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# In Whose Best Interest? Using an Experimental Vignette to Assess Factors Influencing Placement Decisions in Child Welfare

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LOYOLA UNIVERSITY CHICAGO

IN WHOSE BEST INTEREST?

USING AN EXPERIMENTAL VIGNETTE TO ASSESS FACTORS INFLUENCING  
PLACEMENT DECISIONS IN CHILD WELFARE

A DISSERTATION SUBMITTED TO  
THE FACULTY OF THE GRADUATE SCHOOL  
IN CANDIDACY FOR THE DEGREE OF  
DOCTOR OF PHILOSOPHY

PROGRAM IN CLINICAL PSYCHOLOGY

BY

JEFFREY HARRISON SIERACKI

CHICAGO, IL

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"Perhaps no decisions in social casework practice post more awesome responsibilities for the caseworker and are more far-reaching in their potential consequences for the client than those involved in the placement of children in foster care"

- Briar, S. (1963). Clinical judgment in foster care placement.

*Child Welfare, 42, 161-169.*

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## CHAPTER 1

### INTRODUCTION

In the United States it is estimated that approximately 800,000 children are currently served by the child welfare system, with at least 500,000 of these children placed into foster or another form of out of home care (Glisson & Green, 2006; Molin & Palmer, 2005; Rosenfeld et al., 1997; U.S. Children's Bureau, 2007). Due to abuse, neglect, socioeconomic status, and a multitude of other potential factors, children and adolescents in child welfare display an increased rate of emotional and behavioral disturbances, and frequently need psychological or behavioral services. Previous estimates have indicated that between 40% to 85% of this group suffer from an emotional disorder and/or substance use problem and would benefit from mental health services (Armsden, Pecora, Payne, & Szakiewicz, 2000; Burns et al., 2004; Garland et al., 2001; Glisson & Green, 2006; Molin & Palmer, 2005; The American Academy of Child and Adolescent Psychiatry (AACAP) and the Child Welfare League of America (CWLA), 2002). Further, children who are removed from their homes and placed in foster care are even more likely to need mental health services than those who become involved in the

child welfare system but remain in the homes of their biological parents (Armsden et al., 2000; Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998; Halfon, Mendonca, & Berkowitz, 1995; Knitzer & Yelton, 1990; Landsverk & Garland, 1999; Rutter, 2000; Thompson & Fuhr, 1992). As a result, the child welfare system has been called a “de facto behavioral health care system” (Lyons & Rogers, 2004), requiring child welfare agencies to develop policies and a service infrastructure that matches youth with the most effective treatments given their symptoms and strengths.

Once a child is temporarily placed in protective custody of the state, a placement decision is made based on the best interest of the child and with placement permanency as an ultimate goal. Statistically, children who enter into child welfare are most likely to remain with their biological parents (Downs, McFadden, & Costin, 2000). However, if return to biological parents is not deemed to be in the best interest of the child, then he or she will receive a placement within the child welfare system. Placement decisions within the system can range in restrictiveness from traditional foster care to residential care to psychiatric hospitalization, depending on the therapeutic needs of the child. Arguably the most important placement criterion in the current policy environment is known as the Least Restrictive Environment (LRE) criterion, which states that youth should receive services in the least restrictive setting that nonetheless meets their treatment needs.

Placements decisions are made by child welfare professionals such as social workers, juvenile court judges, and mental health workers. They make these decisions based on their knowledge of the system and the evidence that they have at their disposal,

such as documents and testimony from police, crisis workers, the parents, and the children themselves (Britner & Mossler, 2002). Although the child's best interest and clinical variables, such as dangerousness and suicidality, should be the primary factors associated with placement and treatment decisions, evidence also suggests that non-clinical variables sometimes influence decision-making. These variables include demographic factors, such as age and race of the child (Barth, 1997; Beeman, Kim, & Bullerdick, 2000; Iglehart, 1994; Lindsey, 1991). In addition, factors related to both present and previous placements, such as stability of foster care family, have also been linked to placement decisions (Snowden, Leon, Bryant, & Lyons, 2007). Demographic factors related to the professional making the decision (type of position, length of time at job, etc.) also influence decisions (Benbenishty, Osmo, & Gold, 2003; Britner & Mossler, 2002; Gold, Benbenishty, & Osmo, 2001).

Despite the importance of placement decisions within the child welfare sphere, there is a paucity of research on this topic (Courtney, 1998). The studies that have been conducted in this area have examined the role of demographic and clinical factors using retrospective record reviews (Beeman et al., 2000; Iglehart, 1994; Lindsey, 1991; Snowden et al., 2007; Snowden, Leon, & Sieracki, 2008), and experimental research (Britner & Mossler, 2002; Gold et al., 2001). However, the vast majority of research within this area has primarily focused on decision making regarding family reunification versus remaining in state custody (Britner & Mossler, 2002; Drury-Hudson, 1999; Lindsey, 1991; Lindsey, 1992; Pellegrin & Wagner, 1990; Zuravin & DePanfilis, 1997)

or adoption placement versus remaining in state custody (Brooks, James, & Barth, 2002; Earth, 1997; Snowden et al., 2008); far less research has focused on understanding the variables that predict level of care (community versus residential) among youth already in the child welfare system. Therefore, the present study assesses decision making regarding different levels of care in the child welfare system, specifically deciding between community-based placements and residential placements for children who remain in the custody of the state, but borrows from the state custody decision literature to help frame the current study and its hypotheses. Because of current policy mandates (e.g., LRE) and the tremendous societal and economic cost associated with placing children who are in state custody in highly restrictive levels of care, information about how professionals make decisions regarding placement is of direct applied value to both policy makers and clinicians.

Building on prior research that utilizes clinical vignettes to analyze child welfare placement decisions (Briar, 1963; Britner & Mossler, 2002; Donnelly, 1980; Drury-Hudson, 1999; Gold, et al., 2001; Taylor, 2006), the present study employs an experimental format to assess the relative importance that social workers place on variables related to placement decisions, and to study any differences regarding decision making that may emerge among the child welfare professionals themselves. The study consists of a single hypothetical vignette that was sent to social workers in the state of Illinois. Prior to administration of the questionnaire, multiple experts in the field of child welfare were consulted in order to ensure that the vignette was a realistic depiction of a

placement scenario. The study was sent via postal mail to social workers who are both experts and novices within the field of child welfare. The respondents indicated if their preferred placement option would be community-based or residential and completed a portion of a standardized assessment tool based on their impressions of the child in the vignette. The respondents also answered basic demographic questions about themselves, such as the type of clients that they typically work with and the number of years they have been at their job. Finally, the respondents answered questions pertaining to specific experience in decision making in the child welfare domain. The entire study was designed to be completed by the respondents in about five to seven minutes.

Three variables were experimentally manipulated in a vignette about a hypothetical male for whom a placement decision must be made. Building from previous research and based on current issues in the child welfare sphere that will be reviewed in forthcoming sections, the three variables that were manipulated are: race of the child, current foster care environment, and exposure to community-based treatment. Specific hypotheses based on previous research regarding the effect of these independent variables will be proposed in the following pages. The aim of the study is to increase knowledge about the placement decision-making process in a child welfare setting among social work professionals. As stated previously, because of the high rate of behavioral and emotional disturbances in children and adolescents within the foster care system, the centrality of the LRE principle in placement decision-making, and the high costs

associated with treating these children, research in this area is essential to ensuring an organized and rational service system.



## CHAPTER 2

### REVIEW OF RELATED LITERATURE

The following literature review will first examine the history of child welfare in the United States and explore the current structure of the system. Recognizing that states vary slightly with regard to the structure of their systems, the current structure of the Illinois child welfare system will be utilized as an example of a statewide child welfare agency. Next, different forms of placement within the child welfare system (ranging in restrictiveness from standard foster care to inpatient hospitalization and incarceration), and the services that the various placements offer for children and adolescents with emotional and behavioral difficulties will be discussed. The variables that will be manipulated in the study and an overview of decision making research within child welfare will be presented. Finally, building on the previous literature, hypotheses for the current study will be proposed.

#### *History of Child Welfare in the United States*

##### *The Early Years*

The role of the state in raising children and adolescents whose parents cannot care for them has a history that predates the establishment of the United States. The legal

principle of *parens patriae*, "father of the people", was first utilized in England in 1692. This principle placed orphaned children, infants, "idiots", and "lunatics" in the care of the royal crown (Pecora, Whittaker, & Maluccio, 1992). Government intervention in child welfare cases in colonies and later the United States largely stemmed from this principle. Stretching back to the time before independence and continuing to present day, communities within what is now the U.S. placed the responsibility of caring for orphaned, abused, and neglected children on their local or state government (Pecora et al., 1992). Although the United States federal government has enacted legislation pertaining to the ways in which the states must operate their child protection services in order to obtain federal funding, it remains the responsibility of the state to handle these services. Therefore, each of the fifty states has created their own child welfare laws and enforcement agencies and vary slightly regarding specific child welfare policies and practices. In this review, in addition to national laws and acts, the state of Illinois and the Illinois Department of Children and Family Services (DCFS) will be discussed in order to provide an example of a state child protection organization.

Prior to the turn of the twentieth century, living in an orphanage was the most likely placement for children whose parents were deceased or children whose parents could not care for them (Rosenfeld et al., 1997). By the mid-1800s orphanages on the east coast of the country had become overpopulated, and it is estimated that in the years from 1850-1930 approximately 150,000 east coast orphaned children were sent on "orphan trains" to families in the rural Midwest (Cook, 1995). Once these children

arrived at their destination they were adopted by willing families in the more expansive and less overcrowded Midwest. One of the theories behind the orphan train was the recognition that living with a family better prepared children for life in a community compared to being raised in an orphanage. Present day community-based mental health approaches to treating at risk foster care adolescents grew out of the “orphan train” movement and other early services for homeless and immigrant children that were first in place at the turn of the twentieth century (Terpstra & McFadden, 1993). In addition, the field of social work developed during this time and became the primary profession to deliver child welfare services and make placement decisions regarding children in the child welfare system. Policy also changed to reflect the belief that poverty alone, in the absence of parental death, or incapacity to take care of the child, was not sufficient to warrant out-of-home placement (Rosenfeld et al., 1997). However, as will be discussed in subsequent sections, research from the current foster care era suggests that poverty, and other demographic placement variables beyond abuse and neglect, may indirectly continue to play a roll in placement decisions (Lindsey, 1991).

#### *Present Day: Laws and Acts*

In 1962, *The Battered Child Syndrome* was published and received widespread attention in the mainstream media (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962). The book documented the effects of physical abuse on young children. After the publication of the book, individual states began to shift the focus of their child service division away from finding placements for orphans to reporting physical abuse. For

example, largely due to the influence of the book, *The Child Abuse Reporting Act* of 1965, which required physicians to report physical abuse, became law in the state of Illinois. By the end of the 1960s, every state had a law on the books regarding reporting child abuse (Pecora et al., 1992). States also added provisions for reporting parental neglect, typically defined as situations in which a child's legal guardian fails to provide for the child's physical and/or emotional needs. In the state of Illinois, the *Child Abuse Reporting Act* became the *Abused and Neglected Child Reporting Act* in 1975, which required physicians practicing within the state to report not only suspected physical abuse, but also suspected neglect (Gittens, 1994).

Before the 1970s the federal government did not play a direct role in the child protection realm, leaving this important domain to the states. However, recognizing the extreme importance in protecting maltreated children and the potential problems with inconsistent laws within the states regarding child abuse reporting, the federal government passed the *Child Abuse Prevention and Treatment Act* at the national level in 1974 (Public Law 93-247). This act required each state to adopt specific procedures to prevent, identify, and treat victims of child maltreatment and provided federal funding for a range of child services and research provided that the states met the requirements of the Act (Alvarez, Donohue, Kenny, Cavanagh, & Romero, 2005).

Prior to the early 1980s, it was the norm for children to remain in the child welfare system for long periods of time. Many children would remain in the system their entire childhood until they would "age" out at 18 years of age. Because of an increased

focus on identifying abused and neglected children, coupled with the tendency to remain in the system for long periods, the number of children in the child welfare system increased substantially. As Terpstra & McFadden note (pp. 118), "The professionals focused almost entirely on children, excluding their families. It became easier to take children into the system than to get them out and the ranks of children in out-of-home care continued to rise. In 1977, more than 520,000 children were in care". The pendulum was starting to swing toward recognizing the importance of ultimately remaining with the child's birth family. Therefore, the Adoption Assistance and Child Welfare Act (AACWA) of 1980 (Public Law 96-272) was created in order to emphasize family reunification as a permanency goal, as opposed to multiple foster care placements (Downs et al., 2000; Gittens, 1994; Pardeck, 2002). This federal act allowed the state child protection services to focus more on permanency planning by providing subsidies for hard to place children. In addition, AACWA required an investigation of all reports of child maltreatment within 24 hours, and focused on placing children in the least restrictive and most family-like environment, including delivering home-based services to prevent state custody.

Despite AACWA's focus on family reunification, under the Act many children in the state of Illinois and other states spent their entire childhood in foster care waiting to be reunited with their family, and thus did not achieve a permanent placement (Gittens, 1994). As a result, in 1997, the federal government passed the Adoption and Safe Family Act (ASFA) (Public Law 105-89; Hannett, 2007). ASFA focused less on family

reunification and more on finding a permanent home for children regardless of whether that home was a return to the biological parents or adoption. Due to the focus on permanency and stricter time limits on reunification efforts, the adoption of ASFA led to the reduction of children in the child welfare system. Despite the decrease in number of children in the child welfare system, in 2002, 532,000 children were in the foster care system nationally (Children's Defense Fund, 2005).

### *Structure of Current Child Welfare System*

#### *Investigating a Report and Service Delivery*

As a result of the above mentioned laws, DCFS and similar agencies throughout the United States investigate initial reports of child abuse and/or neglect. Although there are a variety of reasons for child welfare involvement, children are most often placed in out of home care as a result of abuse or neglect by biological parents or caretakers. After investigating, a report is determined to be substantiated (i.e., there is evidence of abuse and/or neglect) or unsubstantiated (i.e., there is no evidence of abuse and/or neglect). While more than 65% of children who are investigated nationally remain in their homes (Downs et al., 2000), if the findings of the investigation indicate that the child is at risk for immediate harm, the state may decide to take temporary protective custody of the child. In Illinois, in order to ensure that an individual has a right to due process, within two days of removing a child from their parent's home, a temporary custody hearing takes place to determine if it is in the best interests of the child to remain in DCFS custody.

During the course of this investigation, child welfare workers and mental health professionals are frequently asked to use their expertise to inform decisions about child placement. At the beginning of state involvement, a mental health professional may be asked to perform a court ordered psychological evaluation of the child or the biological parents and testify before the court on the appropriateness of various placement decisions (American Psychological Association, 1999). When professionals make decisions, they should take into account the types of mental health, academic, occupational, and other services that will provide the most benefit, based on the service outcomes literature. As discussed previously, children and adolescents in the child welfare system have an increased likelihood of having a serious behavioral or emotional disorder, and thus needing treatment. Estimates indicate the youth in the child welfare system are as much as 8 times more likely to have a mental health diagnosis than the population overall (Burns, et al 2004; Landsverk & Garland, 1999), and children in foster care are up to nine times more likely to have a mental illness than children not in foster care (McIntyre & Kessler, 1986). Given the extremely high rate of psychopathology in the child welfare population, substantial attention is given to assessing whether children in foster care and residential care have their emotional, behavioral, and developmental needs met by the services that they receive. After the publication of an influential report which indicated that nearly two-thirds of children in need of services were either not provided with services or placed in inappropriately restrictive settings (Knitzer, 1982), policy makers have stressed communication between agencies and streamlining delivery of mental

health services to children and adolescents. Child welfare professionals work to ensure that the children they represent receive services in clinically appropriate settings.

### *The System of Care*

As a result of the aforementioned report (Knitzer, 1982), the system of care (SOC) approach for treating children and adolescents with emotional and behavioral disturbances was developed (Stroul & Friedman, 1986; Stroul & Friedman, 1994). SOC has become the dominant approach to treatment; it emphasizes permanency for children within their own communities and placement in the least restrictive clinically appropriate setting. The model also stresses child-centered, family-focused, culturally competent services. Although SOC does not advocate for particular forms of therapeutic interventions, the model was created in order to encourage inter-agency coordination between multiple service providers in the child welfare sphere in order to keep the best interest of the child at the forefront. The goal of the inter-agency coordination is to allow the children to remain in the home and community when this is in their best interest (Whittaker & Pfeiffer, 1994). A child receiving SOC-based services might be utilizing multiple forms of treatments (e.g., school-based, mental health, juvenile justice services, vocational services, etc.); the goal of the SOC model is to ensure that these agencies regularly collaborate with each other and the family or foster family.

### *The Best Interest of the Child*

Professionals within child welfare rely on the best interest of the child standard in making determinations about the placement fate of children (American Psychological



Association, 1999; Goldstein, Freud, & Solnit, 1973; Banach, 1998). The best interest of a child takes multiple factors into account. Best interest decisions involve assessing the biological parent's ability to parent, exploring the nature of the child's relationship with their parents, and attending to the child's developmental and therapeutic needs. Best interest is related to the child's physical safety and psychological-well being; it is certainly not in the best interest of the child to be in a situation in which physical or sexual abuse or neglect is likely. It is also in the best interest of the child to be with his or her biological parents if this placement is safe and the parents are psychological and emotionally stable (Hall, Pulver, & Cooley, 1996). However, despite various rules and regulations, there are not specific definitions pertaining to every situation that a child might face in child welfare and many of the guidelines and criteria for establishing best interest are vague (Hall et al., 1996; Jameson, Enhrenberg, & Hunter, 1997; Kelly, 1997). As Kelly notes (p. 378), "Because the concept of best interests is rarely defined but heavily relied on, experts, attorneys, court personnel, and parents have an opportunity to create their own meanings." Despite common threads, states differ regarding establishing formal best interest standards. For example, while 24 states consider child's wishes concerning placement in their state statutes on best interest, only three states consider evaluating the home, school, and community records of the child (Hall et al, 1996). Keeping siblings together, identifying availability of child care, and allowing for grandparent visitation rights are all factors that are each listed in only a single state's statute on best interest. Therefore, it is not surprising that policy makers and researchers

have been critical of the vagueness and nonuniformity of the state standards and guidelines regarding best interest (Hall et al., 1996; Kelly, 1997).

