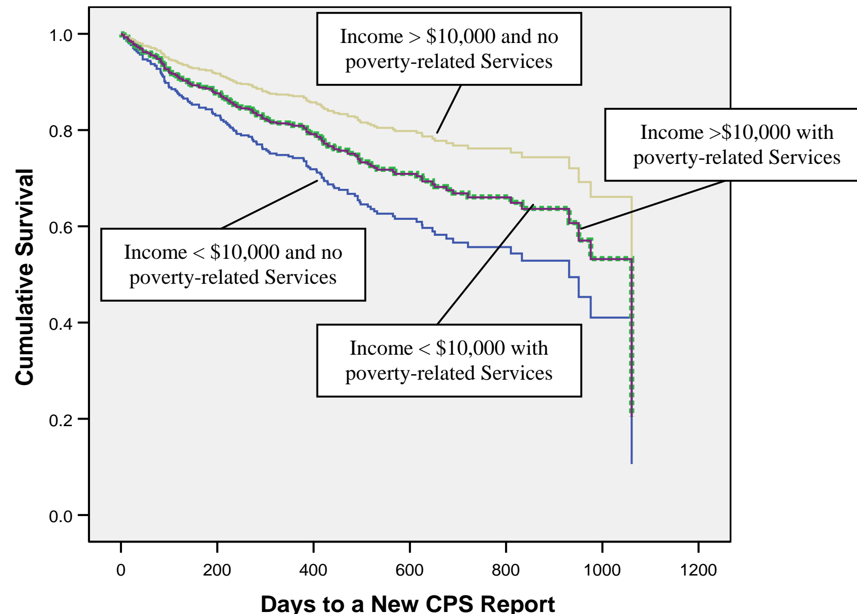


Figure 6.5 Survival Analysis (Proportional Hazards) Families Earning less than $10,000 per year or Earning $10,000 or more by Participation in Poverty Related Services

Social isolation had no effects on report recurrence, nor did the quality of the neighborhood in which PSOP families lived. Satisfaction with the PSOP worker was associated as a trend (p = .08) with reduced subsequent reports (more satisfied families returned less often). Controlling for these three variables there was still a significant relationship between poverty-related services and later reductions of subsequent reports (p = .04). The survival analysis line chart shows this (Figure 6.5).[24] It is evident that the most impoverished families with the least services fared the worst. They were more likely to have new reports and to have them more quickly. Those with higher incomes, who participated in no services fared best. The other two groups fell in between.

These results support and strengthen the findings for the larger population. Controlling for differences in social support/isolation, in the quality of neighborhoods and in family attitudes towards their worker, poverty-related services were still related to improved CPS outcomes among the poorest families in the PSOP population.

[24] Details in Appendix 1.

6.4.2 Examples of Services Addressing Basic Needs of PSOP Families

There is no simple way to characterize the cases that were the focus of this analysis. While it is true that most of the families with basic needs had low incomes, there were a variety of other factors that contributed to the need for basic services, including lack of employment or underemployment, lack of consistent child support from absent parents, little financial support from the extended family, several young children in the family, pregnancies, inadequate housing, and loss of housing. Ignorance of available resources and how to access them is also an important need. The three examples that follow involve all of these and other issues. They also illustrates how providing basic services under PSOP in many cases involved not simply referring a family to services but instruction, collateral contacts, counseling and moral support. The first two examples ended positively. In the third example some issues appeared to be unresolved at the end of PSOP contact and PSOP services did not appear to have averted state custody of the child.

As noted earlier, PSOP during its last year began accepting cases referred directly to PSOP by MFIP financial workers rather than through a report to CPS, but the following case arose from an unaccepted report of child neglect from an MFIP worker. Many of the PSOP cases involved families that were sanctioned by MFIP and, as a consequence, were receiving reduced or no financial assistance. The potential exists in these cases for "neglect of" (that is, inability to provide for) the basic needs of the children in the family. We can question, based upon this case, whether TANF sanctions are useful in the absence of a facilitator like the PSOP worker in this instance. A noteworthy feature of this case is that the PSOP worker not only did things for the mother but through example and instruction helped the mother learn how to deal with the work program bureaucracy. This case is an illustration of the power of positive and supportive approaches to families that characterize PSOP and differential response approaches in child welfare.

Case 6.1 Single Parent Family: Domestic Violence, Basic Needs and Employment Issues

A written report was received for intake from a financial worker (in a rural county) and was screened out for child protection response. The report concerned a mother (A), who was 100% sanctioned from her MFIP (TANF Work Program) grant for refusing to cooperate in doing 35 hours of job search, resume writing and attending workshops at the Work Force Center (WFC). A had two children ages two years and six months. She had no cash income other than irregular payments of child support from the absent father (B). A had food support but the financial worker was concerned that the mother was not meeting the children's basic needs.

The PSOP case for A and her two children began about six months after the MFIP sanctions were put in place. At the time of the initial home visit, B (the father), was incarcerated for domestic violence against A. The worker talked with A about whether she would allow him to return home following his jail sentence. A said that it was hard to keep him away and he continued to return to her home. The worker and A also reviewed her income and bills. Because she was on HUD, A did not have to pay rent. The food program provided about $300 per month. The summer electric bill for the family ran about $45 per month, and the winter bill was about $150 per month. At the time of the interview, the family was about to face a disconnection of power services, due to an unpaid bill of $230. The worker agreed to submit a request for funding through PSOP to cover this cost. Other needs explored included finding daycare, obtaining

daycare assistance, enrolling her daughter in Head Start for fall and obtaining a permit and/or driver's license. Increasing knowledge of parenting strategies, such as time-outs, was also an identified issue.

To determine steps to alleviate sanctions and begin to meet her other goals, the worker began collateral contacts with MFIP workers, a domestic violence counseling agency, public health, and the Driver's License office. A was given a driver's license rulebook to study and was offered some parenting DVDs to watch. Within three weeks, the worker had set up an appointment for A to meet with a battered women's program counselor and had made a trip to a second hand store to find beds, a crib and a dining set for the family. The focus of the direct assistance was financial stability and enhanced parenting skills for A. During home visits, the case manager helped A fill out an MFIP application to begin the necessary four weeks of compliance. She also reviewed material such as "Dealing with Temper Tantrums" and "Time Out". During each family visit, the worker encouraged A to seek support for her abusive relationship to enhance her self-esteem.

Within 45 days, the worker was meeting or speaking frequently with the financial worker to help A achieve compliance. At this time, home visits involved working with A on her Work Force Center journal entries. A team meeting was held at the Work Force Center with all of the individuals involved in A's case. A was to begin to follow a 30 day plan to re-qualify for MFIP and had to begin documenting her job seeking activities on a regular basis. Other activities for A included taking the driver's license exam within one month, attending DV counseling, work on establishing daycare, and 11 hours of job search per week. The PSOP worker was meeting with the family up to two times per week. The PSOP worker secured PSOP funds to pay A's electric bill to avoid a utility shut-off and followed up with A to ensure she was completing her job journals and work search activities. A was actively working to re-qualify for MFIP and achieve her financial stability goal. She began part time work at a local company within the 30-day plan period. The worker and A agreed that the "financial stability" goal would be met when the MFIP sanctions were lifted. A was reading the driver's manual and completing homework assignments given by the worker regarding her DV issue. During this time, both children appeared to be doing well. Within about three weeks, A was back in compliance with MFIP. The worker began to speak to A about developing a budget, now that she was working again. They discussed purchasing affordable beds for the family with a PSOP "match" for A's contribution. A required a uniform for her new job, and the worker assisted her in arranging for the WFC to pay for these items and took A shopping for them. Daycare had become a more pressing issue now that A was working, and the PSOP worker encouraged A to complete the necessary background checks for her mother and four other family members to act as her daycare providers and receive daycare vouchers. These background checks would be paid for with PSOP funds. Even though A was no longer sanctioned from MFIP, she could not receive cash assistance, only Food Support, because she was now working 24-32 hours a week. Furniture costs were shared: A paid for a dining set and a crib and PSOP paid for a full sized bed and a single bed for her child.