Although states differ slightly regarding best interest standards, according to federal law, it is in the best interest of the child to be in the least restrictive environment that is clinically appropriate (see *Olmstead v. LC* 527 U.S. 581). When working with children and adolescents who need psychological services, the least restrictive environment principle should help to guide placement decisions. For example, if a child can handle being in a community setting from a developmental, social, and clinical perspective, then he or she should not be placed in more restrictive care, such as residential treatment. The least restrictive environment standard was designed to keep children and adolescents out of restrictive placements unless they are absolutely necessary. Prior to this paradigm shift, children placed in more restrictive forms of care, such as residential care, would be more likely to remain in that form of care even after showing improvements. Today, in keeping with the SOC emphasis on community-based, family-focused services, these children would be more likely to transition down into less restrictive forms of care. In the SOC, youth in more restrictive settings should demonstrate more severe symptoms/behaviors and perhaps more importantly, should have established through chronic and dangerous behavior that community-based treatment is unsafe. The following section describes the various levels of placement, ranging in restrictiveness from community-based services to psychiatric hospitalization, within the child welfare SOC and their ranges of restrictiveness.

*Different Forms of Placement within Child Welfare*

As discussed previously, the child welfare system is structured at the state level; therefore, the organization and services available may be slightly different between states. As Terpstra and McFadden state (pp. 122), "Services in the United States resemble a crazy quilt pattern, different in every state and, to some extent, different in every county." However, federal laws serve to equalize the service structure to a certain degree. All state child welfare systems offer a continuum of care ranging from highly restrictive settings (e.g., psychiatric hospitalization) to less restrictive settings (e.g., traditional foster care, community-based services, etc.). Children and adolescents who are in need of services frequently cycle back and forth between these settings; on average children spend less time in more restrictive environments.

Compared to previous generations, children are likely to have even shorter lengths of stay in restrictive environments such as psychiatric hospitalization as the managed care system for insurance has become the dominant method of service delivery in the United States (Rosenfeld et al., 1997; Leon, Snowden, & Sieracki, 2008). Although managed care tends to improve access to mental health services across the population, shifts toward less costly services may lead to exclusion of high-cost groups, such as those who need more restrictive services. Psychiatric hospitalization and residential care are typically much more expensive than community-based treatments. In general, the managed care reforms have led to decreased hospital and residential treatment lengths of

stay and an increased emphasis on outpatient services (Fontanella, Zuravin, & Burry, 2006).

Out-of-home placement options within child welfare can be categorized into three levels of treatment based on their restrictiveness (Stroul & Friedman, 1984; Snowden et al., 2007). These categories are community-based services, residential treatment, and psychiatric hospitalization. Table 1 presents a summary of the characteristics of these levels of treatment. The table, and the subsequent discussion of placement options based on this categorization, only includes placements in which the child is removed from their biological parents (although it should be noted that remaining with the biological parents is the most common placement decision in child welfare). In addition, although incarceration within the juvenile justice system is another placement option for children and adolescents with emotional and behavioral disorders who have encountered problems with the legal system, this placement does not usually provide extensive psychological services. The primary purpose of incarceration is protecting the community and punishing the offender. In addition, many of the placements (i.e., specialized foster care, residential treatment, hospitalization) are often utilized as an alternative to incarceration (Chamberlain & Moore, 1998). Because of the lack of emphasis on treatment and the specific factors associated with getting involved in juvenile justice (i.e., breaking the law), this placement option will not be included in the present study and will not be discussed further.

*Community-based*

Community-based services for children in out-of-home care are designed for children and adolescents who are capable of functioning in a community setting and are not dangerous to the community at large. Although all of the levels of placement within community-care are less restrictive than residential treatment, community placements vary in terms of services provided, training and qualifications of the foster parent, and compensation of the foster parent. The following section explores the most common types of community-based placements in child welfare from least restrictive to most restrictive.

Foster care and kinship foster care are the least restrictive out-of-home placements for youth in child welfare. The primary purpose of foster care is providing youth a safe and stable home environment (Morrison, Dore, & Mullin, 2006). The foster parent(s) becomes responsible for the care of the child who was removed from the birth parents by the state. If services are provided, they are of an outpatient, non-intensive nature. Although youth in foster care frequently present with a history of abuse and neglect and a variety of externalizing and internalizing symptoms, for many children removal from the maladaptive situation without further treatment is the least restrictive clinically appropriate setting. As Rosenfeld and colleagues note (pp. 453), “psychotherapy may be unnecessary in situations in which the foster parents are sensitive and knowledgeable, the children resilient, and the biological parents caring and eager to participate in their children’s lives” (Rosenfeld et al., 1997). The ideal foster parents

should aim to understand the foster child's needs and provide a consistent and nurturing environment (which the child usually lacked prior to placement). In order to help cover the cost of providing care and meeting the child's needs, foster parents receive monetary stipends from the state.

Kinship care, also known as "family foster care", is the term given to a foster care placement in which the foster parents are related to their foster children. Relative to several decades ago, children are placed in kinship care at an increased rate; in some states the number of children in kinship care outnumbers the number of children in nonkinship out-of-home placements (Beeman et al, 2000). When compared to children in traditional foster placements, children in kinship foster care are more likely to be children of color and to live in an urban area (Berrick, Barth, & Needell, 1994; Geen, 2004). They are also more likely to have less behavioral problems and less conflict with parents prior to entry into the child welfare system (Geen, 2004). The major benefit of kinship care is that it allows the child to remain connected to his or her birth family. Depending on the circumstances, this could be the ideal placement option given the legal requirements for children to be placed in the least restrictive, most family-like environment. However, the standards for kinship care are often less rigorous than for traditional foster placement, and children in kinship care have longer placements and are less likely to receive needed services (Rosenfeld et al., 1997). Kinship care foster parents also often receive less compensation than standard foster care parents. In addition, children in kinship care are sometimes subjected to the same maladaptive family circumstances that were present

when they were living with their biological parents. Kinship care placements with grandparents can be problematic if the older caregiver does not have the strength or stamina to provide adequate support and supervision. Nevertheless, kinship foster care is a frequently utilized placement in today's child welfare system. In a national study of 3,803 children who were subjected to investigated reports of maltreatment, 4.5% of the children were placed in kinship foster care at the time of the survey, while 4% were in nonrelative foster care (however, almost 90% of the children remained or returned to their homes) (Burns et al., 2004).

Wraparound is a term sometimes used in describing a framework for developing individualized services and supports for children and their families within the community. The wraparound treatment approach utilizes the same basic philosophy as the SOC approach. Although it is not a specific intervention per se, wraparound programs provide services to children and adolescents who would benefit from interventions, but do not need to be in more restrictive forms of care. These programs enlist the help of a team of individuals, including the family, who know the youth well and can identify the strengths that he or she possesses (Burns & Goldman, 1999). This team makes an unconditional commitment to care for the child and emphasizes his or her strengths. In addition, care for the adolescent is set in the context of their community and culture. Community members (such as ministers, coaches, or teachers) may be asked to join the wraparound team. The team determines the nature of care to be offered to the child, purchases the care, and seeks treatment consultation (Huffine, 2002). Wraparound

may include any services that are specifically designed for individual children and their families and enable them to achieve positive treatment gains, such as vocational, juvenile justice, or educational services (Myaard, 2000).

In the state of Illinois, a service option demonstrating wraparound principles was implemented in 2002. This specific program, termed System of Care (not to be confused with the overall global SOC philosophy first articulated by Stroul & Friedman and described earlier), was designed for youth who needed services in their communities but did not need more restrictive levels of care (such as treatment foster care) (Sieracki et al., 2008). All clients who are admitted to the Illinois DCFS SOC program reside in the homes of relatives, traditional foster care placements, or DCFS managed foster homes. Using the wraparound philosophy, regular child and family team meetings are held in which treatment goals are discussed and an individualized plan of care is developed or updated. Agencies coordinate to provide the child with individualized services that are ideally delivered within the child's community. Prior research has indicated that children in this program improve from a behavioral and emotional perspective, although the gains are modest (Sieracki et al., 2008).

Treatment foster care, sometimes referred to as specialized or therapeutic foster care, is designed to meet the needs of children who require the structure of residential care but would also benefit from the influence of a family environment (Glisson & Green, 2006; Morrison & Dore, 2006; Reddy & Pfeiffer, 1997). Treatment foster care is different from standard foster care or wraparound services because it is a placement for



youth who have a history of emotional and behavioral problems and require intensive current services. Oftentimes, children who enter treatment foster care are “stepping up” from more traditional or kinship foster care placements. The treatment foster care method evolved out of a push toward community-based care and away from more restrictive care during the 1970s and 1980s (Morrison & Dore, 2006; Thomlison, 1991). In keeping with the least restrictive environment philosophy, children who might have previously been placed in residential treatment, are now often placed in treatment foster care if they are deemed not severe enough for residential or inpatient settings. The foster parents receive specialized training and are usually compensated at a higher rate than standard foster care parents. Therapy often takes place within the foster home. Other characteristics of treatment foster care programs include considering foster parents as treatment professionals, limiting the amount of children placed in a treatment foster home relative to a standard foster home, providing crisis services 24 hours per day, and coordinating the child's system of care (Hawkings, 1990). In a controlled study of effectiveness, children receiving treatment foster care were placed out of a hospital at a quicker rate and recidivism was less than a group receiving "community treatment as normal" (Chamberlain & Reid, 1991). Children in treatment foster care are also less likely than children in traditional foster care homes to enter residential care, despite the fact that children in treatment foster care theoretically should have more severe behavioral and emotional difficulties at baseline than those in standard foster care (Budde et al., 2004).

### *Residential Treatment*

Residential-based treatment is designed for children and adolescents who require more restrictive, structured, and comprehensive services than are typically available at outpatient settings and specialized foster care programs (Curtis, Alexander, & Lunghofer, 2001). Residential treatment centers ( RTCs) usually provide 24 hour, year round, care in a milieu-based therapeutic environment. Unlike psychiatric hospitalization, RTCs are not usually considered a short-term solution, and the average length of stay at a RTC is eighteen months to two years. The children at RTCs usually attend school on the grounds of the treatment center and have limited access to the community. Older adolescents may live in therapeutic group home settings in which vocational education is emphasized. As a consequence of the more controlled environment, intensive behavior modification and/or psychological services that may not be feasible in outpatient settings are often implemented in RTCs. However, because RTCs are not as widely distributed as foster care placements, it is often necessary to move the child a great distance from his or her family (Courtney, 1998).

Residential care can vary considerably between treatment centers, and there is no standard definition of residential treatment in the research literature (Wells, 1991). However, a typical day for a youth in a RTC would consist of attending an on-site school, participating in a group or individual therapy session, and participating in structured activities, such as chores, games, or playtime, within the milieu. Children in RTCs

interact with teachers, social workers, therapists, case managers, and frontline staff who provide 24 hour coverage.

There are approximately 250,000 children receiving services in RTC's, including children in child welfare and those who are not in the system (Child Welfare League of America, 1999). The number of children in RTCs has decreased in recent years, in the state of Illinois there was a 58% decline between 1995 and 2003 (Budde et al., 2004). The decline is partially due to the push toward SOC, community-based, family-like services, such as treatment foster care intensifying (Courtney, 1988; Stroul & Friedman, 1984). In addition, as described previously, the managed care environment and the heavy cost of residential treatment have also led to decreases in the population of RTCs. RTCs are funded either through public or private funds, or a combination of both. Depending on the source of funding and the services provided, residential treatment costs six to ten times more than traditional foster care and two to three times more costly than treatment foster care (Barth, 2002). Today, individuals in RTCs are likely to present with high levels of psychopathology and complex diagnoses (Leichtman, Leichtman, Barber, & Neese 2001). Youth within the foster care system who enter residential treatment are more likely to have spent more time in foster care and experienced multiple foster care placements. Children in RTCs may also be stepping down from more structured placements such as psychiatric hospitalization or juvenile detention centers. Because of the cost and restrictiveness of RTCs, effective decision making regarding entry and length of stay is vital. In the state of Illinois, Placement Review Teams (PRT) review

referrals that are made to RTCs in order to ensure that children have symptoms severe enough to necessitate such restrictive care.

Children who are placed in RTCs have extensive histories of behavioral and emotional difficulties, usually, although not always, at a level higher than children in community-based care (Curtis et al., 2001). Few studies have directly compared the effectiveness of residential placements to community placements, and preexisting symptomatology is a potential confounding variable in retrospective research in this area. One study in which 79 boys with a history of delinquent behaviors were randomly assigned to residential care or treatment foster care found that boys in treatment foster had fewer referrals for criminal activity at follow-up (Chamberlain & Moore, 1998). However, in their literature review of studies comparing outcomes between children in residential care and community-based care, Curtis and colleagues note that the majority of previous research has not found differences between the two forms of placement (Curtis et al., 2001). The effectiveness of residential treatment versus community-based care is an important topic for individuals and agencies that make placement decisions because of the costs associated with treatment and the tremendous impact that placements have on the lives of the affected youth.

#### *Placement Decision Making*

The preceding section provided an overview of community-based and residential placement options in child welfare. The goal of any placement within the system of care is always to improve psychological and behavioral functioning. However, placements

vary in terms of how they attempt to meet this goal and professionals should consider these goals when they make placement decisions. In community-based settings, improving long-term functioning in the child's permanent environment is emphasized. Among the many benefits of remaining in the youth's community are the potential for an increased sense of permanency, the ability to establish ties with the community, a chance to be with youth who are not behavioral or emotionally disturbed in order to help foster social norms, and keeping ties to family members when this is in the child's best interest. In residential settings, a safe, structured environment is utilized. The milieu based treatment environment offers the opportunity to closely monitor medications and treatment compliance (Bates, English, & Kouidou-Giles, 1997). In addition, the structure of the environment is beneficial for youth who have experienced years of traumatic uncertainty as a result of neglect or abuse. In addition, sophisticated behavioral management techniques, in which a structured, constantly monitored environment is needed, can be implemented. In hospital settings, the goal is short-term, increasing the safety of the individual and reducing the psychiatric symptoms that are causing the child to be unsafe. Within the hierarchy of care in the child welfare system, inpatient or acute hospitalization is the most restrictive level of care (Bates et al., 1997). The behavioral and emotional management programs implemented in psychiatric hospitals may be more intensive and restrictive than RTCs (Curtis et al., 2001). However, unlike community-based or residential placements, psychiatric hospitalization is designed to be short-term crisis management. The typical length of stay for a child psychiatric hospitalization is

rarely over a month and often only a few days (Snowden et al., 2007). Because of the short-term crisis management nature of the psychiatric hospitalization placement option, the present study will only assess placement decisions regarding community versus residential care.

In addition to the goals of the placement, professionals operating within the system of care for child welfare make decisions on where to place children based on a multitude of variables. Prior to the 1980s, placement decisions were largely based on a psychodynamic approach to treatment (Lindsey, 1992). Early work in the field of decision making in child welfare emphasized the level of emotional disturbance exhibited by the child and whether that disturbance was severe enough to upset the family structure (Glickman, 1957; Kline & Overstreet, 1972). Although emotional disturbance and family structure are certainly still considered, more recent decision making models take an increased number of factors into account. Banach (1998) conducted an exploratory and qualitative study in which she interviewed 50 family court judges, caseworkers, and lawyers in the state of New York about making placements and their understanding of the best interest standard. She grouped decision-making factors that could theoretically impact placement and were indicated by the professionals into three categories; precipitating events, guiding principles, and case variables. Precipitating events are the factors that lead to case review, such as family court proceedings, change in circumstances, or regular periodic reviews as mandated by law. Guiding principles are general concepts that are considered when making decisions, including time in care,

family preservation, and prevention of future problems. Case variables are the specific factors related to individual cases. Variables related to parent functioning, child functioning, and abilities of substitute caregiver would fall under this category. Demographic factors, such as age, ethnicity, and family income would also fall under the category of case variables. The professionals interviewed for Banach's study did not directly discuss the role of demographic factors on placement decisions. This is not surprising, few professionals would outwardly endorse that these variables influence their decisions in an interview format, even if empirical evidence suggests otherwise. The present study is primarily concerned with how case variables, both demographic and clinical, in addition to factors related to prior placement, influence placement decisions within child welfare.

Despite the increased sophistication of child welfare decision making models, placement decision making is not a standardized process; therefore, reliability of placement decisions has been criticized (Lindsey, 1992; Pecora et al., 1992). Reliability refers to both the consistency in decision making both between professionals making the decision (often termed inter-rater reliability), and the consistency in decision making of the same professional over time (test-retest reliability). As Lindsey (1992) notes:

“Because removal of a child from his or her home and placement of that child in foster care is such a major decision, with enormous consequences for the child and his or her family, it requires much greater precision in the decision-making process than is currently being achieved” (pp. 74).

The present study will assess inter-rater reliability for decisions by using a hypothetical vignette in which demographic and placement factors will be experimentally manipulated, and important clinical variables will remain constant throughout the conditions. The variables that will be manipulated are based on the results of previous research in the field of child welfare that will be discussed in the next section.

Previous decision making research has primarily focused on variables that influence remaining in the foster care system versus exiting the system (Britner & Mossler, 2002; Brooks et al., 2002; Drury-Hudson, 1999; Earth, 1997; Lindsey, 1991; Lindsey, 1992; Pellegrin & Wagner, 1990; Snowden et al., 2007; Zuravin & DePanfilis, 1997). The results of several of these studies will be discussed in subsequent sections. However, the present study is focused on variables that relate to placement within the system. Thus, the ways in which children and adolescents exit the child welfare system will not be discussed further.

The prior research in decision making in child welfare is difficult to summarize because studies vary greatly in terms of types of children assessed, methodology, and placement options. When commenting on child welfare decision making literature Zuravin & DePanfilis (1997) note that “Studies vary in objective, design approach, data collection, unit of analysis, and analytic strategy. Consequently, findings are difficult to integrate across studies and do not as a group lead to conclusions” (pp. 36). In addition, some studies compare out-of-home placements to return to biological parent, others compare foster care to group placement, and others compare multiple placements. Table



2 presents a summary of the most recent published research assessing the influence of demographic and clinical factors in child welfare placement decisions. In addition, many studies that are not included in the table assess variables associated with length of time spent in foster care, as opposed to placement decisions. Although several of the length of stay studies will be addressed in the subsequent sections, the present study will compare placement decisions as opposed to length of time in the system. In addition, the present study will only compare out-of-home placements within the child welfare system (i.e. community-based treatment versus residential treatment) as opposed to a decision to not remove the child or a return to biological parents.

Demographic variables are those that characterize segments of the population, such as gender, age, and race. In an ideal setting, demographic variables should factor very little in placement decisions. If a child of a certain ethnicity or socioeconomic status is more likely to be placed in restrictive settings after controlling for clinical variables then the placement decision could be considered biased. However, empirical evidence from both retrospective reviews and surveys of child welfare professionals suggests that several demographic factors are related to placement decisions in child welfare. Past research has examined the relationship between different demographic variables and child welfare placement decisions, including age (Knapp et al., 1987, Britner & Mossler, 2002; Danglish & Drew, 1989, Courtney, 1988; McMurty & Lie, 1992, Brooks, James, & Barth, 2002), gender (Budde et al., 2004; Britner & Mossler, 2002, Glisson, Bailey, & Post, 2000), and geographic location in which the child resides (Budde et al., 2004).

Research has also assessed the influence of clinical variables on placement decisions (Courtney, 1998; Snowden et al., 2007; Child Welfare League of America, 2005, Glisson & Green, 2006). In general, the previous research studies have offered support, to varying degrees, that decision makers take into account a multitude of factors when making placement decisions. The previous studies that utilize retrospective reviews are difficult to draw conclusions from because of an inability to establish causality. Therefore, by experimentally manipulating demographic and placement variables, the present research will be able to provide strong evidence as to the relevance of these factors on both placement decisions and professional's ratings of client characteristics via a standardized outcome tool.

The variables that will be experimentally manipulated in the present study are race of the child, foster care environment/SES, and access to community-based services. In order to maximize power only a limited number of variables can be manipulated within an experimental vignette study; these variables were chosen because their potential impact on placement decisions is not well understood, either from a lack of research (foster care environment/SES and community-based services), or a contradictory and unclear body of research (race). The following sections review the issues surrounding each of the experimentally manipulated variables.

#### *Race/Ethnicity*

One of the variables that will be experimentally manipulated in the present study is the race of the child. The studies assessing the association between race/ethnicity and

child welfare placement decisions have primarily assessed differences between Caucasians and African-Americans or white versus “non-white” children. Much of the research has demonstrated that African American or non-white children are more likely to be remain in out-of-home care for longer periods of time than Caucasian children (Finch, Fanshel, & Grundy, 1986; Jenkins & Diamond, 1985; McMurtry & Lie, 1992; Olsen, 1982). For example, Courtney’s (1998) retrospective review of social workers placement preferences indicated that African American children were more likely to be considered for treatment foster care than children from other racial groups. Finch and colleagues' (1986) found that nonwhite children were less likely to be adopted than white children. Beeman and colleagues' (2000) retrospective study of 2,000 children in a large urban county indicated preference for African Americans to be placed in kinship foster care as opposed to traditional foster care. However, other studies comparing out-of-home care to return to biological parent have not found race to be associated with placement (Zuravin & DePanfilis, 1997).

Glisson, Bailey, & Post (2000) reviewed 15 studies that assessed variables that influence time that children spend in state custody. Although these studies did not address placement decisions, per se, time in state custody could be considered a proxy variable for a placement decision of returning home vs. remaining in the foster system (although this is not perfect, because children leave substitute care for a variety of reasons, not all of which are positive). Across the majority of the studies "minority" children experienced significantly longer stays in custody. Although there were several

studies that did not find a significant relationship, none of the studies found that "minority" children remained in the system for shorter periods. Among other child characteristics, age and gender were inconsistent. The authors also note that few studies included family characteristics, such as family structure, socioeconomic status, and parental mental health problems. After reviewing previous research, the authors conducted their own evaluation of 700 children in the Tennessee child welfare system. This study also found a strong effect of race; after controlling for all other variables, minority children had a 42 percent lower probability of leaving custody (Glisson et al., 2000). They did not find main effects for age and gender of the child. Taken together, race appears to be a significant non-clinical factor in influencing placement decision.

Although there appears to be a correlation between minority status and remaining in the child welfare system, the relationship between race and placement decision within the system is not well understood and could be subject to several confounding variables. Because of this preexisting difference in problem presentation, clinical factors could be a confounding variable in retrospective reviews of placement decisions that assess the influence of race. Therefore, the present study is important because race is one of the experimentally manipulated variables; limiting the influence of potential confounding factors. If racial differences emerge in the present study then it is provocative evidence that race influences placement decisions.

In addition to influencing placement decision, it is also possible that race may impact clinical severity ratings and that there may be a tendency toward

overpathologizing ethnic minority members (Lopez, 1983). However, the research on this bias is inconsistent, and the effect is social desirability may influence research in this area, especially in situations in which clinicians are aware of their participation in a research study (Abreu, 1999). Using a priming procedure to examine stereotypes on social perception, Abreu (1999) found that clinicians were likely to rate a hypothetical client less favorably on hostility-related attributes but more favorably on hostility-unrelated attributes. He concludes that clinicians can be affected by African American stereotypes in complex ways. Therefore, the addition of race as an experimentally manipulated variable in the current study helps to explore this complex issue.

#### *SES/Income of Foster Care Placement*

The second variable that will be experimentally manipulated in the present study is the socioeconomic status of the current foster care placement. Studies assessing the influence of SES and income have primarily addressed decision making regarding remaining in the child welfare system versus return to biological parents (Britner & Mossler, 2002; Lindsey, 1991; Zuravin & DePanfilis, 1997). Therefore, the SES variables in question in these studies are related to the biological family. Research has indicated that the SES of the biological family is important in predicting placement decisions (Lindsey, 1991). The present study is not concerned with variables related to the biological family. However, as will be discussed further, the SES and stability of the current foster care placement within child welfare could be a potentially important variable in predicting placement decisions within child welfare. There is a paucity of

previous research assessing the role of SES and foster family demographics on placement decisions within the child welfare system.

Children who are in a stable foster care environment may be more likely to remain in the placement and less likely to move to more restrictive forms of placement. Multiple placements and placement disruption are associated with negative outcomes for the child (Newton, Litrownik, & Landsverk, 2000; Pardeck, 1984). Research in this area is difficult to draw conclusions about because of causality issues. It is difficult to ascertain if the foster family is high functioning because of preexisting conditions involving the family or if the family is high functioning because the child is not exhibiting behavioral or emotional disturbances. In addition, there is not a standard definition as to what constitutes a quality or stable foster care environment. However, children should not be placed in a more restrictive setting simply because their present setting is a less than ideal environment (Newton et al., 2000). Newton and colleagues note (p. 1363), “Children who do not evidence behavior problems may in fact constitute a neglected population that responds to multiple disruptions of their primary relationships with increasingly self-defeating behaviors.” Therefore, clinicians should be careful not to remove a child from their current placement unless the behavioral or emotional needs of the child are not being met. There is little systematic research on the influence of SES/Income of the foster care family in future placements; the present study addresses this gap in the literature.

*System of Care/Wraparound Services Provided.*

As discussed in previous sections, the dominant model in community-based treatments of children and adolescents in the child welfare system is the System of Care (SOC) approach (Stroul & Friedman, 1986; Stroul & Friedman, 1994). SOC and wraparound services encourage inter-agency coordination, involve the foster families as treatment team members, and are centered on the individual needs of the child. However, randomized clinical trials of children and adolescents assigned to SOC versus “treatment as usual” have not found a difference in clinical outcomes (Bickman, Noser, & Summerfelt, 1999). Despite this fact, because of the popularity of the SOC model in today’s child welfare system, it is likely that children and adolescents who receive community-based SOC services and continue to demonstrate emotional or behavioral disturbances are more likely for recommendation into residential treatment than children who have not received community-based SOC services. Professionals may be more likely to recommend children who are not receiving SOC services to these more intensive levels of community-based treatment as opposed to stepping-up to residential care. Prior to the current study, research has not tested the hypothesis that current services received within the community-based SOC will influence future placements. However, the present study includes receiving SOC services as one of the three experimentally manipulated variables.

*Demographics of Professionals Related to Placement Decisions*

Placement decisions are made by child welfare professionals. These individuals have a variety of experience in the field and undoubtedly bring their own biases and life histories into their decisions. Therefore, it is worth studying the influence of caseworker characteristics on placement decisions that he or she makes in the child welfare system, and the present study will assess these variables. However, compared to studies assessing demographic factors of the children in child welfare, there is far less research on how demographic factors of the professionals influence placement decisions. The following is a brief review of the research that has been conducted.

*Type of professional.* Several types of professionals make decisions about placement in the child welfare system. These include, but are not limited to, social workers, caseworkers, police officers, and juvenile justice judges. In addition, a volunteer position called the Court Appointed Special Advocate (CASA) is utilized in many jurisdictions in order to help ensure that the proceedings are in the child's best interest. Previous research assessing the role of the professional is relatively limited; Mandel and colleagues (1995) compared police officers and social workers and found that police officers were more likely to recommend removing a child from home. Because social workers have more experience making placement decisions compared to police officers, the difference in the two occupations can be viewed as a proxy for experience. The more experienced professionals were less likely to recommend removal. A study utilizing vignettes to compare placement decisions of juvenile court judges,



CASA workers, social workers, and mental health professionals found that professionals utilized information differently depending on their profession within the child welfare system (Britner & Mossler, 2002). Specifically, juvenile justice judges considered fewer characteristics overall to be important than other professionals. CASA workers were more likely to indicate that a stable home environment was very important in placement decisions. Social workers and other mental health professionals were more likely to discuss clinically related variables, including abuse history. As mentioned previously, CASA workers are typically volunteers with more limited experiences in child welfare than social workers or other child welfare professionals. Therefore, similar to the previous study, the differences between social workers and CASA workers may be related to experience. The evidence that the less experienced CASA workers prioritize a stable home environment, as opposed to clinical variables, is relevant to the present study because the present study assesses the influence of nonclinical factors, such as stability and SES of foster care environment, on placement decision.

*Experience/Length of time at job.* The research assessing professional education, age, and/or amount of experience at the job in child welfare as it relates to placement decisions is somewhat limited and inconsistent (Zuravin & DePanfilis, 1997). A study assessing differences in placement decisions between Canadian and Israeli child welfare workers found that Canadians with more than 3 years of experience were more likely to recommend more restrictive placements than Israelis with more than 3 years of experience (Gold et al., 2001). However, there was no main effect for amount of

experience in the study, only for the country that the professional lived in. A small quantitative study comparing placement decisions of ten novice social work students with eight social workers with a minimum of ten years experience found that the experts were better at intergrading theoretical and empirical knowledge with practice, although the study only assessed the process of decision making as opposed to assessing potential differences in placement decisions (Drury-Hudson, 1999). A similar study assessing the placement decisions of experts and standard child protection investigators found little difference based on experience; the differences were so small that the authors were comfortable combining the groups for statistical analysis (Rossi et al., 1999). Finally, a questionnaire assessing the importance of various characteristics in decisions to remove indicated that professionals with more years of experience did not consider parental substance use, parental cognitive abilities, the stability of the home environment, the children's attachment to parents, the quality of the child's relationship with siblings, and the availability of "good" placement options to be as important in decision to remove as did professionals with less experience (Britner & Mossler, 2002).

The result of the Britner & Mossler study indicates that experienced professionals are better at filtering out the extraneous information (i.e., family factors, demographic factors, etc.) when making clinical placement decisions. Despite the dearth of literature on experience and placement decisions in child welfare, numerous studies in other fields have concluded that professionals can benefit from certain types of experience. For example, research in medicine (Luft, Garnick, Mark, and McPhee 1990) and

psychotherapy (Leon, Lutz, Martinovich, & Lyons, 2005) suggests that while years of experience in a field is a poor predictor of outcome, the amount of experience treating a specific type of patient (e.g., volume of CABG surgeries performed for heart disease) is a good predictor of outcome. The hypothesis that experienced social workers are better at making placement decisions and filtering out less important information will be further tested in the present study by studying social workers with different levels of exposure to placement decisions involving youth in the child welfare system. Therefore, the following section briefly reviews the typical training that is provided to social workers that specialize in child welfare.

*Social workers.* There are more than 600,000 professional social workers in the United States (National Association of Social Workers; NASW, 2008). The requirements for becoming a social worker are set by the NASW, an umbrella organization which has chapters in every state in the United States. In order to become credentialed by the NASW, social workers need a degree, supervised experience, professional references, and a passing grade on a licensing examination. Although social workers receive certification through the NASW, not all social workers are members of NASW. The NASW has over 150,000 members, 90% of whom hold master's degrees in social work (NASW, 2008). Most individuals that are social workers have master's degrees from an accredited M.S.W. program, although a minority of individuals possesses an undergraduate degree in social work or a doctoral degree in social work. There are over 125 programs accredited by the Council on Social Work Education in the United States.

However, the coursework offered by these accredited schools of social work varies considerably (Burger & Youkeles, 2000). Many social work training programs offer specializations in child welfare and related fields. Other specializations include geriatrics and mental health. Thus, social workers in the field possess a wide variety of educational and work experiences. The present study will assess differences in placement decision making that might exist between social workers with varying levels of experience and specializations.

Table 1

*Characteristics of Out-of-home Placement Options within Child Welfare*

<u>Level</u>	<u>Severity</u>	<u>Length of Care</u>	<u>Type of Services</u>
Community	Capable of community functioning	Indefinite	Foster care Outpatient Specialized foster care Wraparound
Residential	Chronic/Poor Functioning	Longer-term (12 months)	Milieu-based
Inpatient	Acute	Short (<14 days)	Psychiatric

Table 2

*Previous Studies Assessing Influence of Demographic and Clinical Characteristics on Placement Decisions*

Authors/Year	Type	Sample	Placement Options	Significant Factors
Beeman, Kim, & Bullerdick (2000)	1	2,121 children in out-of-home care in a Midwestern urban county	1. Foster care 2. Kinship foster care	Age Race Reason for placement
Britner & Mossler (2002)	2	90 professionals in child welfare	1. Out-of-home placement 2. Remaining in home	Type of professional
Courtney (1998)	1	348 children in out-of-home care in California	1. Foster care 2. Treatment foster care 3. Group care	Age Behavior problems Placement history
Glisson & Green (2006)	1	1,249 children in child welfare in Tennessee	1. Out-of-home placement 2. Remaining in home	Clinical variables Placement
Gold, Benbenishty & Osmo (2001)	2	181 child welfare workers in Ontario and Jerusalem	6 choices ranging from no intervention to removal from home without consent	Country
Martin, Peters, Glisson (1998)	1	633 children in state custody in Tenn.	Placement restrictiveness – a 1-17 point scale	Clinical variables Diagnosis
Rossi, Schuerman, Budde (1999)	2	27 child welfare experts and 103 child protective agencies workers	1. Foster care 2. Remaining in home	Prior history in system
Snowden et al. (2007)	1	13,245 children in foster care in Illinois	1. Foster care 2. Psych. hospitalization	Clinical variables Family problems Hospital
Snowden, Leon, Sieracki (2008)	1	60,000 children in national sample	1. Foster care 2. Adoption	Age Race Clinical variables
Zuravin & DePanfilis (1997)	1	1,035 families in child protection program	1. Foster care 2. Remaining in home	Parent functioning

Type 1 = Retrospective review

Type 2 = Hypothetical vignette study

## CHAPTER 3

### CURRENT STUDY SUMMARY AND HYPOTHESES

#### *Current Study*

The preceding sections discussed the history of foster care, placement options within foster care, emotional and behavioral disorders in the child welfare system, and variables that influence placement decision. The following section first reviews key issues when utilizing vignettes in experimental research and several of the studies that utilized vignettes to study child welfare. Following this review and building on the proceeding research, the hypotheses for the present study will be presented.

#### *Risk Assessment and Decision Making Research*

Making decisions related to placement of individuals with psychopathology is an inexact science; even experience and skilled practitioners often do not accurately predict the behavior of their clients (Lindsey, 1992). Child welfare professionals make dozens of decisions, on a daily basis; however, deciding on placement is amongst the most important (Briar, 1963; Taylor, 2006). Therefore, it is not surprising that experts have called for increased empirical knowledge regarding how child welfare professionals make

placement decisions (Lindsey, 1992; Taylor, 2006). The most common approach to assessing variables associated with placement decisions is using descriptive statistics in a retrospective fashion (Zuravin & DePanfilis, 1997). However, the results obtained from this design are limited as it is difficult to tease apart the influence of the variables. An experimental study using hypothetical case vignettes while controlling for various demographic and clinical factors is one way that knowledge regarding placement decisions can be obtained in a more controlled manner. A study utilizing vignettes will be subject to less systematic, “real-world” error that is unavoidable in a retrospective review of descriptive statistics. As Taylor notes (pp. 1189), “Experimental methods normally simplify the decision to be made so as to produce verifiable conclusions about the aspect of the decision under study. It is usually too complex to determine which factors influence the decision where there are multiple factors”. Clinical vignettes have been used in several previous studies that assess placement decisions in child welfare, although not all of these studies were experimental in nature. The vignettes are typically constructed from practical knowledge, previous research, or actual cases that have been deidentified.