Then there were setbacks: A's phone was disconnected because her sister ran up a big long-distance bill; A had an argument with her family making child care arrangements more difficult; she was unexpectedly arrested for a fine she owed and paid the bail disrupting her budget; she failed her drivers license test; she failed the Certified Nursing Assistant test for her job and could not work for a month until she retested and passed; and she missed some days of work due to an injury and unreliable transportation. At the same time there were advances: A's parenting skills improved, she participated in the parenting exercises provided by the PSOP worker, she and the worker had identified community and family supports, she connected to WIC, applied for fuel assistance and was re-enrolled in MFIP (for support services and Medical Assistance), she took the drivers license test a second time and passed, and she received her driver's license permit and started to look for an affordable vehicle to purchase.

A agreed that once she has some assistance finding a new position, that the worker could close her PSOP case. In the meantime, A filled out an application for MFIP to cushion her until she could find employment. A had become familiar enough with how to work with the WFC that she could look to them for support with future employment issues. In another month, A began a part-time job and began to negotiate the purchase of a vehicle from her uncle. After being open for six months, the case was closed. Both A and the worker believed all of her goals had been met.

Like the preceding case, the next case illustrates the difficulties experienced by mother-only families in meeting basic needs. We can ask whether this family would ever have been reported to CPS, even in absence of PSOP services, since housing support was

being provided by the friend of the family. In this case the PSOP worker may simply have provided support and enhanced the welfare of the family during a period of need. In any one case of multiple services, it is impossible to know what *would have* happened had the worker and the services not been present. The preceding statistical analysis, however, suggests that for groups of families with these needs no assistance leads to poorer outcomes that some assistance.

Case 6.2 Single Parent Family: Immigrant Family with Basic Needs

A family of five was referred to a religious charities organization in an urban area. A single mother (S), originally from (African county), was raising three children and a grandchild, the three-year-old child of her 17-year-old daughter. The mother also had twin infant boys. The family's priority was housing with at least 3 bedrooms. The teen mother also needed health insurance for herself and her child, as well as parenting support. The family agreed to work with PSOP through the charities organization, which was a contract provider for PSOP services.

The family had been living with a friend for almost a year. S had lost her previous housing at about the time she was due to give birth to her twins. S's ex-husband did not want her to have the twins and left the relationship when she refused to have an abortion. The father helped occasionally with diapers and basic needs but did not see the children on a regular basis. The couple did not have a legal arrangement for child support and S was not pursuing this issue. Although the friend they were living with was very gracious to the family, the stay was supposed to be temporary and the mother wanted to get back on her own feet. The family had been on the Public Housing waiting list [for several months] and was hoping to find something in the urban area. Though the family qualified for additional benefit programs, they were not receiving them. Medical insurance, MFIP (TANF work program), food stamps, child support, and childcare assistance were all needed.

The worker assisted the teen mother to enter a mentoring program through the agency. Though she was finding it hard to parent at her age, she was attending a charter school, doing well there, and assisting in caring for her twin brothers. The teen mother's child was healthy and happy, but there was no contact with the child's father. Case-management services were successful in helping S find new transitional housing through (a religious charities organization), with support services and a month-to-month lease agreement. A furniture assistance referral was made, as the family moved in with few belongings. S was employed but still occasionally needed cans of formula and help finding necessary items, such as strollers. Staff worked on a budget to assist in the goal of achieving financial security. S kept in contact with her family in (African county), where she had another son, and would sometimes send them money when they asked for her help. S felt that even though her financial situation was tight, she had no choice but to help them, as there were no supportive agencies in that country. She was hoping to become a permanent resident and have her son come to live with her in the US. The case closed after several months after most of the original goals had been met. S was very appreciative of the program and stated that the most helpful part was having someone else to listen to her.

The assistance provided to the family in the following case did not ultimately prevent the removal of their child. We can ask whether the family would have still been living in a tent without the assistance provided by the PSOP worker. It seems clear that the short-term situation of the family was improved and that the safety of their daughter was enhanced. There were outstanding medical and drug-related issues that were not addressed that were presumably connected to recommendations of the Guardian Ad Litem (GAL). Perhaps these issues were beyond the capacity of a voluntary program like PSOP. We will see in the next section the kinds of substance abuse cases in which PSOP appeared to contribute to beneficial outcomes.

Case 6.3 Two Parent Family with Basic Needs, Medical Needs and Possible Substance Abuse

A young family of three—mother (K), her five-year old daughter (B), and mother's paramour and child's father (R)—began PSOP services after being discovered living in a tent in [a public outdoor area]. The family had been in this situation for at least four weeks, had no transportation, and was relying on campers they met for food and supplies. The report was screened out for maltreatment because basic needs were being met marginally.

The family needed housing, transportation, medical treatment, and financial assistance. R had been having seizures of unknown origin and had not recently been able to work. The family had been receiving MFIP (TANF Work Program) financial assistance but had been sanctioned and could not get any cash until 30 days after beginning to attend Workforce Center (WFC) meetings. The family had no transportation and no access to bus tokens, but had received assistance from another county department for clothing and food in months prior.

The worker began work on obtaining necessary identification to apply for a lease. There had been a previous custody case and R had only temporary custody of B pending a drug test and a parenting assessment. The worker contacted the GAL in the custody case to learn the background of the family. After consulting with the MFIP case manager, the family's sanctions were lifted. Removal of MFIP sanctions allowed the family to qualify for housing assistance, and a referral was made to this program. As the housing search began, the county PSOP worker provided transportation to allow the family to meet with leasing companies and participate in necessary appointments. The agency also paid some outstanding bills.

However, the family had a poor rental history and had some driving violations, a misdemeanor charge for lease fraud, and two unlawful detainers for $2,000 on their criminal record. B had spotty school attendance. Food scarcity was a recurring problem and the family relied heavily on the local food shelf, which only allowed a certain number of visits in a given period of time. This caused K ongoing anxiety about losing B to child protection. As needed, the worker provided the family with small grocery vouchers to support them until their food support benefit was available.

R's seizures interfered with his ability to work or participate in Work Force Center activities, and because of missed appointments, the family was continually at risk of MFIP sanctions. R would not visit [a medical clinic] for an assessment although referred by a doctor. The worker had a report that R was using methamphetamines. The worker also spoke with staff at a local housing program and discovered that the family would not qualify unless they found a unit that was no more than 30% of their income. The family also did not qualify for assistance through the Housing and Redevelopment Authority due to the family's rental history.

After about three months, the family had stabilized somewhat. B was reportedly doing well in school, but K stated that she was feeling depressed herself. The worker discussed counseling as an option for her to consider. R had found a job doing tree trimming but was still having seizures daily and was not in good spirits. After four months of service, the plan was reviewed and the family had met many of their initial goals. The family had secured housing and had a vendor payment arrangement. They had not needed to access the food shelf recently and had sufficient funds on their EBT card. K had just started actively looking for work and did not want any further assistance with employment. K and the worker mutually agreed to end services. K was referred to a special program for Christmas gifts. She was encouraged to come back or call if they needed services in the future.

At the six-month follow up, the family had re-entered the child welfare system following the closing of the PSOP case. Though PSOP had been helpful in providing housing advocacy and financial assistance, the GAL on the custody case had filed a CHIPS petition for B and the county agency supported it. Due to the new court order, the family would be able to access additional services. At the time of the follow up, chemical use was a growing concern.

6.4.3 Employment and Employment-Related Services

In several of the case reviews in this and previous chapters, families were having problems with employment or with MFIP participation. The latter, as noted previously,

is Minnesota's version of the TANF program including its work requirements. Under TANF, cash welfare, medical insurance, employment and training are closely interrelated for low-income families with children.