In an experimental study of placement decisions, the dependent variable, the outcome being measured, is the placement decision of the child welfare workers; the independent variable is the experimentally manipulated variable or variables. The experimentally manipulated variable can be any of the aforementioned demographic, clinical, or placement factors related to the child or the parents. For example, Gold and



colleagues (2001) presented child welfare workers in Canada and Israel with case vignettes and had them make recommendations for interventions. There was one experimentally manipulated variable in the study, how cooperative the biological mother was with the case worker in the hypothetical vignette. The researchers then asked the professionals to choose between 6 options for intervention and they asked the sample what the degree of risk to the child was on a 7 point likert scale. The options ranged in restrictiveness from no further intervention to removal for the child from the home for an extended period of time, even without parental agreement. The design of the present study is somewhat similar in nature to the study conducted by Gold et al, although there are several key differences. The present study also uses a scale assessing severity, however; as will be discussed further in the methods section, the study only utilizes two levels of the dependent variable, community-based treatment or residential placement. Another difference is that children and adolescents in the hypothetical vignette of the present study have already been removed from their biological parents.

In one of the earliest studies utilizing vignettes to assess foster care placement decisions, Briar (1963) asked child welfare case workers to make decisions about three hypothetical cases. The central experimentally manipulated variables were clinical problems and support of the biological mother with regard to entering foster care placement. The results indicated that there were substantial differences between workers making the decision, even when there is agreement on diagnosis. In addition, preference of the mother made a significant difference in placement. Later studies have provided

further evidence that decision makers often disagree. For examples, Donnelly (1980) asked caseworkers in different counties in California to read 15 vignettes and make placement decisions. There was substantial variation in decision to remove the child from the home. The present study continues to explore this important phenomenon, using a scenario of children already in the child welfare system.

### *Summary and Hypotheses*

The preceding literature review has explored the history and structure of the child welfare system, the levels of placement within child welfare, and the influence of demographic, clinical, placement, and professional factors on placement decisions. The current incarnation of the child welfare system in the United States focuses on the best interests of the child, permanency, and placement in the least restrictive clinically appropriate setting. However, the ways in which child welfare professionals utilize client information and make placement decisions is still not well understood. Building on previous research, the present study experimentally manipulates three demographic and placement factors that could potentially influence placement decisions within the child welfare system. Given that placement decisions should be guided primarily by clinical variables (dangerousness, suicidality, etc.), the study seeks to assess if these other, non-essential, variables also influence treatment planning. If the other variables are significantly related to placement this would be a provocative finding.

In order to simplify the experiment and make it applicable to professionals who may not be experts in child welfare, the placement decision in the present study is

dichotomous, placement in community treatment vs. placement in residential treatment. As will be discussed in the methods section, this format mimics a placement decision making paradigm that child welfare professionals must make on a frequent basis. The study will also use a standardized decision making tool, the Child and Adolescent Needs and Strengths (CANS) to assess respondents views of the hypothetical child (Lyons, 1999).

In an experimental study, as the number of independent variables increases, the statistical power in the analysis is reduced. Therefore, even though there have been dozens of clinical and demographic variables that have been studied before in previous retrospective, chart-review research, the present study is limited in the amount of experimentally manipulated variables that can be included without sacrificing statistical power. However, the benefit of the experimental study is the ability to isolate the variables that are selected in order to assess their importance in placement decisions. The experimentally manipulated variable in a vignette study can be categorical, ordinal, or interval (Taylor, 2006). However, variables that are ordinal or interval include increased levels of the independent variable, and thus, reduce power. The three categorical, dichotomous variables experimentally manipulated in the present study are race of the child (African American vs. Caucasian), foster care environment (high SES foster care environment vs. low SES foster care environment), and current community interventions (system of care/wraparound treatment vs. standard treatment).

Given the aforementioned constraints, decisions regarding the experimentally manipulated variables were based on the previous research. The vast majority of previous research has demonstrated that older children are more likely to be placed in restrictive settings or to remain in out-of-home care for longer periods of time (Barack, 1986; Knapp et al., 1987; Courtney, 1908; McMurty & Lie, 1992, Brooks et al., 2002) . Therefore, given the limited amount of variables that can be manipulated without sacrificing statistical power, age was not included as an independent variable. Gender was not included in the present study as an independent variable because the majority of the previous research has not found a relationship between gender and placement decisions (Britner & Mossler, 2002; Courtney, 1998; Glisson et al., 2000). The independent variables in the study (race, foster care family SES, and system of care environment) are similar in that previous research has found some evidence to suggest that these variables influence placement decisions, however; their influence is not fully understood. In addition, these variables are not directly related to the clinical functioning of the child and, therefore, should not theoretically substantially influence placement decision. Clinical functioning, treatment needs, and other variables will also be assessed using a decision support tool that is commonly used in making placement decisions in the state of Illinois DCFS, the Child and Adolescent Needs and Strengths (CANS).

Factors related to the professional completing the experiment are also included as potential independent variables. Previous research indicates that individuals with more experience in child welfare are more likely to filter out information that is less relevant to

placement decisions (i.e., demographic factors, environment of the foster family, etc.).

Therefore, it is hypothesized that those with more experience in child welfare will be less influenced by the experimentally manipulated variables than those with less experience.

In other words, professional experience in child welfare will moderate the influence of the three experimentally manipulated variables. The following sections propose general research questions and specific research hypotheses for the present study.

### *Research Questions*

The following general research questions form the basis for the present study.

*Research Question #1:* Previous research has indicated that, in addition to clinical factors, other factors also influence placement decisions. Therefore, a central research question in the present study is:

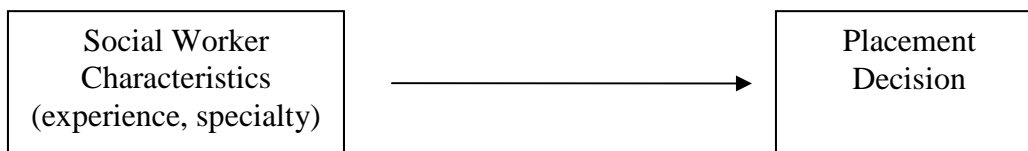
To what extent do various clinical and non-clinical factors (such as demographic and placement factors) influence placement decisions in child welfare and are there interactions between various factors that influence decisions?



*Research Question #2:* The research assessing experience and other factors related to the child welfare professional is less developed than the research assessing factors related to the child. Therefore, another central research question in the present study is:

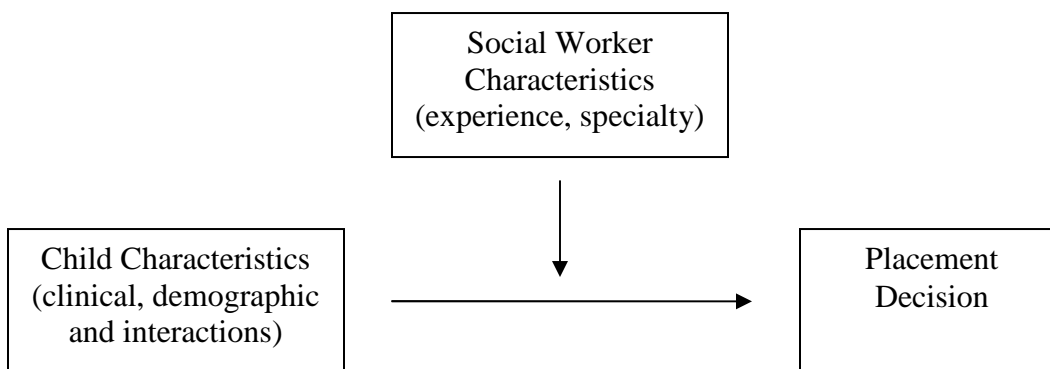
To what extent is amount of experience in child welfare and other demographic characteristics of the individual making the placement decision related to

placement decisions in the child welfare system?



*Research Question #3:* Individuals who are more experienced in child welfare should be able to focus on the more relevant pieces of information when making decisions (i.e. clinical variables). However, the research in this area is somewhat limited. Therefore, a central research question in the present study is:

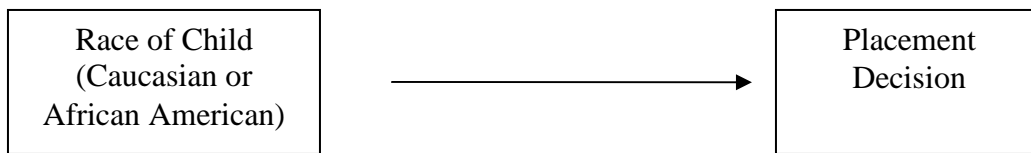
Is there an interaction between characteristics of the individual making the decisions and the importance of various child characteristics that influence decisions?



Given the results of previous research explored in the above sections and the general research questions proposed, the following specific directional hypotheses are predicted:

*Research Question #1: Experimental Variable Hypotheses*

*Hypothesis #1a:* When race is the experimentally manipulated variable, the African American youth vignette is more likely to be recommended for placement in residential treatment than the Caucasian.



*Hypothesis #1b:* When race is the experimentally manipulated variable, the African American youth vignette is more likely to be rated as having severe psychopathology and risk behaviors as measured by the Child and Adolescent Needs and Strengths (CANS). Specifically, the African American vignette will display higher scores (indicating a need for intervention) on the following items:

- a. Oppositional behavior
- b. Antisocial behavior
- c. Temporal consistency of problems
- d. Danger to others

*Hypothesis #2a:* When foster care environment is the experimentally manipulated variable, the child with the low SES foster care environment is more likely to be recommended for placement in residential care than the child in the high SES foster care environment.



*Hypothesis #2b:* When foster care environment is the experimentally manipulated variable, the child with the low SES foster care environment is more likely to be rated as having severe psychopathology and risk behaviors as measured by the CANS than the child in the high SES foster care environment. Specifically, the low SES foster care environment vignette will display higher scores (indicating a need for intervention) on the following items:

- a. Oppositional behavior
- b. Antisocial behavior
- c. Temporal consistency of problems
- d. Danger to others

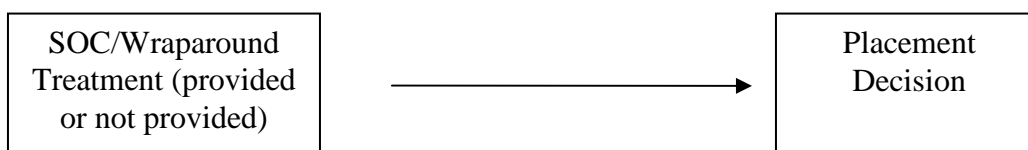
*Hypothesis #2c:* When foster care environment is the experimentally manipulated variable, the child with the low SES foster care environment is more likely to be rated as needing improvements in service delivery as measured by the CANS than the child in the high SES foster care environment. Specifically, the low SES foster care environment vignette will display higher scores (indicating a need for intervention) on the following items:

- a. Intensity and organization of monitoring
- b. Intensity and organization of treatment
- c. Caregiver supervision



- d. Caregiver involvement with care
- e. Caregiver resources

*Hypothesis #3a:* When SOC/wraparound treatment is the experimentally manipulated variable, the child with previous SOC treatment is more likely to be recommended for placement in residential care than the child without this intervention.



*Hypothesis #3b:* When SOC treatment is the experimentally manipulated variable, the child who has received SOC treatment is more likely to be rated as having severe psychopathology as measured by the CANS. Specifically, the child who has received SOC treatment will display higher scores (indicating a need for intervention) on the following items:

- a. Oppositional behavior
- b. Antisocial behavior
- c. Temporal consistency of problems
- d. Danger to others

*Hypothesis #3c:* When SOC treatment is the experimentally manipulated variable, the child who has not received SOC treatment is more likely to be rated as needing improvements in service delivery as measured by the CANS than the child who has previously received treatment. Specifically, the child who has not received SOC

treatment will display higher scores (indicating a need for intervention) on the following items:

- a. Intensity and organization of monitoring
- b. Intensity and organization of treatment
- c. Caregiver supervision
- d. Caregiver involvement with care
- e. Caregiver resources

In addition to main effects for the three experimentally manipulated variables, interactional effects will be tested, however; there are no specific hypotheses regarding interactions between race, foster care family, and community interventions.

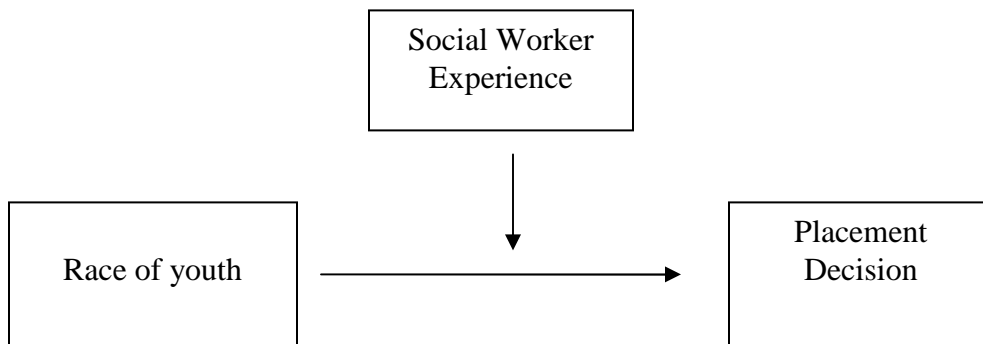
*Research Question #2: Professional Factors*

The second research question pertains to the direct influence of professional experience on placement decision. Although there is a hypothesized interaction between experience and the experimentally manipulated variables (Research Question #3), there are no specific hypotheses about the direct role of experience on placement.

*Research Question #3: Interactional Hypotheses*

It is hypothesized that there will be an interaction between respondent's experience in child welfare and the experimentally manipulated variables. The specific directions are presented below.

*Hypothesis #4a:* When race is the experimentally manipulated variable, less experienced social workers will be more likely to recommend the African American child for placement in residential care than the Caucasian.

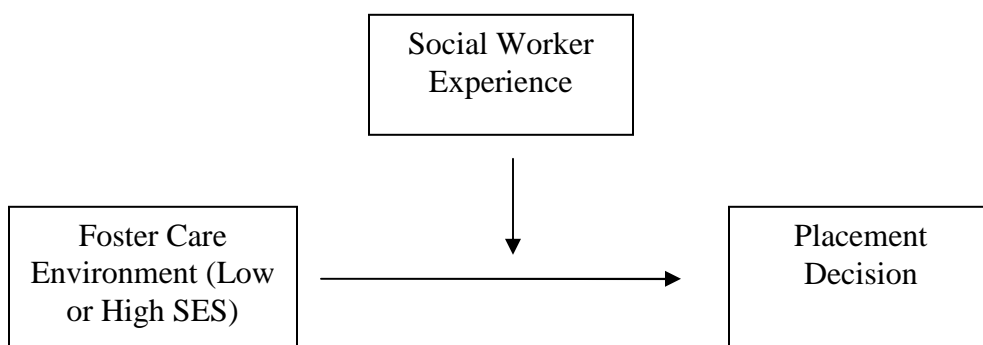


*Hypothesis #4b:* When race is the experimentally manipulated variable, less experienced social workers will be more likely to rate the African American child as having severe psychopathology and risk behaviors as measured by the CANS. Specially, less experienced social workers will rate the African American vignette as higher (indicating a need for intervention) on the following items:

- a. Oppositional behavior
- b. Antisocial behavior
- c. Temporal consistency of problems
- d. Danger to others

*Hypothesis #5a:* When foster care environment is the experimentally manipulated variable, less experienced social workers will be more likely to recommend the child

from the low SES foster care environment for placement in residential care then the high SES foster care environment

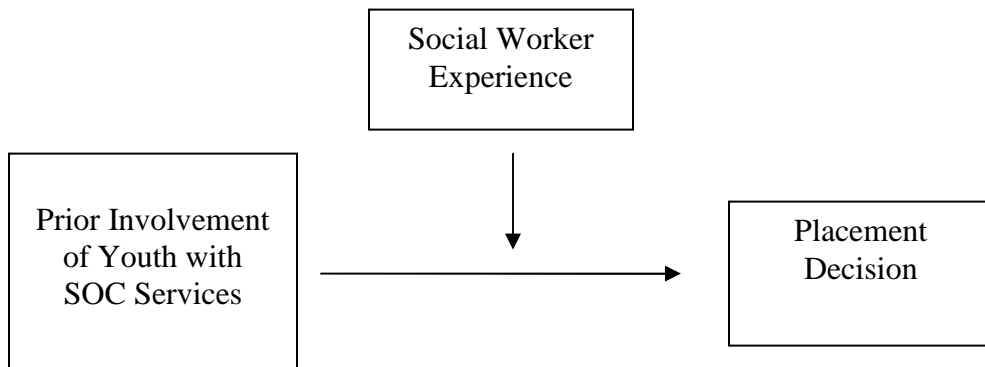


*Hypothesis #5b:* When foster care environment is the experimentally manipulated variable, less experienced social workers will be more likely to rate the child with the low SES foster care environment as child as having severe psychopathology and risk behaviors as measured by the CANS. Specially, less experienced social workers will rate the low SES foster care vignette as higher (indicating a need for intervention) on the following items:

- a. Oppositional behavior
- b. Antisocial behavior
- c. Temporal consistency of problems
- d. Danger to others

*Hypothesis #6a:* When previous treatment is the experimental variable, because of their knowledge of the child welfare system and various treatment options, more experienced social workers will be more likely to recommend the child who has received

SOC/wraparound treatment for placement in residential care than the child who has not received SOC/wraparound treatment. After the experienced child welfare social workers read that SOC/wraparound treatment has been tried unsuccessfully, they will be more likely to recommend a more restrictive placement. Less experienced social workers will not be affected by this variable.



*Hypothesis #6b:* When previous treatment is the experimentally manipulated variable, more experienced social workers will be more likely to rate the child who has received previous SOC/wraparound treatment as having severe psychopathology and risk behaviors as measured by the CANS. Specially, more experienced social workers will rate the previous SOC/wraparound treatment vignette as higher (indicating a need for intervention) on the following items:

- a. Oppositional behavior
- b. Antisocial behavior
- c. Temporal consistency of problems
- d. Danger to others

## CHAPTER 4

### METHODS

#### *Participants*

##### *The National Association of Social Workers (NASW) Illinois Chapter*

Participants in this study were recruited from the membership database of the Illinois chapter of the National Association of Social Workers (NASW). There are 8,100 members of the NASW Illinois chapter. Members of NASW can choose to indicate that they specialize in a particular field; 972 members (12%) indicated that they specialized in child/family welfare, 2,211 members (27.3%) indicated that they specialized in another field (i.e., school social work, health, mental health), and the remaining 4,917 members (60.7%) did not indicate an area of specialty. The NASW does not provide information about the number of members specializing in child/family welfare who make placement decisions, however; participants were asked about this variable in the study.

##### *Study Recruitment*

Institutional Review Board approval for this study was obtained from the Committee for Protection of Human Subjects at Loyola University Chicago. One-thousand licensed clinical social workers in the state of Illinois who are members of the National Association of Social Workers (NASW) were recruited for participation in this study out of a total of 8,100 members of the NASW Illinois Chapter (12.3%). The study

oversampled for social workers who indicated specialization in child/family welfare. Five hundred social workers who specialized in child/family welfare were randomly selected for solicitation to participate (51.4% of those who indicated the child/family welfare specialization), and five hundred social workers who specialized in other areas or did not indicate a specialization were randomly selected for solicitation to participate (7% of the remaining population of Illinois NASW social workers). Because a large portion of members did not indicate a specialty, it is likely that some of the members who were randomly selected for inclusion from the non-child welfare specialty still work in child welfare. Demographic information of the participants, including age, length of time at job, and experience with child welfare (including experiences making placement decisions), and response rate details were collected. Based on previous research utilizing a similar design with a similar group of professionals, the response rate was anticipated to be around 30-40% (Dillman, 2000; Stevanovic & Rupert, 2004). This would yield an expected sample of around 300 to 400 professionals.

### *Materials and Design*

#### *Introductory Letter*

An introductory letter was mailed to the potential participants. The letter explained to the potential participants that they would be receiving a short survey in a couple of days, provided a brief summary of the project, and explained how participants were selected for inclusion. The introductory letter is included in Appendix A.

### *Cover Letter of Study*

Four days after the mailing of the introductory letter, the potential participants received the second mailing. The second mailing consisted of a cover letter, the vignette, the questionnaire, and a self-addressed stamped envelope. The cover letter functioned as a de facto informed consent. It indicated that the purpose of the study was to assess how social workers and other professionals made judgments regarding placement. The cover letter stated that the study would take around five minutes to complete and that there are no known risks inherent in participation. In addition, it noted that it is acceptable if the professional has little experience in child welfare and/or making placement decisions, and that experience in decision making was one of the variables to be studied. The consent ensured that the participants remain anonymous and that the questionnaires and return envelopes would be destroyed once the study was completed. Participants were instructed to return the survey in the prepaid envelope. Contact information for the study coordinator was also provided. Although the participants were thanked for their time, an incentive was utilized in the present study (see the discussion for more information about the use of incentives in survey research). The cover letter is included in Appendix A.

### *The Vignette*

The study consisted of a single vignette with three experimentally manipulated variables, resulting in a total of eight randomly assigned conditions (see Table 3). The full vignette, with all of the possible experimentally manipulated conditions, is reproduced in Appendix B. As discussed previously, subjects were randomly assigned to



a condition. The experimentally manipulated, independent variables were race of the child (African American vs. Caucasian), foster care family (Low SES Foster Care Environment vs. High SES Foster Care Environment), and community-treatment (SOC/wraparound services vs. treatment as usual). All other clinical and demographic information were held constant throughout the conditions. Using this format, if significant differences in the dependent variables were obtained between conditions, the evidence would strongly suggest that the experimentally manipulated variable caused the difference.

The vignette was constructed based on the recommendations provided by Taylor (2006) in an article on using vignettes to study professional judgment in social work. These recommendations include using true-to-life case scenarios, randomly assigning the independent variable (the experimentally manipulated variables) and removing any unrealistic scenarios. The vignette was carefully designed to be similar to a scenario involving placement decisions that child welfare professionals have to make on a daily basis. Prior to the construction of the vignette, a casebook on placement decisions was consulted (Brown, 2002). The vignette is an amalgamation from the various cases presented in the child welfare casebook, combined with new details regarding the experimentally manipulated variables. Following completion of the initial draft and prior to the distribution of the questionnaire to the participants, several experts in child welfare, including clinical psychology professors, practicing social workers, and a DCFS contract

worker reviewed the vignette and provided additional feedback to the author about the realism of the scenario.

Each participant in the study received a single vignette. Multiple vignettes were not utilized because previous research has indicated that if different characteristics are systematically manipulated in multiple scenarios in decision making research, respondents are likely to use the information systemically. However, in real world decision making situations, decision makers often use a simpler, heuristic strategy that is not well represented by decisions ascertained from the multiple scenario studies (Konecni & Ebbesen, 1982). For example, in a study assessing decisions of judges using multiple vignettes, the judges utilized all of the information that was manipulated between vignettes in a simulation study, however; for real decisions they typically only used the recommendations of the prosecuting attorney (Konecni & Ebbesen, 1982). Because the present study attempts to best replicate the processes in which social workers make decisions in real world situations, the single vignette strategy was utilized. In addition, multiple detailed vignettes would increase the amount of time necessary to complete the study, thus risking a reduction in potential participants.

#### *Placement Questions Following the Vignette*

After reading the vignette, participants were asked a series of questions (see Appendix C). The central dependent variable was placement option. This variable was a dichotomous option, either residential placement or community placement. The options indicated are both out-of-home placements, as opposed to return to biological parent.

The dichotomous option was utilized because it was considered to be a realistic decision making paradigm. Child welfare professionals would be less likely to decide between multiple placement options with wide ranging levels of restrictiveness (psychiatric hospitalization, residential care, treatment foster care, foster care, etc.) for one particular case. Instead, it is far more likely that the decision would be between two different levels within the continuum of restrictiveness. In addition, it was hypothesized that individuals with little child welfare experience would likely not know the differences between the more specific levels of care (i.e., treatment foster care, wraparound care, etc.); therefore, including the specific levels of care would be inappropriate for this study. Participants were also asked to rank on a 0-100 scale the need for this child to be placed in a residential, as opposed to clinical setting. In addition, they were asked "what else would you need to know before making this decision?" This question was open ended and was designed to gather qualitative feedback.

#### *The Child and Adolescent Needs and Strengths (CANS)*

After reading the vignette and completing the placement recommendation, participants were asked to complete a portion of the Child and Adolescent Needs and Strengths measure for the hypothetical child in the vignette (CANS; Lyons, 1999; see Appendix C). The CANS was created to assess clinical and environmental factors related to adolescent development. The CANS instrument evaluates the needs and strengths of a child or adolescent across multiple domains and is used as an assessment, decision-support and outcome measure instrument (State of Illinois DCFS, 2003). The full version

of the CANS consists of 44 dimensions across six factors; symptoms, risk factors, functioning, care intensity & organization, placement/system factors (caregiver needs and strengths), and child strengths (Buddin Pread Foundation, 2008). However, in the present study only the dimensions relevant to the vignette were included. The complete CANS item pool and the specific items that were included in the present study are listed in Appendix C.

On the CANS ratings for each particular item are based on a 0 to 3 scale. Across all dimensions, a score of 0 indicates no need for action, a 1 indicates the need for watchful waiting to see whether action is warranted, a 2 indicates need for action, and a 3 indicates the need for immediate or intensive action (see Appendix C for sample items). Detailed descriptions for what constitutes each numerical rating for each dimension are were provided to the individuals participating in the study. The CANS has been documented to be a reliable and valid measure (Lyons et al., 1999) It is a useful tool for predicting the level of care that a child is placed in and is correlated with another measure of child outcomes (the Child and Adolescent Functional Assessment Survey: CAFAS; Hodges, McKnew, Cytryn, Stern, & Klein, 1982). The CANS is an ideal outcome measurement for the current study because the multiple factors assess variables related to the child, such as psychopathology and dangerousness, and variables related to placement, caregiver, and present environment.

### *Demographic Information of the Participants*

Lastly, the participants were asked demographic information including questions regarding their experience with child welfare and placement decisions (see Appendix B). The demographic information includes gender, age, and ethnic background. The section also contained professional/work related questions about the respondent's specialty area, credentials, length of time at their present job, length of time as a social worker, and type of work setting. The participants were asked if they ever were directly responsible for making placement decisions in child welfare, and, if so, how many such decisions they have made. Finally, the participants were asked if they ever worked for the Department of Child and Family Services (DCFS) and, if so, for how many years.

### *Reminder Postcard*

Two weeks after mailing the questionnaire, a reminder postcard was sent to all of the participants (as it was not possible to know which individuals had returned the survey). The postcard is included in Appendix A.

### *Procedure*

The survey employed the Tailored Design Method (Dillman, 2000) to ensure an effective survey implementation procedure and maximize the rate of participation from all potential participants. The method utilizes multiple contacts in order to ensure maximum response rate. Numerous studies of mail surveys have demonstrated that multiple contacts are related to increased response rates (Dillman, 2000; Dillman, Clark & Sinclair, 1995; Kaplowitz, Hadlock, & Levine, 2004; Keegan & Lucas, 2005).

As discussed previously, the participants received three contacts; an introductory letter, the study, and a reminder postcard. The survey was mailed with a prepaid return envelope. The cover letter explained the purposes of the study and noted that the participants are guaranteed anonymity. Participants were instructed to return the survey in the prepaid envelope. A reminder postcard was sent to all of the social workers two weeks after mailing the survey. After data from all of the respondents was entered into SPSS 16.0 for statistical analysis, the mailing labels were destroyed in order to ensure complete anonymity.

The appropriateness of the sample size of 1,000 was determined by conducting a sample size analysis using the GPower computer program (Steiger & Fouladi, 1992). As discussed previously, the sample was randomly assigned to one of the eight conditions (see Table 3). A sample size of 360, with 40 subjects per group, was necessary in order to obtain enough participants in each of the eight experimental conditions to detect an effect size of .25 and an alpha level of .05 (the standard medium effect size according to Cohen, 1992) for a three-way interaction. Given the study design (soliciting 1,000 participants) and assuming a 30-40% response rate, the minimum sample size of 360 for a three-way interaction was the goal. In the event that this sample size was not obtained, it is still likely that the sample size will be large enough to detect the presence or absence of main effects (race, SES, previous treatment, respondent demographics) and two-way interactions.

### *Data Analysis Plan*

The data analysis plan includes first examining descriptive statistics regarding the sample. This includes basic information such as age gender, race, number of years employed as a social worker and amount of experience in the field of child welfare. Based on the sampling procedures, it is expected that the sample will include a diverse range of experiences and expertise in the field of child welfare. Given the demographics of the Illinois NASW, it would also be expected that the sample be predominantly European-American, female, and work in the Chicago area. Descriptive statistics will also be gathered on placement decision, community vs. residential scale, and CANS ratings. Following the descriptive statistics, inferential statistics will be conducted examining the effects of the experimentally manipulated variables on placement decisions and examining the variables associated with the child welfare professional that completes the survey. The study design utilizes three experimentally manipulated variables in one vignette, therefore; the study is a 2X2X2 design. Cell sizes for each of the eight conditions will be reported in the results section.

Chi square tests will be utilized to test the main effect hypotheses involving the dichotomous placement outcome variable and the dichotomous experimentally manipulated independent variables (*Hypotheses #1a, #2a, #3a*). One-way analysis of variance tests (ANOVAs) will be conducted to test the main effect hypotheses involving the community vs. residential treatment scale and the experimentally manipulated

independent variables (*Hypotheses #1a, #2a, #3a*). ANOVAs will also be utilized to test the main effect hypotheses involving the CANS tool (*Hypotheses #1b, #2b, #2c, #3b*).

In order to analyze the research question assessing the relationship between experience and placement decision, first latent variable structural equation modeling will be used to combine the various measures of experience into a unidimensional model of experience.

Assuming this model fits, the influence of experience on placement decision will be tested using correlations and ANOVAs. The interaction hypotheses will be tested using logistic regression and chi square tests (for placement option as the outcome measure) (*Hypotheses #4a, #5a, #6a*) and ANOVAs (for CANS factors as the outcome measure) (*Hypotheses #4b, #5b, #6b*).



Table 3

*2X2X2 Factorial Design of the Study*

		Race			
		African American (A)		Caucasian (C)	
SOC/ Wraparound (S)	Previous Treatment	Condition 1	Condition 2	Condition 5	Condition 6
		A,S,U	A,S,L	C,S,U	C,S,L
Treatment as usual (T)		Condition 3	Condition 4	Condition 7	Condition 8
		A,T,U	A,T,L	C,T,U	C,T,L
		Upper Class (U)	Lower Class (L)	Upper Class (U)	Lower Class (L)
		Foster Care Environment		Foster Care Environment	

## CHAPTER 5

### RESULTS

#### *Response Rate*

One-thousand addresses of members in the National Association of Social Workers - Illinois Chapter were obtained from the organization. Two participants were excluded from the study because they participated in the development of the vignette, and one participant was excluded because he had collaborated extensively with the author on several clinical cases. Of the 997 surveys mailed to participants, 232 were returned (a response rate of 23.5%). This response rate was below the expected response rate based on previous studies utilizing a similar methodology (Kaplowitz, Hadlock, & Levine, 2004; Stevanovic & Rupert, 2004). Potential explanations regarding the low response rate will be presented in the discussion section. One survey was returned but not completed leaving a total of 231 surveys included in all data analyses. The numbers of participants across each of the eight conditions are presented in Table 4. The response rate did not differ based on the assigned experimental condition  $\chi^2(7, N = 231) = 3.49, p = ns$ .

### *Participant Demographics*

The sample was largely female ( $n = 198$ , 86.8%) and European-American ( $n = 194$ , 85.4%). Further ethnic breakdown was as follows; African-American ( $n = 12$ ; 5.3%), Biracial/Multiracial ( $n = 7$ ; 3.1%), Latino/a ( $n = 6$ ; 2.7%), Asian-American ( $n = 4$ ; 1.8%), Native-American ( $n = 1$ ; .4); Not Reported ( $n = 2$ ; .8%). The average age of the participants was 50.6 ( $SD = 15.3$ ), the median was 54, and the range was 24-80. Participants reported working in the following regional areas; Chicago suburbs ( $n = 99$ ; 43.4%), Chicago ( $n = 72$ ; 31.9%), Central Illinois ( $n = 26$ ; 11.5%), Southern Illinois ( $n = 8$ ; 3.5%), Out of State ( $n = 4$ ; 1.8%), Rockford Area ( $n = 4$ ; 1.8%), St. Louis Region ( $n = 4$ ; 1.8%), Other/unemployed/retired ( $n = 10$ ; 4.4%). The majority of participants reported their highest degree as an MSW/masters level degree (201; 88.1%), 19 participants (8.4%) possessed doctoral level degrees, and 7 participants (3.0%) reported that their highest degree was a BA/BS.

The participants reported an average of 21.1 years in the social work field ( $SD = 14.5$ ), and had been at their current jobs for an average of 9.4 years ( $SD = 10.3$ ). Ninety-one participants (39.9%) reported zero years experience in child welfare. Of those that had at least one year experience in child welfare, the mean was 15.0 years ( $SD = 14.0$ ). Information regarding social work specialization is presented in Table 5. Child welfare was the most commonly chosen specialization, with a little over 20% of the respondents indicating this specialization.

The majority of participants had never made a child welfare placement decision either in their career ( $n = 118$ ; 53.6%), or in the past year ( $n = 193$ ; 85.4%). The average number of career-to-date placement decisions made among the participants was 65.32 ( $SD = 221.4$ ); when just including individuals who had made at least one placement decision in their careers, the mean was 140.9, ( $SD = 309.1$ ). The average number of placement decisions made in the past year was 2.12 ( $SD = 10.8$ ); when just including individuals who had made at least one placement decision in the past year the mean was 14.55 ( $SD = 25.26$ ). Ten participants (4.4%) were currently working for DCFS, 26 (11.4%) had worked for DCFS in the past, and the remainder ( $n = 192$ ; 84.2%) had never worked for DCFS.

#### *Survey Results: Descriptive Statistics*

##### *Community vs. Residential*

For the dichotomous dependent variable (recommend community versus residential placement), participants were almost equally likely to choose the community option (106 participants; 49.8% of the valid responses) as the residential care option (108 participants; 50.2%). Fifteen participants (6.5%) did not choose a placement setting option, despite completing the other questions in the survey. For the continuous dependent variable, "using a 0-100 scale, indicate the need that Shawn has for a residential versus a community placement" variation again emerged across participants; the mean for this item was 60.4 ( $SD = 24.6$ ) and the range was zero to 100. The effects

of the experimental manipulation of the independent variables on placement decision, both dichotomous and continuous, are presented below.