In this section the question is whether PSOP families that were underemployed or unemployed benefited from participation in the kinds of services in the second category of summary service measures (Chapter 5, Section 5.5, Category B): welfare, medical, training and employment. The most important services included within this measure were:

Medical/Dental	TANF/SSI/Food Stamps	Educational
Vocational/Skill Training	Employment	Recreational
Transportation	Disability Services	

Underemployment and unemployment were measured using a question in the Family Needs and Strengths (FNS) instrument that was simplified to two categories: 1) employed or no need for employment; 2) underemployed or unemployed. As might be assumed, this was not uncorrelated with the measure of basic needs used in the preceding section. Among families with adequate basic needs or some deficiencies, 43.7 percent were underemployed or unemployed. By contrast, in families with serious or chronic basic needs deficiencies, 82.4 percent were underemployed or unemployed. Thus, among families with the most acute basic needs program the large majority also had employment problems. But this analysis also shows that a substantial proportion of families without basic needs deficiencies (43.7 percent) also had employment problems. Thus, the preceding analysis and the current analysis are related but not identical.

A simple name for the service measure might be *Welfare-E&T* for services related to welfare (medical, TANF, food stamps, etc.) and to Employment and Training (education, vocational training, employment services, transportation, etc.). PSOP families received and participated in this service at various levels. After categorizing the measure, 126 families participated at no or very low levels, 650 at low levels, 586 at moderate levels and 431 at high levels. The Welfare-E&T measure in this categorical form was very weakly but positively associated with the poverty-related services measure of the preceding section (Tau-b = .06).

The simplest and most straightforward analysis is shown in the following chart (Figure 6.6). The primary groups of interest in the chart are 1 and 3. This compares families with underemployed or unemployed caregivers that participated strongly in Welfare-E&T services (1) and the same types of families that did not participate or participated at low levels (3). The second group returned to CPS at a rate of 35.8 percent while the first returned at a rates of 27.9 percent, a difference 7.9 percent. This suggests that *to the extent these families are similar* provision of such services had an effect on factors leading to new CA/N reports. Interestingly, employed families with low services (4) did only slightly better, with a return rate of 24.2 percent.

Some families that were employed or had no need of employment according to workers still participated in these services at high levels (2). This also was expected

because some of the services included in the measure (for example, transportation) are related to other needs than employment.

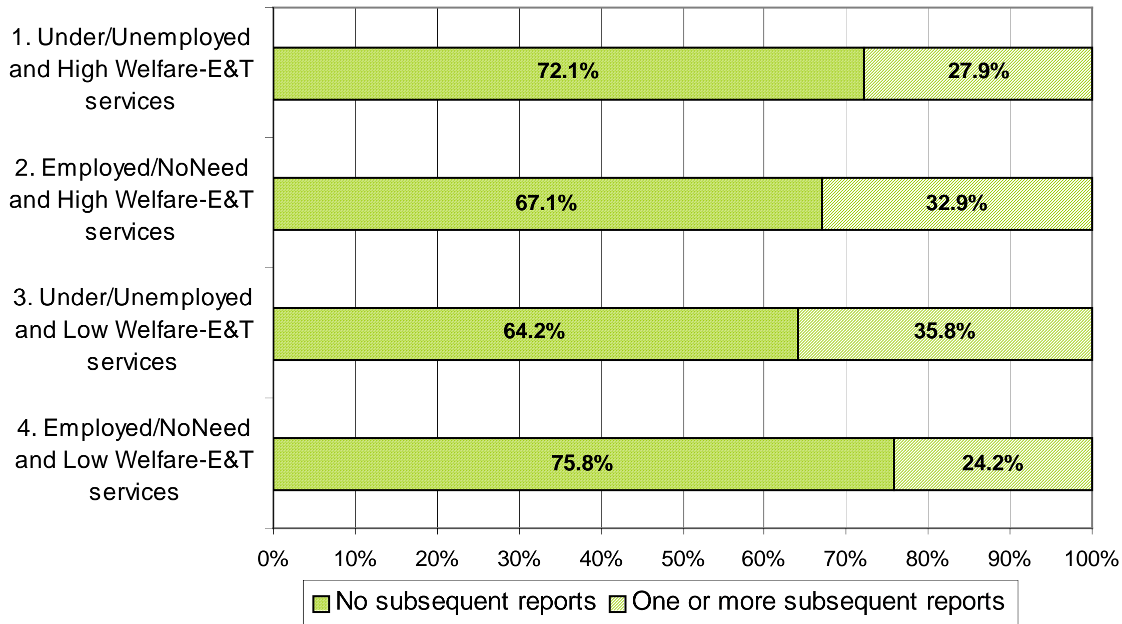


Figure 6.6 Subsequent Accepted CA/N Reports for Employed versus Under or Unemployed PSOP Families that Received Low or High Welfare and Employment/Training Services

As was the case in the previous analysis, survival analysis represents a better analytic approach and, as was also the case, that analysis (Figure 6.7) reflects the cross-tabulation underlying Figure 6.6.[25] As indicated, survival refers to the proportion of families remaining without a new CPS report. Thus, the higher the line the better the outcome. The comparison of interest is between the two lines for Under/Unemployment. Families with high Welfare-E&T service participation had better outcomes than similar families with no or low amounts of service participation.

Results in this and the preceding sections suggest that families in poverty benefited when they received and participated in poverty-related services. In addition, unemployed or underemployed families appeared to benefit from the combination of welfare, medical and employment and training services. The populations in need overlapped but were not identical. If this analysis is correct we can conclude that PSOP improved the welfare of families and the longer-term safety of children by providing families with the opportunity to participate in these kinds of services.

[25] Details in Appendix 1.

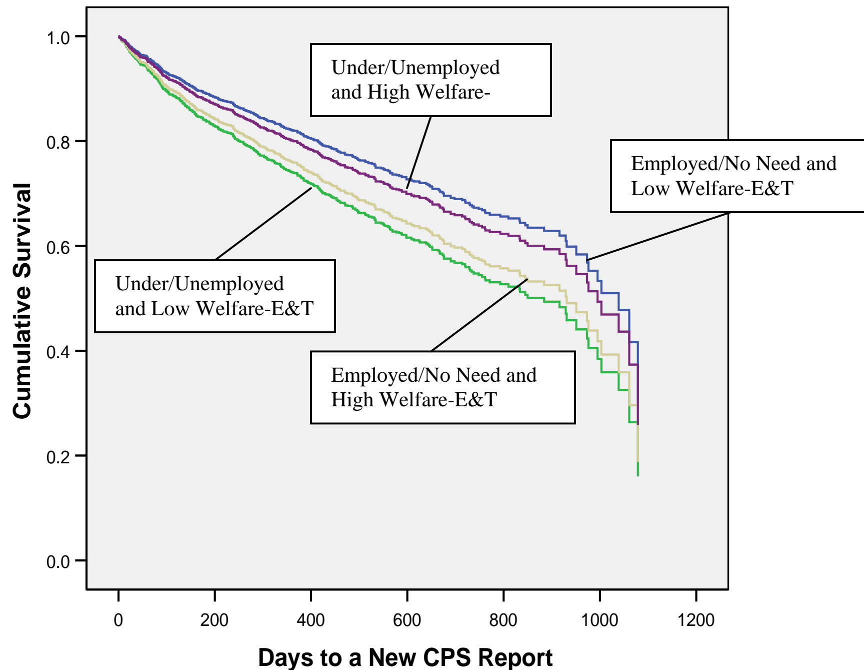


Figure 6.7 Survival Analysis (Proportional Hazards) for CA/N Reports for Employed versus Under or Unemployed PSOP Families that Received Low or High Welfare and Employment/Training Services

6.4.4 Substance Abuse and Substance Abuse Treatment Services

The analyses in this section are based on determinations of needs and services by workers for 1,791 PSOP families. Of the 1,791 families in this analysis, 333 were identified as having moderate or serious alcohol or drug problems in their families. We first present the results of statistical outcome analyses and then include case descriptions to highlight the nature of the service interventions.

Families in which the caregiver or other adult had such a problem were primarily identified when workers indicated any one of the following: alcohol abuse, methamphetamine abuse or other drug abuse. In a minority of cases families were identified in which the worker had not indicated the presence of the problem for an adult (at the moderate or severe level) but nonetheless noted that services were offered. Being offered or referred to the services was a different measure than the degree of participation or utilization of the services. We will refer to alcohol and drug use as *substance abuse* (SA) in the remainder of this section. SA can be considered to be synonymous with the term *chemical dependency* (CD), which may also be used in this section.