#### *Child and Adolescent Needs and Strengths (CANS)*

Ratings for the CANS across the entire sample are presented in Table 6. On average, participants rated Shawn as having significant problems across several domains, including oppositional behavior and the danger to others variables. Several of the respondents indicated that they did not have sufficient information to complete the supervision (29 left blank; 12.7% of total sample) and involvement (26; 11.4%) questions.

#### *Survey Results: Research Questions*

##### *Research Question #1: Experimental Variable Hypotheses*

The first research question pertained to the influence of the three experimentally manipulated dichotomous variables (child race, foster family SES, prior SOC services) on placement decision and ratings of psychopathology, risk behaviors, and service delivery as measured by the CANS variables. Specific main effect hypotheses for each of the three experimentally manipulated variables influence on placement decision and CANS items were proposed (see Chapter 4). Chi square tests were used to test for significant differences in the dichotomous placement variable dependent on the dichotomous experimental manipulations; independent samples t-tests were used to test for significant differences in the continuous community versus residential scale dependent on the dichotomous experimental manipulations; and independent samples t-

tests were used to test for the significant differences in the CANS variables dependent on the dichotomous experimental manipulations.

*Hypothesis #1: The experimental manipulation of race.* Hypothesis #1 concerned the experimental manipulation of the race variable. The specific sub-hypotheses were that the African-American manipulation would be more likely to be recommended for placement in residential (*Hypothesis #1a*), would score higher on the community versus residential scale (*Hypothesis #1a*), and would have higher scores on CANS variables assessing psychopathology and risk behaviors (*Hypothesis #1b*).

The manipulation of race had no effect on the dichotomous placement decision  $\chi^2(1, N = 213) = .005, p = ns$ ; the African American was as likely to be recommended for residential treatment as was the European American (45.1% residential for the European American versus 47.9% residential for the African American, respectively). Similarly, the race manipulation had no effect on the continuous placement decision item (White  $M = 61.2, SD = 22.84, N = 107$ ; African-American  $M = 59.59, SD = 26.18, N = 111$ ) ( $t(216) = .472, p = ns$ ).

Most of the CANS variables assessing psychopathology and risk behaviors did not differ significantly depending on the experimental manipulation of race (Oppositional Behavior  $t(217) = -1.6, p = ns$ ., Antisocial Behavior  $t(219) = .297, p = ns$ ., Temporal Consistency  $t(150) = 1.8, p = ns$ , Danger to Others  $t(223) = .57, p = ns$ .). The exception was the Temporal Consistency of Problems variable. Respondents in the European American condition indicated that Shawn had displayed problems longer than

respondents in the African-American condition (Temporal Consistency White  $M = 2.59$ ,  $SD = .71$ ,  $N = 106$ ; Temporal Consistency African-American  $M = 2.37$ ,  $SD = .77$ ,  $N = 112$ ;  $t(216) = 2.2$ ,  $p < .05$ ). Overall, the results of the study failed to support the hypothesis that race of the child in the vignette is related to placement decision and ratings of clinical severity with the exception of the consistency of problems. However, respondents who received the vignette with the European American child rated the child as having problems for a longer period of time compared to respondents who received the vignette with the African-American.

*Hypothesis #2: The experimental manipulation of foster care SES.* Hypothesis #2 concerned the experimental manipulation of foster care SES. The specific sub-hypotheses were that the child with the low SES foster care environment would be more likely to be recommended for placement in residential (*Hypothesis #2a*), would score higher on the community versus residential scale (*Hypothesis #2a*), and would have higher scores on the CANS variables related to psychopathology and risk behaviors (*Hypothesis #2b*), and higher scores on the CANS variables related to service delivery (*Hypothesis #2c*).

Similarly to the race variable, the manipulation of foster family SES had no effect on the dichotomous placement decision  $\chi^2(1, N = 213) = .226$ ,  $p = ns$ ; the Low SES group was as likely to be recommended for treatment as was the High SES group (44.8% residential for the High SES group versus 48.0% residential for the Low SES group, respectively). The Low SES group scored slightly higher on the community vs.

residential continuous placement decision item, although this difference was not significant (High SES  $M = 58.6$ ,  $SD = 26.6$ ,  $N = 99$ ; Low SES  $M = 61.8$ ,  $SD = 22.7$ ,  $N = 119$ ) ( $t(216) = -.944$ ,  $p = ns.$ ).

None of the CANS variables assessing psychopathology and risk behaviors differed significantly depending on the experimental manipulation of foster care SES (Oppositional Behavior  $t(217) = -.09$ ,  $p = ns.$ , Antisocial Behavior  $t(219) = .19$ ,  $p = ns.$ , Temporal Consistency  $t(216) = -1.55$ ,  $p = ns$ , Danger to Others  $t(223) = -.77$ ,  $p = ns.$ ). However, as hypothesized, several of the CANS service delivery variables differed significantly depending on the manipulation of the foster care SES, with the group receiving the low-SES condition scoring higher on the following CANS variables (indicating more severe problems on these domains): Resources  $t(213) = -14.3$ ,  $p < .001.$ , Caregiver Involvement  $t(200) = -3.1$ ,  $p < .001.$ , Caregiver Supervision  $t(197) = -3.4$ ,  $p < .001$ , Inclusion  $t(213) = -2.5$ ,  $p < .05$ ). The two groups did not significantly differ on the Intensity and Organization of Monitoring variable  $t(223) = -1.3$ ,  $p < ns$  and on the Intensity and Organization of Treatment variable  $t(218) = .74$ ,  $p < ns$ . The results of the study failed to support the hypothesis that SES of the foster care family in the vignette is related to placement decision and ratings of clinical severity; although the study did provide substantial support for the hypothesis that SES of the foster care family is related to beliefs about the effectiveness of service delivery. Respondents who received the low SES foster care vignette rated the child as having more problems related to receiving services than the high SES foster care vignette.



*Hypothesis #3: The experimental manipulation of previous treatment.* Hypothesis

#3 concerned the experimental manipulation of the type of previous treatment that the child in the vignette received. The specific sub-hypotheses were that the child with previous SOC/wraparound treatment would be more likely to be recommended for placement in residential (*Hypothesis #3a*), would score higher on the community versus residential continuous scale (*Hypothesis #3a*), and would have higher scores on the CANS variables related to psychopathology and risk behaviors (*Hypothesis #3b*). In addition, it was hypothesized that the child who did not have previous SOC/wraparound treatment would have higher scores on the CANS variables related to service delivery (*Hypothesis #3c*).

As with the other independent variable manipulations, the manipulation of previous treatment had no effect on the dichotomous placement decision  $\chi^2(1, N = 151) = .005, p = ns$ ; the child that had previously received SOC services was as likely to be recommended for residential treatment as was the child that did not previously receive SOC services (46.5% residential for the group that previously received SOC services versus 46.6% residential for the group that did not previously receive SOC services, respectively). Participants who received the SOC/wraparound vignettes did rate the child as slightly more in need of residential care, although this difference was not significant (SOC  $M = 61.53, SD = 25.57, N = 107$ ; Non-SOC  $M = 59.23, SD = 23.6, N = 111$ ) ( $t(216) = .69, p = ns$ ).

Participants who received the SOC/wraparound vignette versus the non SOC vignette did not rate the child differently on any of the CANS variables assessing psychopathology/risk behaviors (Oppositional Behavior  $t(217) = 1.4, p < ns$ , Antisocial Behavior  $t(219) = .09, p = ns$ , Temporal Consistency  $t(216) = -.23, p = ns$ , Danger to Others  $t(223) = 1.0, p = ns$ ). As hypothesized, several of the CANS service delivery variables differed significantly depending on the manipulation of previous treatment, with the group not receiving previous SOC/wraparound treatment condition scoring higher on the following CANS variables (indicating more severe problems on these domains): Caregiver Involvement  $t(200) = -4.9, p < .001$ , Inclusion  $t(213) = -3.5, p < .001$ , and Resources  $t(213) = -1.93, p < .05$ ). The results of the study failed to support the hypothesis that receiving previous SOC/wraparound treatment is related to placement decision and levels of clinical severity; although the study did provide support for the hypothesis that previous SOC/wraparound treatment is related to beliefs about the effectiveness of service delivery. Respondents who received the treatment as usual (non-SOC/wraparound) vignette rated the child as having more problems related to receiving services than the SOC/wraparound vignette.

*Power analysis of three main effects.* Whenever a statistical test fails to find significance with a given sample, the question naturally arises as to whether low power explains the lack of statistical significance. If sample size is too small, then even large effects will be nonsignificant. Once a particular sample size has been obtained and a statistical test has revealed a lack of statistical significance, it is therefore important to

determine post hoc the smallest effect size for which the given sample size provides sufficient statistical power.

In the present study, Pearson chi-square tests revealed that race, SES, and previous treatment each had a nonsignificant relationship with respondents' decision about how to treat the child described in the experimental vignette. Accordingly, a retrospective (post hoc) power analysis was conducted using Power Analysis and Sample Size software (PASS; Hintze, 2006) in order to determine the smallest effect size for which the obtained sample size of 213 provides sufficient (i.e., 80%) power to detect at two-tailed  $p < .05$  using a Pearson chi-square test. Following Cohen's (1988) recommendations, the statistic  $W$  was used to quantify effect size, where  $w$  is defined as the square root of  $\chi^2/N$ . According to Cohen (1988),  $W \leq 0.1$  is considered small,  $W = 0.3$  is considered medium-sized, and  $W \geq 0.5$  is considered large.

Results revealed that the present sample size of 213 achieves 80% power to detect an effect size ( $W$ ) of 0.192 using a Pearson chi-square test with  $df = 1$  at two-tailed  $p < .05$ . The effect sizes observed for the three chi-square tests in the present study were 0.0048 for race, 0.0326 for SES, and 0.0048 for previous treatment. PASS software revealed that these effect sizes are so small that the sample size necessary to attain 80% power to detect them as statistically significant at two-tailed  $p < .05$  with a Pearson chi-square test is too large to calculate. Based on these findings, it seems reasonable to conclude that low statistical power does not explain the observed nonsignificant effects for race, SES, and previous treatment.

*Research Question #2: Professional Factors and Creating an Experience Score*

The second research question concerned the relationship between professional experience and placement decision. There were no specific a-priori hypotheses about the role of experience on placement. In the present study, experience was assessed in several ways, including: social work specialization, number of years worked in the social work field, number of years worked in child welfare, questions about making child welfare placement decisions, and whether the respondent has worked for DCFS. In total, the data set included 8 variables designed to assess the level of social workers' experience in making child welfare placement decisions. Of these 8 variables, 5 were measured using a continuous, equal-interval scale; number of years worked in the social work field, number of years worked at present job, number of years worked in child welfare, estimated number of child welfare placement decisions made during career, estimated number of child welfare decisions made in the past year; and 3 were measured using an ordinal scale that was either dichotomous (whether or not the respondent indicated a specialization in child welfare, whether or not the respondent had ever worked for the Illinois DCFS) or involved multiple responses—frequency of child welfare placement decisions (1 = never, 2 = occasionally, 3 = major part of current job).

Correlations were calculated to assess for the relationship between the experience variables with each other and each experience variable with the 0-100 placement decision scale. For the correlational analyses, and all subsequent analyses involving experience, the specialization variable was collapsed into a dichotomy (either child/family welfare or

other) and the DCFS variable was also collapsed into a dichotomy (either DCFS experience or no DCFS experience). Results of the correlational analysis are presented in Table 7. As expected, there were strong correlations between all of the experience variables. However, rating on the community vs. residential placement scale was not correlated with any of the individual experience variables. Although none of the relationships were significant, 7 out of the 8 experience variables were negatively correlated with the 0-100 scale. In other words, more experienced individuals tended to rate the respondent as less in need of residential services, although this relationship was nonsignificant.

*Creating an Experience Score.* The previous analysis provided initial evidence that the questions assessing respondent experience were highly correlated with each other. To investigate the influence of respondent experience in making child welfare placement, it was necessary to find a statistical means of capturing the variance that all 8 of these experience variables shared, to serve as a composite index of experience in subsequent analyses. Accordingly, latent variable structural equation modeling was used to evaluate the goodness-of-fit of a unidimensional model to the mixture of continuous and ordinal variables. To facilitate structural equation modeling, listwise deletion of cases with missing values was used to obtain a subset of cases ( $N=219$ ) from the original sample ( $N=231$ ) who had all valid responses to the set of 8 experience measures. The responses of these 219 social workers were then analyzed to construct a single composite summary measure of experience.

Following procedures recommended by Joreskog and Sorbom (1996a), robust diagonally-weighted least-squares estimation was used in LISREL to fit a one-factor confirmatory factor analysis model to responses to the eight experience variables. As an initial step in the analysis, PRELIS (Joreskog & Sorbom, 1996b) was used to compute a mixed matrix of continuous and ordinal correlations among the 8 experience variables. Specifically, Pearson correlations were used as measures of association among continuous variables. Polychoric correlations were used as measures of association (a) among noncontinuous ordered variables, (b) between continuous variables and noncontinuous ordered variables, (c) between noncontinuous ordered variables and dichotomous measures, and (d) among dichotomous variables. Polyserial correlations were used as measures of association between continuous and dichotomous variables. PRELIS was also used to compute the asymptotic covariance matrix for the 8 experience variables, in order to adjust observed correlations for bias due to nonnormality. The matrix of mixed continuous and ordinal correlations and the asymptotic covariance matrix were then both used as input for the one-factor confirmatory factor analysis.

Supporting the notion that all 8 experience variables measure the same underlying construct, results revealed that the hypothesized one-factor model provided an excellent fit to the data,  $\chi^2(20, N = 219) = 190.799$ , RMSEA = 0.00, GFI = .99, CFI = 1.00, NFI = 1.00. Factor loadings ranged from modest (.216 for number of years on the job) to large (.855 for number of placement decisions made in career) in magnitude, and all loadings were statistically significant. Squared multiple correlations for measured variables

ranged from .047 to .732, with a median value of .46, indicating the latent experience variable typically explained about half the variance in the measured variables. A factor reliability coefficient was computed (Bagozzi & Yi, 1988; Werts, Linn, & Joreskog, 1974) to assess the degree of internally consistency reliability for the composite factor, yielding a value of .784. This reliability coefficient indicates that the single latent experience variable, which represents the variance that the 8 experience variables have in common, is reasonably reliable.

Accordingly, LISREL was used to write individual factor scores on the latent experience variable to an external file, which was then merged with the SPSS data file in order to add the latent experience scores to the data set. Latent experience scores ( $N = 219$ ) were then standardized and saved for subsequent analysis. Not surprisingly, latent experience scores showed a high degree of positive skewness (skewness value = 4.843), largely reflecting a single respondent who reported an extremely high level of experience ( $z = +8.256$ ) relative to other respondents. Because the presence of outliers in the data can distort results, it was decided to run analyses of experience effects twice, once including all cases ( $N = 219$ ), and once removing this extreme outlier, in order to examine the effects of the extreme case on obtained results.

#### *Multivariate Analyses to Examine Effects of Experience, Experimental Variables, and Interactions*

Following the creation of a latent experience variable, logistic and linear regressions were conducted to assess for the influence of experience on placement

decision (*Research Question #2*), and the interaction of experience and the experimental variables on placement decision (*Research Question #3*). In addition, interactions between the experimental variables were also assessed using this methodology (*Research Question #1*). Methods for testing the multi-layered influences of experimental categorical variables include multiple chi-square analyses and logistic regression (for a comparison of the two methods see Witta, 1997). The advantage of the logistic regression methodology, as opposed to multiple chi-squared tests, is an ability to directly test an interaction effect, as opposed to having to compare multiple significance tests with no direct method of assessing higher order interactions (Witta, 1997). Because of this reason, a logistic regression was utilized to assess the influence of the predictor variables on the dichotomous placement decision. A linear regression was utilized to assess the influence of the predictor variables on the continuous 0-100 placement scale.

In addition, because respondents should have considered clinical factors (psychopathology, risk behaviors, etc.) when making placement decision, the 10 CANS variables were also included as predictor variables in the regressions.

*Logistic Regression.* A stepwise logistic regression was conducted to assess for the influence of several variables on dichotomous placement decision. The variables included in the logistic regression were the three experimental variables (race, foster-family SES, and previous treatment), the interactions between each of these three variables (race X SES, race X previous treatment, SES X previous treatment, and race X SES X previous treatment), the latent experience factor score, the interaction of



experience and each of the experimental variables (race X experience, SES X experience, previous treatment X experience), and the 10 CANS items (oppositional behavior, antisocial behavior, temporal consistency of problems, danger to others, monitoring, treatment, supervision, involvement, resources, and inclusion).

The results of the logistic regression are presented in Table 8. The CANS variables, oppositional behavior, caregiver monitoring, and caregiver supervision were significant predictors of placement decision, but the other variables were not significantly related to respondents' placement decision, and thus were not included in the regression equation. For every one unit increase in oppositional behavior rating, the odds of residential increased by a factor of 4.1; for every one unit increase in caregiver monitoring rating, the odds of residential increased by a factor of 2.1; and for every one unit increase in supervision rating, the odds of residential increased by a factor of 2.0.

The results of the logistic regression do not provide support for a significant relationship between experience and dichotomous placement decision (*Research Question #2*), or an interaction between experience and the experimentally manipulated variables on placement decision (*Research Question #3*). However, the results provide initial evidence that the CANS variables are associated with placement decision.

*Linear Regression.* A stepwise linear regression was conducted to assess for the influence of several variables on the continuous dependent variables ("using a 0-100 scale, indicate the need that Shawn has for a residential versus a community placement").

The variables included in the linear regression were the same as those included in the logistic regression.

The results of the linear regression are presented in Table 9. The CANS variables, Danger to others, Antisocial behavior, and Supervision were significant predictors of placement decision, but the other variables were not significantly related to respondents' placement decision, and thus were not included in the regression equation.