Substance abuse is a risk factor for child abuse and neglect. Families in which one or both caregivers is abusing substances are significantly more likely to be reported for child abuse and neglect than families where no substance abuse is occurring. This was immediately obvious from the present data in that 27.1 percent of families with no

SA had a subsequent report to CPS while 41.4 percent of SA families had such a report. This was a substantial and statistically significant difference ($p < .0001$).

Individuals in this category were sometimes provided with other services such as family counseling or support groups.[26] However, because this condition reflects a need for these specific kinds of services, we decided to limit service participation specifically to the two categories of SA treatment (alcohol or drug abuse treatment). These consisted of six-point scales (0 to 5) ranging from *no participation (0)* in such services through *participated very little (1)* to *participated very much(5).* Again, for simplicity of presentation, scores for families were summed and then coded into *no treatment, low treatment or moderate to high treatment.*

Figure 6.8 shows the differences among these three groups and the remaining families for whom no SA was reported and consequently no SA treatment was offered.

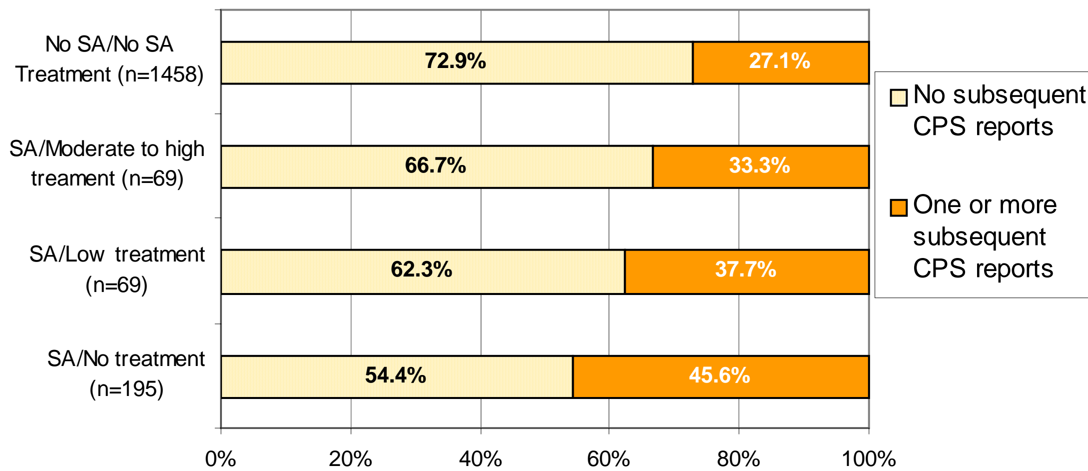


Figure 6.8 Proportions of Families with No SA and SA with Three Levels of Treatment that had a Subsequent Report of Child Maltreatment

As can be seen the majority of families in Figure 6.8 with SA did not participate in such services (195 of 333 or 58.6 percent). The remaining 138 families (41.4 percent) were evenly divided between those with low participation and moderate to high participation. The table shows substantial differences between the three SA treatment groups with growing recurrence of CPS reports of child maltreatment corresponding to lower or no treatment participation. These differences were statistically significant ($p < .001$).

Since the cross-tabulation underlying Figure 6.8 was statistically significant it was not surprising to find the same results for the more appropriate and statistically stronger survival analysis for these data. The survival analysis patterns are shown in Figure 6.9. In this case the overall difference among the groups was highly statistically significant (p

[26] See Appendix 1.

< .001). This analysis is strengthened by the order of differences between the groups. Among families with a substance abusing adult, outcomes were progressively better for families with greater participation in treatment services. Yet, each of the three SA groups did more poorly than families in which no substance abusing adult was reported.[27]

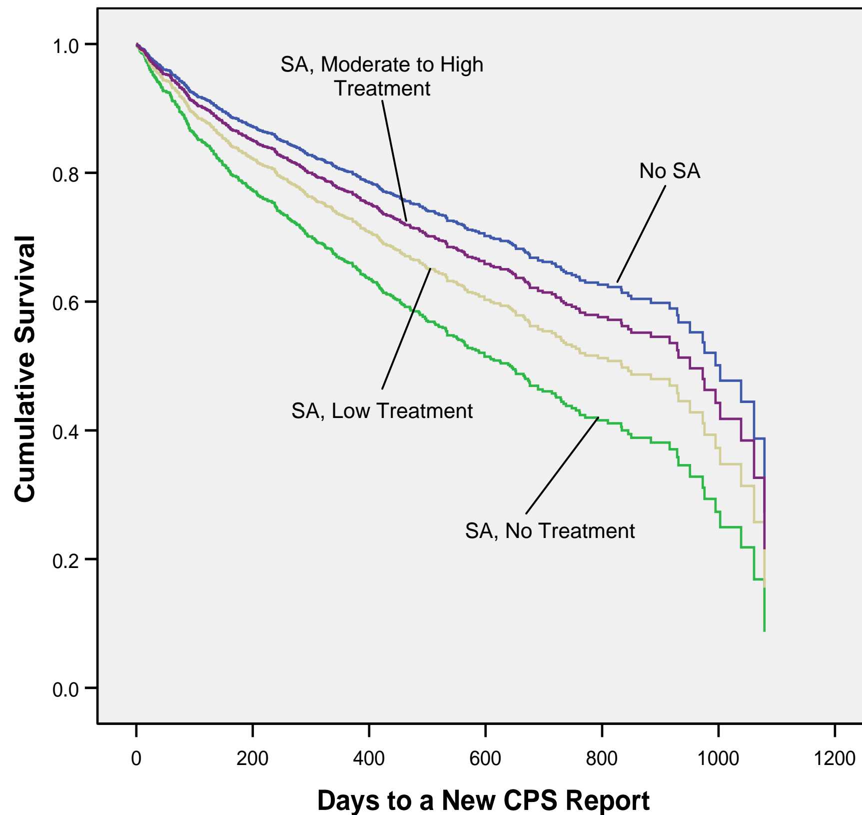


Figure 6.9 Survival Analysis (Cox Proportion Hazards) Families with No Substances Abuse (SA) versus Families with Substance Abuse at Three Treatment Levels

Example of Services for Substance Abuse Treatment for PSOP Families. Case notes were examined in cases in which workers indicated a high level of participation in drug and alcohol treatment services. Of the 69 cases of this kind, 24 had sufficient case notes for reviews. Among these, 10 cases involved a parent that was already in treatment or had recently completed treatment at the time the PSOP case was opened. In these instances, the PSOP case was opened to help support the mother or father in sustaining their sobriety and to provide assistance managing other aspects of their lives. In these cases, it appears that the worker did not address the SA issues directly, as the parent had already accepted that treatment and recovery were necessary, but instead acted to ensure that the parent did not have cause to relapse. Two cases involved clients that began outpatient or inpatient treatment during the course of the case. These types of situations may be rarer in programs outside CPS like PSOP because child

[27] See Appendix 1

maltreatment reports on heavy drug or alcohol users are more likely to be accepted and to lead to child protection cases. In the majority of the other cases reviewed, the substance abuse involved another family member who needed to seek treatment, a domestic situation that was escalated by alcohol use, or a the primary caregiver that had been in recovery but was facing significant life challenges that could trigger the urge to relapse. Finally, a handful of cases of pregnant women with current drug addictions likely to lead to the removal of their child at birth were targeted under PSOP. The following vignettes illustrate some of these themes.

In the following example a caregiver was already in SA treatment when the PSOP worker entered the case. The contribution of PSOP appeared to be support and linkage to other programs addressing basic needs like housing and financial preparation and counseling for one of the children in the family.

Case 6.4 Pregnant Mother with Chemical Dependency

A woman, (L) called CPS intake requesting help with her situation. She was currently facing criminal charges for stealing drugs at her prior workplace, she was in treatment for cocaine and alcohol addiction, was going through a divorce, had two children (ages 9 and 2), and was pregnant. As a self-referral, the report was screened out of child protection and referred to PSOP.