The results of the linear regression do not provide support for a significant relationship between experience and the continuous placement decision (*Research Question #2*), or an interaction between experience and the experimentally manipulated variables on placement decision (*Research Question #3*). Similar to the logistic regression, the linear regression provides evidence that the CANS variables are associated with placement decision.

#### *Research Question #2 Summary*

As discussed above, the experience factor score was not significantly related to either placement decision variable. The variable was excluded in both regressions. Correlations were also calculated to assess for the relationship between the latent experience variable and ratings on the CANS variables. Although none of the CANS variables were significantly related to the experience variable, 9 of the 10 CANS variables were negatively correlated with the latent experience variables. In other words, more experienced individuals tended to rate the respondent as less in need of interventions as indicated by the CANS, although the relationship was nonsignificant.

In summary, the results of the analyses assessing professional factors/experience on placement decision and CANS ratings did not yield any statistically significant relationships between experience and respondent decision. Although there was some evidence that individuals that are more experienced in child welfare are more likely to rate the child as less in need of restrictive care and less in need of more intensive interventions, the results of these analyses were not statistically significant.

#### *Research Question #3 Summary*

The third research question postulated that there would be an interaction between respondent's experience and the experimentally manipulated variables (*Hypotheses #4a, #5a, #6a*) and ratings of child psychopathology (*Hypotheses #4b, #5b, #6b*). Specific interaction hypotheses for each of the three experimentally manipulated variables and respondent experience influence on placement decision and CANS items were proposed (see Chapter 4).

The aforementioned logistic and linear regression analyses did not yield any significant interactions. All of the interaction variables were excluded from both the linear and the logistic regressions. Thus, there is no evidence to suggest that the interaction of experience and the experimentally manipulated variables influenced placement decision (*Hypotheses #4a, #5a, #6a*).

In order to test the interaction of experience and race on CANS items (*Hypothesis #4b*), a regression was conducted to predict the 4 CANS items assessing psychopathology or risk behaviors from the race variable, the latent experience variable, and the interaction

between the race variable and the latent experience variable. None of the interaction terms were significant for the four dependent variables (Oppositional behavior  $\beta = -.12$ ,  $t = -1.1$ ,  $p = ns$ , Antisocial behavior  $\beta = .01$ ,  $t = .08$ ,  $p = ns$ , Temporal consistency of problems  $\beta = .01$ ,  $t = .86$ ,  $p = ns$ , Danger to others  $\beta = .08$ ,  $t = .73$ ,  $p = ns$ ). Overall, the results of the study failed to support the hypothesis that an interaction between the race of the child and respondent experience would significantly impact placement decision and CANS variables.

In order to test the interaction of experience and foster family SES on CANS items (*Hypothesis #5b*), a regression was conducted to predict the 4 CANS items assessing psychopathology or risk behaviors from the foster family variable, the latent experience variable, and the interaction between the foster family variable and the latent experience variable. None of the interaction terms were significant for the four dependent variables (Oppositional behavior  $\beta = -.07$ ,  $t = -.66$ ,  $p = ns$ , Antisocial behavior  $\beta = .06$ ,  $t = .50$ ,  $p = ns$ , Temporal consistency of problems  $\beta = .04$ ,  $t = .35$ ,  $p = ns$ , Danger to others  $\beta = .02$ ,  $t = .21$ ,  $p = ns$ ). Overall, the results of the study failed to support the hypothesis that an interaction between the foster family SES and respondent experience would significantly impact placement decision and CANS variables.

In order to test the interaction of experience and previous treatment on CANS items (*Hypothesis #6b*), a regression was conducted to predict the 4 CANS items assessing psychopathology or risk behaviors from the previous treatment variable, the latent experience variable, and the interaction between the previous treatment variable

and the latent experience variable. None of the interaction terms were significant for the four dependent variables (Oppositional behavior  $\beta = .01$ ,  $t = .05$ ,  $p = ns$ , Antisocial behavior  $\beta = -.02$ ,  $t = -.25$ ,  $p = ns$ , Temporal consistency of problems  $\beta = -.13$ ,  $t = -1.5$ ,  $p = ns$ , Danger to others  $\beta = -.05$ ,  $t = -.55$ ,  $p = ns$ ). Overall, the results of the study failed to support the hypothesis that an interaction between the previous treatment that the child has received and respondent experience would significantly impact placement decision and CANS variables.

### *Exploratory Analyses*

#### *CANS Variables and Placement Decision*

The logistic and linear regression analyses provide initial evidence that the CANS variables, and not the experimentally manipulated variables or experience, were the primary variables associated with placement decision. In order to further explore the relation between CANS items and placement decision, an ordinal correlation analysis was conducted utilizing all 10 CANS items and the 2 placement decision variables. Although a relation was not specifically proposed in the hypotheses, it would be expected that high CANS scores (indicating need for intensive action) would be associated with higher likelihood of residential placement. Polychoric correlations were computed to analyze the relation between the dichotomous placement decision and each of the 10 ordinal CANS variables, while polyserial correlations were computed between the continuous 0-100 placement scale and each of the 10 ordinal CANS variables. The analyses were conducted using listwise deletion of missing values, leaving only cases that had all valid

data in the analysis ( $N = 166$ ). Results for each of the ten CANS variables are presented in Table 10.

Overall, placement decision, both using the dichotomous and continuous measure, was strongly related to all of the symptomatology/risk behaviors CANS variables (oppositional behavior, antisocial behavior, temporal consistency of problems, and danger to self). Placement decision was related to some of the service delivery variables (monitoring, treatment, inclusion) but not others (involvement, resources). The supervision variable displayed some evidence of being related to placement decision although the supervision variable was not related to the 0-100 scale. The results of these analyses provide further evidence that respondents were considering clinical factors when making the placement decision.

Table 4

*Number of Participants across the Experimental Conditions (N = 231)*

		Race			
		African American (A)		Caucasian (C)	
SOC/ Wraparound (S)	Condition 1	Condition 2	Condition 5	Condition 6	
	<i>N</i> = 28 (12.1%)	<i>N</i> = 34 (14.7%)	<i>N</i> = 26 (11.3%)	<i>N</i> = 27 (11.7%)	
Previous Treatment Treatment as usual (T)	Condition 3	Condition 4	Condition 7	Condition 8	
	<i>N</i> = 25 (10.8%)	<i>N</i> = 30 (13.0%)	<i>N</i> = 26 (11.3%)	<i>N</i> = 35 (15.2%)	
		Upper Class (U)	Lower Class (L)	Upper Class (U)	Lower Class (L)
		Foster Care Environment		Foster Care Environment	

Table 5

*Participant Specialization*

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<u>Specialization</u>	<u>N</u>	<u>% of Total</u>
Child welfare	46	20.2%
School social work	44	19.3%
Adult mental health	41	18.0%
Child mental health	31	13.6%
Health	14	6.1%
Adult & child mental health	11	4.8%
Other/None	41	17.9%



Table 6

*Child and Adolescent Needs and Strength (CANS) Results*


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<u>CANS Question</u>	<i>M</i>	<i>SD</i>	<i>N</i>
Oppositional behavior	2.18	.54	219
Antisocial behavior	2.15	.66	221
Temporal consistency	2.48	.75	218
Danger to others	2.22	.47	225
Monitoring	1.74	.67	225
Treatment	2.27	.55	220
Supervision	.84	.68	199
Involvement	.98	.68	202
Resources	1.72	1.0	215
Inclusion	1.95	.70	215

Table 7

*Correlational Analysis between Experience Variables and Placement Decision Scale*

	SW	CJ	CW	D	C	PY	DCFS	Spec	Scale
Yrs. in social work	----	.64*	.54*	.34*	.25*	.14 <sup>^</sup>	.17 <sup>^</sup>	.13	-.05
Yrs. at current job		---	.31*	.16 <sup>^</sup>	.14 <sup>^</sup>	.07	.12	.11	-.06
Yrs. in child welfare			---	.49*	.41*	.29*	.33*	.48*	-.07
Decisions (1-3 ordinal)				---	.44*	.35*	.39*	.40*	-.06
Career decisions					---	.48*	.27*	.42*	-.08
Past year decisions						---	.10	.14*	.01
Illinois DCFS							---	.39*	-.03
Specialization								---	-.12

\*  $p < .001$ . <sup>^</sup>  $p < .05$

Table 8

*Summary of Stepwise Logistic Regression Analysis for Predicting Placement Decision*

Predictor	<i>B</i>	<i>SE B</i>	<i>e<sup>B</sup></i>
Variables in the equation			
Oppositional behavior	1.41***	.41	4.1
Monitoring	.74**	.29	2.1
Supervision	.68*	.28	2.0
Constant	-4.73		
$\chi^2$	31.99		
<i>df</i>	3		

*Note:* variables included in the analysis that were not included in the stepwise logistic regression include Race, SES, SOC/previous treatment, Race X SES, Race X SOC, SES X SOC, Race X SES X SOC, Experience, Race X Experience, SES X Experience, SOC X Experience, Antisocial, Temporal consistency, Danger to others, Treatment, Involvement, Resources, and Inclusion

$\underline{e^B}$  = exponentiated *B*

\*  $p < .05$ , \*\*  $p < .01$ , \*\*\*  $p < .001$

Table 9

*Summary of Stepwise Linear Regression Analysis for Predicting Placement Decision*


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Predictor	<i>B</i>	<i>SE B</i>	$\beta$	<i>t</i>
Variables in the equation				
Danger to others	12.31	3.9	.24	3.1***
Antisocial behavior	7.55	2.9	.20	2.6**
Supervision	6.1	2.6	.17	2.3*
Constant	11.75	9.8		
$R^2$	.14			

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*Note:* variables included in the analysis that were not included in the stepwise linear regression include Race, SES, SOC/previous treatment, Race X SES, Race X SOC, SES X SOC, Race X SES X SOC, Experience, Race X Experience, SES X Experience, SOC X Experience, Oppositional behavior, Temporal consistency, Monitoring, Treatment, Involvement, Resources, and Inclusion

\*  $p < .05$ , \*\*  $p < .01$ , \*\*\*  $p < .001$

Table 10

*Polyserial and Polychoric Correlational Analysis between CANS Variables and Placement Decision*

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	Dichotomous Placement Decision	0-100 Scale <sup>^</sup>
Oppositional behavior	.47*	.30*
Antisocial behavior	.39*	.29*
Temporal consistency	.27*	.14*
Danger to self	.31*	.37*
Monitoring	.39*	.28*
Treatment	.38*	.28*
Supervision	.25*	.06
Involvement	-.03	-.05
Resources	.07	.03
Inclusion	.20*	.16*

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\*  $p < .01$

<sup>^</sup> Dichotomous placement decision correlations are polychoric correlations; 0-100 scale correlations as polyserial correlations

## CHAPTER 5

### DISCUSSION

The purpose of the present study was to assess the influence of several factors on placement decision in a sample of social workers. Both factors related to the child (i.e., demographic and clinical variables) and factors related to the provider (i.e., experience, specialization within social work) were studied. Nine-hundred ninety seven members of the National Association of Social Workers – Illinois Chapter were mailed a vignette and a brief questionnaire. The vignette described a hypothetical child with a history of emotional and behavioral disturbances. Three details were experimentally manipulated in the vignette; the race of the child (African-American or White), the socio-economic status of the child's foster care family (high SES or low SES), and the previous treatment that the child had received (system of care (SOC)/wraparound treatment vs. treatment as usual). After reading the vignette, respondents were asked to indicate a preference for placement (either community care or residential care), and asked to rate on a 0-100 scale the child's need for residential services. They were also asked questions about the child's psychopathology, risk behaviors, and whether the services he was provided met his needs. Finally, they were asked several questions about their demographics and work

experience. Specific hypotheses regarding the influence of the experimentally manipulated variables and the respondents experience were proposed by the researchers (see Chapter 3 for more detail). Two-hundred thirty two surveys were returned (a response rate of 23.5%).

The sample demographics were similar in most respects to the overall population of Illinois NASW members. Respondents were largely female (86.8%), European American (85.4%), and worked in Chicago or the Chicago suburbs (75.3%). Although the study author attempted to oversample for individuals in the child welfare sphere, only 20.2% of the respondents indicated that they specialized in child welfare. This is a significant difference from the 50% split between child welfare specialists and other social workers solicited for participation. Therefore, it is possible that child welfare specialists were less likely to return the surveys than other types of social workers. It is also possible that due to the differences in the way that the specialization question was posed to the respondents, social workers who had earlier indicated a specialization of child welfare to the chapter did not indicate this specialization in the present survey. A final possibility is that the mailing list conditions requested by the researcher (i.e., 50% child welfare specialists and 50% other specialists) were not met by the Illinois NASW.

The discussion will first focus on the results of the placement decision across the entire study. Next, the influence of the experimentally manipulated variables, respondent experience, and CANS variables will be reviewed. A summary of the hypotheses and whether they were supported is presented in Table 11 and will be referred to throughout

the section. The discussion ends with a summary of the limitations of the study and suggestions for future research.

### *Community vs. Residential Placement*

Across the entire sample, social workers were almost evenly split in their placement preference (108 for residential and 106 for community), and the results of the community vs. residential 0-100 scale also demonstrated substantial variability. If the assumption is made that the vignette developed for the study had appropriate external validity, then the significant variability in placement decision opinions made by the participants may indicate that professionals in the field vary in their real-world decision-making as well. However, as will be discussed further, respondents who rated the child as more problematic on several CANS items were more likely to recommend a more intensive placement, indicating that placement decisions are driven by a professional's perceptions, and possibly less by differences of opinion about the criteria by which placement decisions are made.

Given the variability in placement decision-making found across the participants, the results suggest that the vignette contained a sufficient amount of uncertainty that the respondent had to consider when making the placement decision. In the face of uncertainty, biases (i.e. race and SES) and mitigating variables (i.e. caregiver variables, comorbidities) should have a more pronounced impact on decisions (Kahneman, Slovic, & Tversky, 1982; Tversky & Kahneman, 2005). The social psychology literature on decision making indicates that people rely on a limited number of heuristic principles



which may contain bias when assessing probability and predicting uncertainty. For example, the representativeness heuristic suggests that people make decisions based on how representative the uncertain stimulus or situation is to other stimuli or situations. For instance, if Jason was described as being 7 feet tall and athletic and respondents were asked to guess what his profession was based on the preceding description they might answer “professional basketball player” based on his description being representative of the stereotype of a basketball player. In the study vignette, if respondents were biased, they may have relied on what they assumed to be representative characteristics of youth involved in residential or community care. Perhaps this would be based on demographic information or other extraneous variables. Decision makers are often insensitive to prior probability of outcomes (Tversky & Kahneman, 2005). Therefore, even though social workers may be aware that more children are placed into community-based treatments, they may not actively utilize this knowledge when speculating about individual placement decisions. Despite these biases in assumptions, as will be discussed further, the manipulated demographic and previous treatment variables had no effect on placement decision. The variables that had a significant influence on placement decision were related to the psychopathology of the child and caregiver factors (as assessed by the CANS).

The high variability in respondents’ placement decision-making suggests that the vignette was ideally constructed for the purposes of this study. A result strongly favoring one option over the other (i.e., a substantial majority of respondents choosing either

community or residential care) would have made it harder to unearth an effect associated with the manipulations. Although the vignette had not been used in previous studies, several experts in the field of child welfare and social work provided input regarding the vignette's content. The purpose of the vignette, to present a case in which respondents would be presented with a difficult placement decision, was successfully achieved (one respondent even emailed the experimenter stating that after she completed the study she had shared the vignette for training purposes with a group of social workers who work for DCFS and are working toward licensure).

#### *Experimentally Manipulated Variables*

Three variables were experimentally manipulated by the researcher (race, foster family SES, and previous treatment). These variables were hypothesized to influence placement decisions. The results of the study indicate that none of the variables were related to dichotomous placement decision (see Table 11). In fact, for race and previous treatment, the decision was almost completely identical between the different conditions (chi square values of .005 for each, indicating almost no difference). Only the SES variable displayed any difference (with individuals receiving the low-SES condition slightly favoring residential), and this difference was not large enough to be statistically significant. Differences between the experimentally manipulated conditions on the 0-100 community versus residential scale were also nonsignificant (with the groups differing by no more than 3 points among the experimentally manipulated variables). Contrary to the proposed hypotheses, there is no evidence to suggest any main effects for the

experimentally manipulated variables on placement decision (*Hypotheses #1a, #2a, #3a*).

In addition, although no specific a-priori hypotheses regarding interactions between the experimentally manipulated variables were made, the results of the study do not provide evidence to suggest that there were any interactions between the three variables that influenced placement decision.

### *Race*

Overall, the experimental manipulation of race was not related to placement decision in any way. Although overt forms of racial prejudice are decreasing due to social norms, many people who report being low in racial prejudice show bias on responses that measure areas that are not as amenable to control (Devine et al., 2002). From the social psychology and criminology literature, there is substantial evidence to suggest for racial biases in decision making in areas such as getting stopped by the police while driving (Warren et al., 2006), belief in whether an individual is carrying a weapon (Bishara & Payne, 2009; Payne, 2006), and identifying criminal offenders (Dabney, Dugan, Topalli, & Hollinger, 2006). Devine and colleagues (2002) conducted several studies in which they assessed for implicit bias toward African Americans using priming tasks. They found that individuals that had high levels of internal motivation and low levels of external motivation were most effective at controlling race bias, even on difficult-to-control responses (i.e., questions assessing implicit bias). Given social work's emphasis on social justice and reducing inequalities, perhaps individuals that are attracted to the social work profession are more likely to display high levels of internal

motivation for controlling biases and prejudices and thus be less susceptible to the race manipulation in the present study.