At the start of the case, L was working part time, was currently participating in outpatient cocaine treatment, attending NA/AA, and already seeing a therapist for depression. PSOP services focused on following through with a plan for dealing with her divorce, moving out of her house, finding stable housing for herself, and supporting her children. The worker assisted with setting up counseling for L's son and helping L prepare herself financially for being on her own. Referrals to community agencies such as the food shelf and Christmas gift programs were made. L applied for MFIP (TANF Work Program) and WIC with the help of the social worker. With the support of PSOP, L was able to stabilize her life situation and complete drug treatment. At closing, she reported that her divorce, custody, and criminal proceedings were almost resolved. Her pregnancy was healthy and she was not feeling the urge to use. She was still searching for a permanent place to live, but felt that she would be able to manage that on her own.

The next example concerns a pregnant woman with mental health issues who begins using drugs during her pregnancy. In this instance the PSOP worker was instrumental in obtaining drug treatment and possibly avoiding the birth of a drug-exposed child.

Case 6.5 Pregnant Mother with a History of Substance Abuse

A referral from a financial worker was received, regarding a young woman (C) who had two children and had been sanctioned from MFIP (TANF Work Program) nine times. C was pregnant, suffering from depression and had a past history of methamphetamine and marijuana abuse. At the time of the referral, the mother's entire TANF grant was going to her rent. C felt that there was no one who could help her. The living and financial situation for C and her children was very precarious. C was having trouble managing the requirements of her benefit programs due to her unstable mental health. The PSOP worker on this case provided guidance, support and transportation to try to bring C into compliance with her MFIP requirements and to re-start mental health treatment. Assistance with job searches, attending regular counseling and finances were the main goals. Although C had been considering an abortion, she changed her mind during the course of the case, but began using drugs again. A second report, concerning drug use, was made about the family while PSOP was open. This changed the focus of the case somewhat to address the drug use and maintain a healthy pregnancy. PSOP support allowed C to attend outpatient treatment and provided a way of monitoring C's behavior, through frequent visits and random urinalyses, to ensure the well-being of the fetus. C had serious difficulty managing her life and was frequently behind on bills and relied heavily on the help of her worker to locate financial assistance. The case remained open

until the baby was born. The baby was healthy and at the time, C was temporarily stable. She had a tubal ligation to prevent future pregnancies. Though still struggling with depression, C had begun to build a better relationship with her own mother and felt that she had adequate support with her drug treatment and counseling.

The third example involves alcohol abuse and domestic conflict in the context of financially-related needs.

Case 6.6 Domestic Conflict and Alcohol Abuse

The Sheriff's Department responded to a domestic call that occurred between a man (T) and his girlfriend (R). They were the parents of a small boy. Both had marks and scratches, but R was held for misdemeanor domestic assault charges. The report was forwarded to social services out of concern for the well-being of their son. The report was screened out for maltreatment and referred to PSOP.

Initial concerns for the family included a history of domestic arguments involving alcohol use by both individuals, the immigration status of T, lack of medical insurance for both parents, need for counseling or family therapy to improve communication, temporary unemployment of T, the current jailing of R and separation of T and R due to the latest dispute. T was concerned about losing his son, as R usually took him with her when the couple separated. T was also facing a possible foreclosure in the next few months, if he could not make payments on the couple's mortgage. The caseworker began the case by working with both parents separately, T in the home, and R in jail. Legal custody of the child would remain with the mother due to her American Indian heritage and ICWA laws. Both parents had Orders for Protection against the other. Services facilitated by the social worker through PSOP centered on helping the couple to determine how they wanted to interact and deal with the care of their son, as well as how to gain control of their alcohol use and financial issues. Initially, this support included a Rule 25 assessment (a Minnesota criminal court treatment program for substance abusers) for R to allow her to seek chemical dependency treatment without insurance, and reduce her jail sentence. T wanted to work on maintaining the relationship and agreed to seek individual counseling for his behavior and anger. R eventually also decided to allow T to continue to raise their son and the couple began to work towards reunification. R completed a short inpatient treatment program for alcohol use. During this time, the couple's house moved to foreclosure. T experienced homelessness for a time and relied on food shelves, but he continued to go to the MFIP Work Force Center and seek employment. Toward the end of the case, both the father and mother admitted that alcohol had been a major contributor to their problems, and T asked to complete outpatient chemical dependency treatment himself. The family moved into a supportive transitional apartment complex together for a period of time. However, the couple had another domestic incident that involved physical violence and separated again. The notes did not indicate the circumstances under which the case was closed.

6.4.5 Other Analyses under the Dosage Model

As noted at the beginning of this section some needs and services lend themselves to this kind of analysis and other do not. Analysis of the service measure for counseling and domestic violence services (Chapter 5, Section 5.5, Measure C) yielded non significant results for families that exhibited high domestic discord or domestic violence compared to families that had supportive relationships or only occasional problems. The numbers of families in which high domestic discord or domestic violence was noted by workers were relatively small and counseling services were delivered to a much larger group of families. When services were limited to domestic violence services only, numbers were too small for analysis. This does not mean there were no benefits to these families. It means that the research design and the size of the sample did not permit a meaningful analysis.

Similarly, respite care and childcare services were delivered very broadly to families with a variety of problems. As noted, these are the kinds of services that address a wide variety of family needs, making it impossible to isolate families whose primary need was for childcare services. Again no effects were discernable under the dosage model.

6.5 Outcome Differences by Race

The outcome analyses just described (Section 6.4) were attempted for the two largest racial/ethnic groups in the study sample: African American and American Indian. These analyses proved to be impractical. As noted at the beginning of that section, the dosage model is dependent on identifying sufficient numbers of families in a particular category of need. Equally important, those families must exhibit a range of utilization of services from low to high. On both counts these two racial groups had too small a representation in the evaluation to permit valid analyses. For example, families in these groups in the serious or chronic basis needs category, while relatively large as proportions of the sub-samples, were numerically small (less than 100). In addition, within these subsets of families, the numbers that *did not receive* needed services was vanishingly small. Put simply, families of color tended to participate in higher proportions in basic poverty-related services. The same was true of the Welfare-E&T analyses. And as should be apparent from the total number of substance abusing families in that analysis, the numbers of African American and American Indian families in that category were much too small for separate analyses. These kinds of outcome analyses by racial/ethnic groupings would require a study specifically designed for that purpose, which the current evaluation was not.

The assessment of families of color regarding the outcome of PSOP (Figure 6.10) resembled and was generally the same as the assessment of the entire sample (Figure 6.1). The apparent difference for African American families in the *somewhat worse off* category represented the responses of 20 families and was not significantly different from responses as a whole. Likewise, the apparently greater response of American Indian families in the *much better off* category was not significantly different.

The same relationship between the sense of having been helped and the appropriateness and sufficiency of services (see Section 5.1) was positive for African American and American Indian families. Families that felt better off tended to regard the services they received as the *kind they needed* and *enough to really help*. No difference was found among the responses of families from different racial/ethnic groups to outcomes resulting from PSOP.

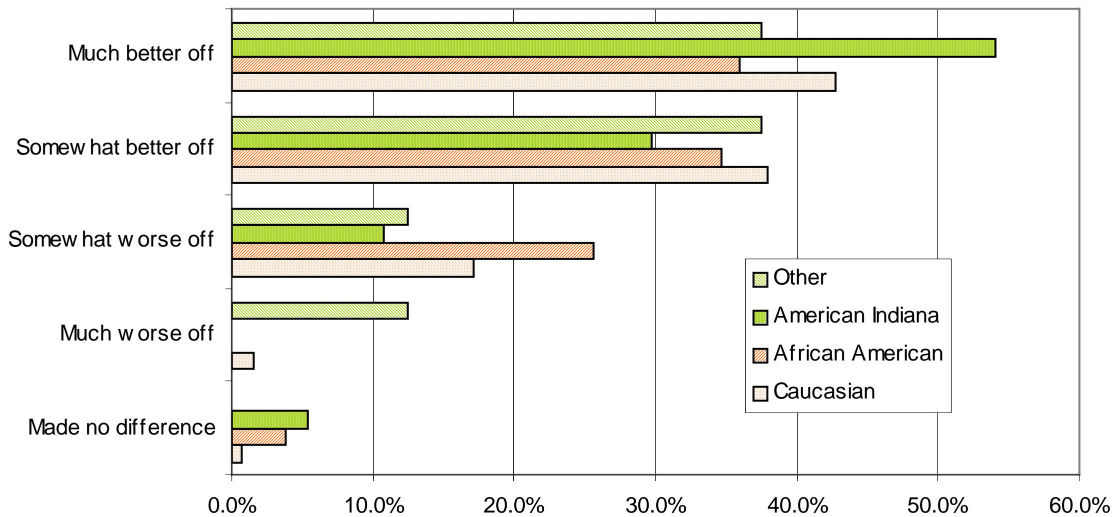


Figure 6.10 Family Responses by Race to the Question: Overall, is your family better off or worse off because of this experience?

6.6 Impact of PSOP on the Flow of Accepted CA/N Reports

Finally, we asked whether any impact of PSOP could be detected on the total number of accepted reports of child abuse and neglect during the years of the project. If the effects discussed in the preceding pages of service participation on subsequent reports to CPS are valid it is reasonable to expect that the number of reports coming into local agencies might impacted. Services to families at risk of CA/N, however, is only one among many ecological factors that lead to changes in the rate of reports of child abuse and neglect. If an impact—presumably a reduction in the rate of accepted reports—did occur, therefore, the problem was detecting it.

The years of the project from 2005 through 2008 saw slight decline in CA/N reports accepted for further action by CPS in Minnesota. Statewide counts based on official state data were: 18,673 (2005), 18,818 (2006), 18,348 (2007) and 17,001 (2008).[28] The decline varied across the 87 counties in the state with some positive and others, particularly smaller counties showing proportionate increases in some years.

The Potential Impact of PSOP. Each of the 87 Minnesota counties can be viewed as a separate laboratory in which something new, the outreach program, was attempted with varying degrees of success or was not tried at all. Individual county comparisons were possible, but a better approach was to group counties in terms of the potential of PSOP to have an impact on new reports. Since PSOP was implemented in only a minority of counties, the potential impact for most local offices was zero.

[28] 2008 data were provisional and may change slightly before official publication by the state.

Several different methods might have been selected for measuring the possible impact of PSOP on families and on subsequent CA/N reports, including the organization of the program (see the description of models in Chapter 2), the success of counties in attracting families into the program, or the level of services delivered to families. The most logical measure, however, and one that could be consistently determined, was the number of families accepted into the program relative to the number of accepted CPS reports in the county. For example, consider a county that averaged 500 new reports annually while accepting 25 families each year into PSOP—a ratio of 25/500 = .05 or 5 percent. If all 25 of those families were assisted in a way that averted later reports to CPS during the following year we might expect 475 new reports (95 percent of 500), all other things being equal. The maximum impact under these assumptions would be a 5 percent reduction but would likely be less. On the other hand, if in the same county 300 families were accepted into the program, a larger impact might be expected.

Potential impact was calculated in the following manner. The average of the yearly ratios of PSOP accepters to total hotline reports was calculated for each county in the state. Here is an example from one county (the best in the state):

Year:	2005	2006	2007	2008
Accepted CA/N reports (R):	132	138	118	121
PSOP Accepters Served (P):	20	125	189	162
Yearly Ratio (P/R):	0.152	0.906	1.602	1.34
Average Yearly Ratio ([Sum of P/R]/4):	.999			

The measure is a kind of index of potential impact that enabled a ranking of PSOP counties. For example, a county with an average ratio of .3 would indicate that over the four year period for every 10 reports accepted by CPS, 3 families were served outside of CPS through PSOP. Non-PSOP counties had ratios of zero (0), indicating no potential impact. The county data shown in the table with an average ratio of .999 served one PSOP client outside CPS for every report accepted and acted on by CPS.

Impact measures for PSOP counties ranged from .02 to 1.07. As noted, the best approach was to combine counties rather than analyzing each separately. In this way peculiarities found in individual counties, particular smaller rural offices, were averaged out. Using the impact index as a rank, counties were divided into four categories:

	Potential Impact of PSOP	Number of Counties	Number of Accepted Reports in 2005
High	.35 to 1.07	13	2,287
Moderate	.20 to .34	17	3,811
Low	.02 to .10	8	6,815
None	0	49	5,633

The low potential impact group included Hennepin County (Minneapolis) where, as described earlier, the program remained relatively small in relation to the size of the county, along with small rural counties that participated in PSOP marginally. The cut between the high and moderate categories was relatively arbitrary and could have been made at several points above or below.34/.35, without seriously changing the following analysis.

Changes in Reports Accepted by CPS. Measures of changes in reporting were limited to a three year period from 2006 to 2008. It did not seem reasonable to expect PSOP to affect the change in levels of reports between 2005 and 2006. (Recall that the program only fully began during the final quarter of 2005.) The percent changes in reports from 2006 to 2007 and 2007 to 2008 were calculated and averaged for each of the four groups. For example, the county in the potential impact calculation above experienced a decline of (14.5) percent between 2006 and 2007 but an increase of 2.6 percent between 2007 and 2008 for an average decline of (6.0) percent. This calculation was made for combined counts of reports for each of the four groups (None through High) described above.

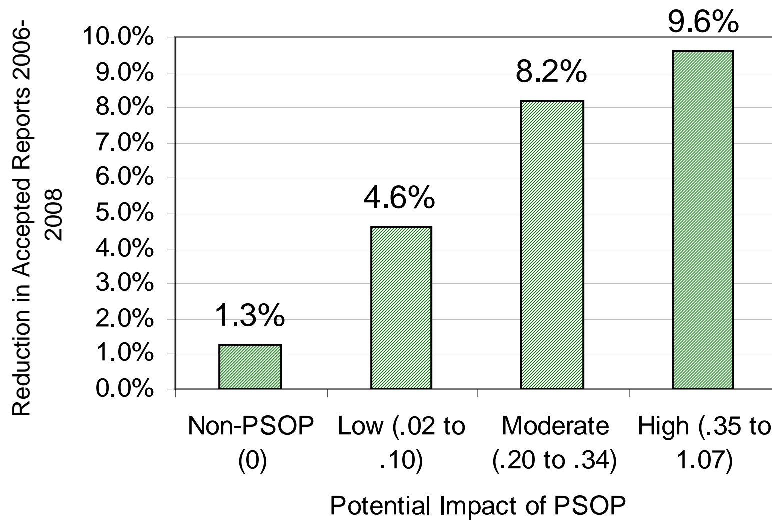


Figure 6.11 Average Reduction in Accepted Child Abuse and Neglect Reports by Counties Ranked for Potential Impact of PSOP

The results are charted in Figure 6.11. Reductions are shown as positive numbers in the chart. As noted above, the cut between the moderate and high groups was arbitrary and could have been made at other positions or the two categories could well have been combined into counties with a potential impact of 20 percent or higher. The distinction into two groups illustrates that there was some variation in the expected direction *among* PSOP counties that served large number of families. Statistical tests indicated that the differences illustrated in Figure 6.11 were statistically significant ($p < .001$).[29]

[29] The analysis was an ANOVA ($F = 191$) of the four categories in Figure 6.11 with counties weighted by their 2005 CPS intake counts. A separate similarly weighted correlation of the average change in reporting (2006 to 2008) with the average ratio of PSOP to CPS (2005 to 2008) yielded an $r = -.134$, $p < .001$. The negative value shows that increased relative utilization of PSOP was correlated with greater declines in CPS reports.

Discussion. The consistent pattern evident in the chart shows that a greater reduction of child maltreatment reports (and by implication, child maltreatment itself) occurred in counties that participated in PSOP at moderate to high levels. Were PSOP activities responsible for the difference observed in the chart? An alternate explanation is that the kinds of counties that participated fully in PSOP also had in place other programs or experienced other events that assisted families at risk of CA/N. Under this interpretation, higher relative participation in PSOP and greater reductions in new reports would both have resulted from other characteristics of counties. It is also possible, and most likely in our opinion, that PSOP produced impacts alongside the impacts of other programs and events in these counties. In the light of earlier analyses in this chapter, it is reasonable to assume that some part of the observed reductions in CA/N reports can be attributed to Parent Support Outreach activities.

6.7 Conclusions

The large majority of families felt they had been helped by PSOP. Workers indicated that there were discernable improvements in the majority (at least six in ten) of families they worked with in at least one of the family functioning areas studied. A great deal of evidence was proffered of positive immediate and instrumental outcomes of PSOP. There was also evidence based on the proportion of reduced subsequent accepted (screened-in) reports to CPS (utilizing the *dosage model*) showing that at least some of the treatment approaches produced a difference when utilized by families that needed the services. In addition, analyses indicated that it is reasonable to conclude that the PSOP, when utilized heavily, had a general impact on the flow of reports into CPS.

Thus, within the limitations of the outcome design for the evaluation, we conclude that PSOP was a success for most participating families and, to the extent that rates of return to CPS were reduced, PSOP was a success for Child Protection Services and the public as a whole. The potential impact of PSOP on the flow of new reports is of importance and illustrates the value of preventive services in child welfare.

What made the difference? As was the case with the evaluation of differential response in Minnesota, it was apparent to us that successes resulted from a combination of causes. First, various services, especially basic poverty-related and employment-related services, were delivered to families under the program. As we have indicated, it is hard to find evidence that these would have come to families had they not been approached and assisted under PSOP. Second, as the case examples were intended to illustrate, the services were often delivered in the context of supportive relationships between workers and families. In some instances, workers provided services directly. In others, they helped families utilize services, some of which were already in place (such as substance abuse treatment). Together these combined to produce benefits for families.

Appendix 1
Technical Notes

Identifying Families Screened Out of CPS or Referred from other Sources

As noted in Section 1.2, data on the reporter of CA/N reports was received but no categorical source of information was available to the evaluators of referral sources for families referred in other ways. Intake narratives were available for 84.5 percent of families that accepted PSOP services and on whom other extended need data were available. A content analysis of these narratives after March 2006 was conducted. Inspection of narratives, showed that the term "screened out" was used as a general identifier by intake workers. Screened out families were coded based on the presence of the following in narratives: screened out, screened-out, child maltreatment, sexual abuse. Of the 2,208 narratives, 54.6 % had at least one of these terms. The accuracy of this coding was confirmed through visual inspection of a sample of cases. The method was conservative and may have yielded an undercount of screened out reports.

The Family Sample

Families were contacted via a letter as soon as the PSOP case was closed in SSIS extracts. Because of the lag between closing, data entry, data extraction and transfer from Minnesota to IAR, preparation of mailings and reception of the letter, some families had moved with no forwarding address by the time the letter reached their home. Families that responded were paid $20 for the initial family survey. Responses were received from 608 families. The family sample was compared to the entire population on a variety of variables to determine whether any biases or imbalances occurred due to non-responses. For variables associated with family strengths and needs, no statistically significant differences ($p < .05$) for the following variables: emotional/mental health, parenting skills, substance use, family relationships, child characteristics (severe/chronic problems), caregiver abuse/neglect history, communication/interpersonal skills, physical health, employment/income management and community resource utilization. Statistically significant differences were found in three areas: 41.1% of the sample vs. 34.7% of the population were considered to have adequate basic needs; 14.6% of the sample vs. 10.7% of the population were considered to have a strong social support network; and, 19.9% of the sample vs. 15.2% of the population were considered to have good life skills. These difference indicate a slight bias toward families that were slightly better off in terms of basic needs and social support. No statistically significant differences ($p < .05$) were found in the services offered directly (see Figure 4.3) except transportation which was offered more often to sample families (23.4% to the sample vs. 18.8% to the population, $p = .007$). No statistically significant differences ($p < .05$) were found between the family sample and the population in 19 of the 20 community referral categories (See Figure 4.2), the exception being emergency food, where 75.2% of sample were referred vs. 71.1 percent of population ($p = .025$). Differences in these service and referral categories at these levels would be expected by chance alone when comparing this number of variables. These indicate relatively small difference in the response of workers to sample families as compared to the entire PSOP population of families served. On this basis, the decision was made to avoid weighting the sample in analyses.

Service Constellations

Service constellations are discussed in Section 5.5. These resulted from a factor analysis of service participation/utilization scores. Scores of 0 indicated that the service was not offered or referred to during PSOP participation and was not in place at the start of PSOP participation. When services were present the level of participation was rated from 1 (low) to 5 (high). Scores were present for 24 service

categories for 2,614 families. A principal components analysis was conducted with Varimax rotation and Kaiser normalization. After inspection, the analysis was limited to five factors. Results are shown in Table A.1, where factor loadings greater .3 are in bold.

Table A.1 Five Service Constellations based on Factor Loadings for Service Participation

	Poverty-Related Services	Welfare, Medical Services, Training and Employment	Counseling, Domestic Violence and Support Groups	Substance Abuse Treatment	Childcare and Respite Care
Childcare/Daycare	0.14	0.18	-0.04	-0.01	**0.72**
Respite care/crisis Nursery	0.03	-0.11	-0.01	0.02	**0.80**
Medical or dental	0.21	**0.61**	0.01	-0.02	0.04
Marital/family/group counseling	-0.02	0.15	**0.54**	0.25	-0.05
MH/Psych services	-0.07	**0.34**	**0.39**	0.17	0.07
Drug Abuse treatment	0.09	0.06	0.10	**0.79**	0.06
Alcohol abuse treatment	0.06	0.07	0.08	**0.80**	0.01
Domestic violence services	0.29	-0.11	**0.66**	-0.06	0.02
Emergency shelter	**0.43**	-0.08	**0.36**	-0.08	-0.02
Rent/house payments	**0.66**	0.11	0.05	0.04	0.03
Housing	**0.60**	0.04	0.15	0.07	0.01
Basic household needs	**0.59**	0.11	0.05	-0.04	0.14
Emergency food	**0.63**	0.13	0.09	0.13	0.03
TANF/SSI/FS	0.30	**0.58**	0.02	0.01	0.02
Transportation	**0.44**	**0.38**	-0.06	0.00	0.07
Employment	**0.41**	**0.39**	-0.11	0.13	0.00
Voc/skill training	0.13	**0.41**	0.03	0.12	0.01
Educational services	-0.04	**0.58**	0.13	-0.03	0.03
Legal services	0.20	0.13	**0.51**	-0.14	-0.12
Parenting classes	-0.02	**0.34**	0.23	0.08	**0.36**
Homemaker/home management	0.17	0.10	0.26	0.16	**0.24**
Support groups	0.02	0.08	**0.58**	0.21	0.15
Disability services	-0.07	**0.38**	**0.33**	-0.07	0.02
Recreational services	0.05	**0.40**	0.08	0.07	0.04

The names of the service dimensions were assigned based on the set of services categories with the highest loadings highlighted in the table. For example, the highest loadings for the first factor, poverty-related services, were: emergency shelter, rent/house payments, housing, basic household needs, emergency food, TANF/SSI/food stamps, transportation and employment. Based on the loadings, service participation scores of each participant for each service were created. In this way a score was generated for each family on each of the five dimensions. While the method used led to largely distinct service dimensions with very low intercorrelations, some overlap can be seen in the highest factor loadings.

Social Isolation

Items for the social isolation scale are listed in Figure 3.7. Each was scored from 1 (low isolation) to 4 (high isolation). Frequencies of summated scores are shown in Table A.2. Chronbach's Alpha = .87.

Table A.2 Social Isolation Scores

Score	Freq.	Cum %	Score	Freq.	Cum %
7.00	27	4.6	18.00	32	75.2
8.00	33	10.2	19.00	26	79.6
9.00	36	16.3	20.00	29	84.6
10.00	38	22.8	21.00	20	87.9
11.00	44	30.2	22.00	20	91.3
12.00	46	38.0	23.00	10	93.0
13.00	42	45.2	24.00	15	95.6
14.00	34	50.9	25.00	10	97.3
15.00	43	58.2	26.00	7	98.5
16.00	42	65.4	27.00	2	98.8
17.00	26	69.8	28.00	7	100.0

Quality of Neighborhoods

The 8 items utilized for quality of neighborhoods of PSOP families are listed in Table 3.4. Frequencies of summated scores are shown in Table A.3. Chronbach's Alpha = .84.

Table A.3 Neighborhood Quality Scores

Score	Freq.	Cum %	Score	Freq.	Cum %
8.00	3	.5	19.00	52	66.5
9.00	3	1.1	20.00	38	73.2
10.00	1	1.2	21.00	40	80.3
11.00	7	2.5	22.00	36	86.7
12.00	13	4.8	23.00	29	91.8
13.00	16	7.6	24.00	18	95.0
14.00	52	16.8	25.00	18	98.2
15.00	47	25.2	26.00	5	99.1
16.00	61	36.0	27.00	2	99.5
17.00	63	47.2	28.00	1	99.6
18.00	57	57.3	32.00	2	100.0

Caregiver Stress

Items utilized in the stress measure can be seen in Table 3.5. The frequencies of summated scores are shown in Table A.4 below. Scores ranged from 4 (a lot) to 1 (no stress). Chronbach's Alpha for the scale = .852.

Table A.4 Caregiver Stress

Score	Freq.	Cum %	Score	Freq.	Cum %
1.00	8	1.4	14.00	23	66.2
2.00	22	5.2	15.00	30	71.4
3.00	14	7.6	16.00	33	77.1
4.00	12	9.7	17.00	29	82.1
5.00	19	13.0	18.00	22	86.0
6.00	20	16.5	19.00	24	90.1
7.00	8	21.8	20.00	24	94.3
8.00	34	27.7	21.00	10	96.0
9.00	33	33.4	22.00	9	97.6
10.00	41	40.6	23.00	6	98.6
11.00	36	46.8	24.00	2	99.0
12.00	47	54.9	25.00	6	66.2
13.00	42	62.2			

Mean stress scores for income categories are shown in Table A.5. Statistical tests indicated no relationship (p = .77).

Table A.5 Mean Caregiver Stress by Income

Household income during previous 12 months	Mean
Less than $4,999	11.8396
$5,000 to $9,999	12.6161
$10,000 to $14,999	12.2255
$15,000 to $19,999	11.5574
$20,000 to $29,999	11.5342
$30,000 to $39,999	12.2927
$40,000 to $49,999	13.1667
Greater then $50,000	10.8571
Total	12.0588

Survival Analysis: Poverty-Related Services

The final variables of the regression equation for the survival analysis described in Section 6.4.1 were:

	B	SE	Wald	df	Sig.	Exp(B)
Need and Services			5.827	3	.120	
Adequate to Some Needs/ Services Low to None	.121	.164	.543	1	.461	1.128
Adequate to Some Needs/ Services Moderate to High	.255	.160	2.539	1	.111	1.290
Serious to Chronic Needs/ Services Low to None	.481	.249	3.748	1	.053	1.618

Analysis in Section 6.4.1.1:

	B	SE	Wald	df	Sig.	Exp(B)
Social Isolation	.003	.019	.034	1	.855	1.003
Neighborhood Quality	.038	.026	2.191	1	.139	1.038
Satisfaction with Worker	.217	.124	3.076	1	.079	1.242
Income and Services			8.131	3	.043	
Income < $10,000 / Services Low to None	.344	.248	1.922	1	.166	1.410
Income < $10,000 / Services Moderate to High	-.004	.247	.000	1	.989	.996
Income < $10,000 / Services Low to None	-.422	.260	2.643	1	.104	.656

Analysis in Section 6.4.3:

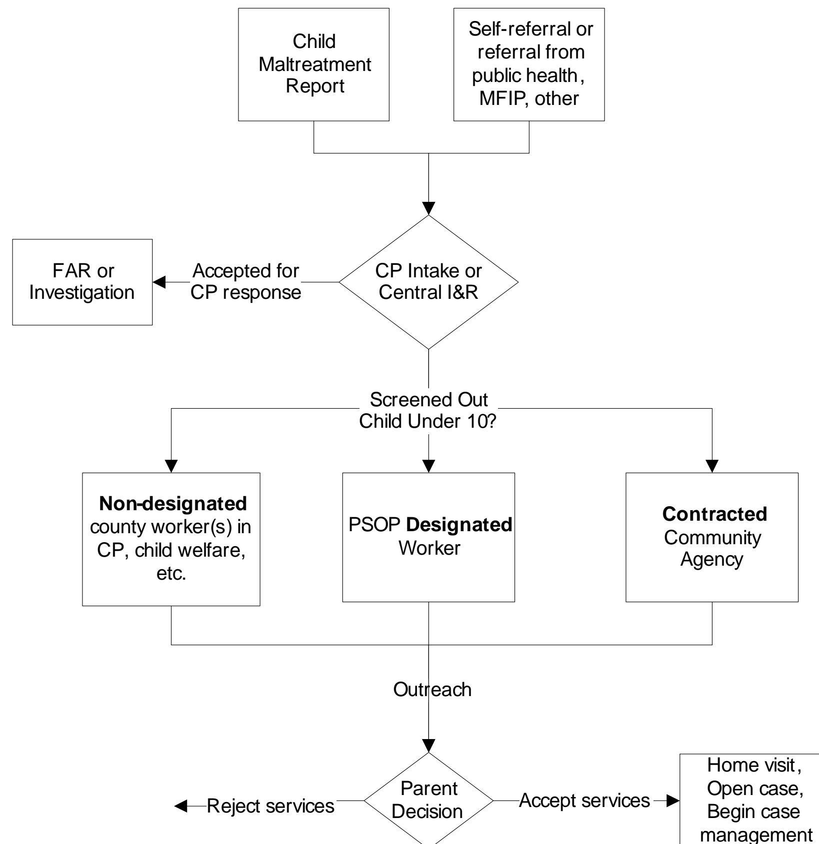
	B	SE	Wald	df	Sig.	Exp(B)
Employment / Welfare-E&T			13.348	3	.004	
Employed-No Need / Low Welfare-E&T	-.116	.126	.851	1	.356	.890
Underemployed-Unemployed / Low Welfare-E&T	.304	.122	6.159	1	.013	1.355
Employed-No Need / High Welfare-E&T	.212	.114	3.431	1	.064	1.236

Analysis in Section 6.4.4:

	B	SE	Wald	df	Sig.	Exp(B)
Substance Abuse / Substance abuse treatment			30.125	3	.000	
No SA / No SA treatment	-.165	.215	.593	1	.441	.848
SA / Low SA treatment	.464	.234	3.927	1	.048	1.590
SA / Moderate SA treatment	.192	.287	.448	1	.503	1.211

Appendix 2
The Organization of PSOP

The following flow chart is a representation of the general case-flow for PSOP referrals. Reports and referrals nearly always came through the Central Intake Unit. Any referrals that were screened out of CPS were reviewed further for possible referral to PSOP.



When families met the general criteria—a child under 10 was present and at risk—the case was forwarded to the appropriate PSOP worker. These varied according the program model (see Chapter 2) being utilized: 1) a child protection or child welfare worker responsible for PSOP cases in addition to their regular caseload, 2) a designated county worker that handled only PSOP cases, or 3) a contracted community agency worker. After the receiving the case, the worker attempted to secure the family's participation.

Some counties had slightly modified processes for involving families. For example, in Anoka County, which used three different contracted agencies for case-

management, there were two minor deviations (see the following flow chart). When community referrals to PSOP were received, they were often sent directly to the PSOP coordinator for review bypassing the intake unit. In addition, the county PSOP Coordinator conducted outreach with all families screened out of CPS and enrolled them in the program before sending the referral on to the contracted agency.