Social psychology research on biases and stereotyping has often demonstrated the importance of race and ethnicity on judgment; the research assessing the influence of race on placement has also suggested that race plays a significant role in child welfare placement. However, much of the previous research has assessed length of stay within placements as opposed to placement decision (e.g., Glisson et al., 2000; Finch et al., 1986; Jenkins & Diamond, 1985; McMurtry & Lie, 1992). The majority of research that has found effects for race on placement decision was conducted utilizing retrospective reviews that could be subject to confounding variables including diagnosis, SES, and family factors. Despite these retrospective reviews, the present study suggests that race does not play a role in placement decision within child welfare. This evidence should surely be interpreted as positive news for professionals, families, and stakeholders in the field of child welfare.

#### *SES of the Foster Family*

Compared to race, there has been less research conducted on the influence of the other two experimentally manipulated variables, foster family SES and previous system-of-care treatment, on placement decision. One study found that SES of the biological family was significantly related to placement decision (remaining in the child welfare system vs. returning to the biological family) (Lindsey, 1991); however, there is little research on the SES of the foster family. This study suggests that SES does not play a

role in placement decision, but, as will be discussed below, does play a role in beliefs about the caregiver and the quality of services that the child is receiving.

### *SOC/Previous Treatment*

The results are similar for the third experimentally manipulated variable, the influence of SOC/wraparound treatment. No effects for placement decision were obtained, but whether the child had received SOC treatment influenced respondent beliefs about service delivery, the caregiver, and the quality of services. The present study offers initial evidence that foster family socio-economic standing and whether the child has ever received system-of-care services are unrelated to placement decision.

The lack of a relationship between SOC/wraparound treatment and placement decision is interesting because it would be expected that respondents that read that the child had already received intensive community services and was still having difficulty would be more likely to opt for more intensive placement. System-of-care/wraparound services are the current “gold standard” of intensive community-based placement options for children and adolescents in foster care (Stroul & Friedman, 1994). Perhaps the individuals in this sample were not familiar with the SOC model and the implications of the child in the vignette having already received intensive community services. However, the experience variable also did not predict placement decision or moderate the relationship between race and placement decision. The results suggest that social workers would benefit from an increased knowledge of more intensive forms of community-based placement and the purpose that these models of treatment serve. Of

course, it cannot be ruled out that the manipulation was not strong enough to produce the desired effect or that there was a methodological flaw in the creation of the SOC/previous treatment condition. However, the manipulation of SOC/previous treatment did produce significant effects on several of the CANS variables.

#### *Relationship of Experimentally Manipulated Variables to CANS Ratings*

In addition to questions related to placement decision, a subset of CANS items was included in the questionnaire. These items were related to psychopathology, risk factors, service delivery needs, and caregiver strengths/capacity. The experimentally manipulated variables were hypothesized to be related to psychopathology and risk factors. Respondents rated the European-American vignette as having problems over a longer period of time than the African-American vignette, although they did not differ on any of the other psychopathology variables based on race (*Hypothesis #1b*). The reason for the relationship between the race variable and length of problems existing is unclear. Because the effect was small, many tests were run, and the previous literature utilizing the CANS has not found an effect for race on temporal consistency of problems (Griffin, Martinovich, Gawron, & Lyons, 2009; Sieracki et al., 2008), it is possible that this effect was due to chance (i.e., a Type I error). The likelihood of a Type I error is further supported by the fact that neither of the other experimentally manipulated variables was related to any psychopathology and risk factor CANS items (*Hypotheses #2b & #3b*).

Although the experimentally manipulated variables had little impact on placement decision and psychopathology and risk factor ratings, the variables did significantly

influence ratings of service delivery needs and caregiver strengths/capacity. (*Hypotheses #2c & #3c*). Foster care SES and previous treatment were hypothesized to influence caregiver capacity item scores on the CANS. The results provide evidence in support of this relationship.

The low-SES foster care condition had higher scores on the resources, caregiver involvement, caregiver supervision, and inclusion items, suggesting that the respondents believed that these families had fewer resources, less involvement, less supervision, and less involvement with the community. Although the poor family condition likely has less access to resources than many foster families, thus justifying a significant difference on this variable, no information was given in the vignette to suggest that they would have less caregiver involvement, supervision, or community involvement compared to other foster families. Therefore, this study offers evidence that social workers may make assumptions about foster families capabilities based on their socioeconomic status. Previously, the study of SES in child welfare placement decisions has almost exclusively been confined to the status of the biological parents (Berger, 2006; Hansen et al., 2004; Wells & Guo, 2006). An undeniable relationship exists between the SES of the biological family and likelihood of being involved in the child welfare system (Drake & Zuravin, 1998). The simplest explanation for this relationship is that rates of abuse and neglect are higher amongst individuals from low-SES backgrounds. However, several writers have argued that the system is biased toward identifying abuse and neglect in low-SES as opposed to high-SES families (Drake & Zuravin, 1998; Finhelhor & Baron,

1986). The social psychology literature also suggests many examples of bias against individuals from low-SES backgrounds in situations such as legal decision making (Espinoza & Willis-Esqueda, 2008) and criminal sentencing (Wu, Cernkovich, & Dunn, 1997). The present study is another example of bias against individuals from low-SES backgrounds, and suggests that child welfare decision makers may be more likely to believe that poor foster care families are less capable than wealthier families.

The treatment as usual (non SOC/wraparound) condition had higher scores on the resources, caregiver involvement, and inclusion items. These CANS items are not directly related to previous treatment per se. Perhaps the respondents in the SOC condition believed that the caregiver had higher resources due to the child's involvement in more coordinated care. These children may also be viewed as more involved in their communities, as SOC treatment is community-based care. It is also likely that a foster parent involved in SOC/wraparound treatment will be more involved in care, as a central tenet to the SOC model is treatment caregivers as full partners in treatment (Stroul & Friedman, 1986).

The significant findings related to the experimentally manipulated variables of foster family SES and previous treatment suggest that these manipulations were strong enough to make a difference in the answers of the respondents. These significant findings provide more credence to the conclusion that the experimentally manipulated variables did not influence placement decision making, as opposed to the idea that the manipulation was simply not strong enough to take effect.



*Variables Related to the Respondent: Experience*

In addition to the experimentally manipulated variables, the study also assessed the influence of respondent experience on placement decision, although no a-priori hypotheses about respondent experience were proposed (*Research Question #2*). The results of the study indicate that respondent experience was not related to placement decision-making (see Table 11). The research on the role of professional experience in child welfare placement decisions is limited (Zuravin & DePanfilis, 1997), and previous studies have found main effects related to experience (Britner & Mossler, 2002), an interaction effect of experience regarding the country in which the social worker practices (Gold et al., 2001), and no effect of experience (Rossi et al., 1999). Parada, Barnoff, and Coleman (2007) conducted a qualitative study assessing decision-making within the Ontario child welfare system in which they interviewed 10 social workers who regularly made placement decisions. One of the themes the authors identified in the interviews was the participants' level of experience in the child protection system, a variable which was highly determinant of how they made decisions. Parada et al. (2007) note, "once workers have experience within the system, they start to make decisions based on their practice wisdom, rather than simply blindly following the dictates of the institutional protocol" (p. 49). Similarly, Britner & Mossler (2002) found evidence that more experienced social workers were better at filtering out extemporaneous information when making decisions. Despite the results of the aforementioned studies, the author is not aware of any quantitative study that has assessed child welfare placement decision that

has found a direct main effect for experience on placement decision (as opposed to other factors such as an analysis of the role that experience plays on the factors that the respondents consider when making the decision). The results of this study indeed suggest that experience does not have a direct influence on placement decision-making in child welfare.

Although main effects for respondent experience were not hypothesized, several hypotheses were made related to the interaction between experience and the experimentally manipulated variables (*Research Question #3*). These hypotheses were based on the aforementioned previous research that suggests that more experienced social workers are better at identifying important information related to placement decision and ignoring less relevant information (Britner & Mossler, 2002). The hypotheses were that less experienced social workers would be more likely to recommend the child for residential if they received the African American vignette (*Hypothesis #4a*) or the low SES foster family vignette (*Hypothesis #5a*), while more experienced social workers would be more likely to recommend the child for residential if they received the SOC/wraparound previous treatment vignette (*Hypothesis #6a*). According to the results of the logistic and multiple regressions, none of the proposed interaction effects had a significant impact on placement decision. Therefore, while more experienced social workers may claim that they use different methodology when making placement decisions or are better than less experienced social workers (Drury-Hudson, 1999; Parada et al., 2007), the results of the present study do not support this claim.

Although a controversial topic in the field, several theorists and researchers have made compelling arguments that experienced therapists and clinicians do not produce better therapeutic outcomes than less experienced clinicians. In a classic review of 42 studies comparing paraprofessionals to professionals, Durlak (1979) found results that were “consistent and provocative. The clinical outcomes paraprofessionals achieve are equal to or significantly better than those obtained by professionals” (pp. 89). In his book *House of Cards*, Dawes (1996) argues that mental health professionals are not provided the immediate feedback that medical professionals are often provided and that this lack of feedback lessens the importance of experience. For example, a clinician may make a residential placement decision, and the child may stay in residential for over a year, yet the clinician may never know if the placement decision was a success and whether or not it achieved the stated objectives. Without this feedback, Dawes argues that clinicians are susceptible to emotionally charged ideas or memories of particular cases (as will be discussed in further detail in the next section). Therefore, experience may not be important in child welfare because decision makers are far too often not provided with feedback regarding the outcome of the decision.

#### *Clinical Factors*

The lack of significant results related to the experimentally manipulated variables, respondent experience, and placement decision, combined with the total sample’s variability on the outcome measure, suggest that respondents were not influenced by race of the child, foster family SES, or previous SOC/wraparound treatment when making

placement decisions. Experience was also unrelated to placement decision. Perhaps the reason why no main effects for the experimentally manipulated variables were obtained is that the experimental manipulations were not strong enough. When manipulating variables the researcher must walk a fine line between not creating a strong enough manipulation and creating a manipulation that is so strong that it draws the attention of the respondent, causing the respondent to question the purpose of the study and possibly influence the results (Alexander & Becker, 1978). It is for this reason that multiple vignettes were also not included; previous research suggests that when multiple vignette are used, respondents become too cognizant of the experimentally manipulated variables and this influences their answers (Konecni & Ebbesen, 1982). However, as discussed previously, the experimentally manipulated variables were significantly related to several CANS items that measured service delivery (i.e., *Hypotheses #2c & #3c*). These findings suggest that SES and previous treatment influence beliefs about service delivery, providing evidence that the manipulations were strong enough to influence the respondents in expected directions.

Given the aforementioned evidence that the variables were sufficiently strong enough to influence the respondent, it is likely that the central variables the respondents considered when recommending placement decision were clinical factors as opposed to demographic factors. This belief was tested by assessing the influence of CANS factor scores on placement decision utilizing a logistic regression for the dichotomous decision and a linear regression for the 0-100 scale. The variables that were significantly related

to placement decision were oppositional behavior, danger to self, antisocial behavior, monitoring, and supervision. Thus, three out of the four CANS variables assessing psychopathology were significantly related to placement decision, after controlling for the influence of all of the other variables. Therefore, the evidence suggests that clinical factors, and not demographic factors, influenced placement decision-making. What is the explanation behind the significant relationship of clinical factors as assessed by the CANS and placement decisions? Although the criterion regarding residential placement are not uniform across all states and agencies, if an individual is judged to be a danger to himself or others, then more intensive placement is warranted (Wells, 1991). Therefore, the positive relationship between higher scores on this variable and placement in residential is indicative of the seriousness with which clinicians treat individuals who are a danger to others. The evidence that clinical factors are related to placement decision above any other variables is an encouraging finding for the social work and child welfare field; this study suggests that social workers are not influenced by demographic variables but instead use information derived from youths' clinical characteristics to make placement decisions. In his review of 348 children placed in out-of-home care in California, Courtney (1998) found a similar relationship between clinical severity and placement decision (either foster care, treatment foster care, or group care). The children that were rated as more behaviorally disordered were placed in more restrictive care. Courtney notes:

“Although this finding will not be surprising to many child welfare practitioners, it is nevertheless important for at least two reasons. First, it provides empirical support for the argument that there is, in fact, some logic to the placement decisions made by social workers: these decisions may not be idiosyncratic at all... Second, the strong association between perceived child behavior and the placement preferences of social workers provides support for the conventional practice wisdom that specialized placement is one way that social workers attempt to address the perceived emotional/behavioral problems of children in out-of-home care.” (pp. 298).

Courtney concludes that the significant relationship between clinical severity and placement outcomes is indicative of the fact that social workers do not utilize personal, and thus, more difficult to quantify, factors when making decisions. However, as will be discussed below, these same idiosyncratic factors may also be the reason why the decision maker rated the individual higher on the clinical variables.

#### *The Idiosyncratic Nature of Placement Decisions*

While it is encouraging that clinical factors played such a prominent role in placement decision, it is important to remember that all participants were making their decisions based on the same vignette. This suggests that clinical characteristics per se are not driving placement decisions but rather the participant's *perceptions* of youths' clinical characteristics. In other words, the design of the study makes it impossible to infer causation. It cannot be stated with certainty that high psychopathology and risk factors

are causing individuals to opt for a residential placement; these variables are simply related to each other. Child welfare professionals are instructed to consider the best interest of the child as the guiding factor in placement decisions. What constitutes the child's best interest is often an individual judgment, and definitions are neither clear-cut nor consistent from state to state (Hall et al., 1996; Kelly, 1997). Although the best interest standard was not directly mentioned in the questionnaire, even if social workers understand and apply the best interest standard in uniform ways, they may still differ with regard to assessing severity of psychopathology and beliefs about which treatments are best suited to treating various presenting problems. In other words, placement decisions are more influenced by a professional's perception as opposed to disagreements about the meaning of the best interest standard or other criteria by which placement decisions are made.

Given that the respondents were presented with an uncertain situation (i.e., a vignette in which dichotomous placement decision was almost evenly split), and they were not influenced by extraneous variables such as race or SES when making placement, it is worth speculating as to other potential unmeasured factors that might have impacted placement. As discussed in the preceding sections, perhaps individuals responded differently not based on experience with child welfare, but based on their own idiosyncratic experiences with particularly memorable clients (Briar, 1963; Jones, 1993; Maluccio & Marlow, 1972). This method of decision making would be consistent with the social psychology literature on the representativeness heuristic (Tversky &

Kahneman, 2005). For example, suppose that a decision maker has a particularly powerful memory of a particular child that was severely conduct disordered and later harmed himself or someone else. Perhaps when this individual is presented with similar client after this experience, he or she may be more likely to opt for a more restrictive placement because of the representativeness of the previous situation. In a review of the literature on placement decisions in substance abuse cases, Lordan, Kelley, & Peters (1997) note that despite the efforts of the field to create specific client-treatment matching processes, most substance abuse clinicians rely on largely idiosyncratic strategies for placement decision making.

It is also worth noting that although all of the CANS variables assessing psychopathology, risk factors, and service needs were negatively correlated with the experience variable, the correlations were all nonsignificant. Although there was no relationship between experience and severity, this does not control for idiosyncratic experiences of the respondent or distinctive characteristics or policies of the respondents agency that may influence placement decision. As discussed in the previous section, due to the nature of child welfare and the lack of follow up data that clinicians receive, experience may not be as important as other variables.

#### *Limitations*

There were several limitations to the study, and the generalizability of the findings is limited by the study's sample methodology and sample. Despite the vignette being prescreened for several social workers and experts in the field, because it was



created solely for the present study and has not been used previously reliability and validity are unknown. Because only one vignette was used, it certainly could not represent the wide spectrum of cases that child welfare professionals and social workers are presented. As discussed previously, multiple vignettes were not used because of concerns about the participants becoming aware of the manipulation and basing their results based on previous vignette answers. Although it is possible that the some respondents in the present study became aware of the manipulation and this awareness influenced their responses, the absence of multiple vignettes makes this scenario less likely.

However, given that the vignette yielded a diverse set of results on the outcome measures (the dichotomous placement decision, the 0-100 scale, and the CANS items), the vignette met the stated goals of the experimenter. As discussed previously, the results indicate uncertainty among the respondents. Homogenous results (i.e., almost all respondents indicating a preference for either community or residential care) would have made trends in the data more difficult to ascertain. The fact that the experimentally manipulated variables did not affect placement decision despite the presence of uncertainty suggests that they were unrelated to decision. The results of the power analysis provide further evidence that the variables were unrelated to decision. Because of this lack of significant findings, it is possible that the manipulations were not strong enough to make a difference in respondent's opinions about the vignette. However, as discussed previously, the significant findings related to two of three experimentally

manipulated variables and CANS items provides evidence that the manipulations were strong enough to make a difference in response.

The open ended question asking what else respondents would like to know about the case indicated that many social workers were interested in knowing more about Shawn's preferences for placement and also his medication management. Because of space limitations and the nature of a vignette, it was not possible to include all of the information that participants could find relevant in the vignette. In fact, one social worker didn't answer any questions because he noted that "the vignette leaves too many questions unanswered". Although a vignette is certainly different than a real life placement decision, child welfare professionals must often make decisions without access to absolutely all of the information that may be relevant.

The sample was comprised entirely of social workers from within the state of Illinois. Given the variability of child welfare state agencies and policies, it is unknown if social workers in different states would have responded to the questionnaire in a different fashion. As is always the case with mail surveys, sample selection effects are possible. This may be especially true given the 23.3% response rate. The response rate potentially compromised the ability to detect interactions in the data and to detect differences between different groups of respondents (i.e., DCFS workers vs. non-DCFS workers, specializations within social work). However, the respondents did not significantly differ from the characteristics of the overall members of the Illinois NASW chapter (i.e., largely female, possessing an MSW, working in the Chicago area).

*Response Rate*

The response rate of 23.3% was lower than anticipated. Given the generalizability and data analysis problems associated with low response rates, it is worthwhile to discuss potential contributions to the response rate of the present study. Previous studies utilizing the Tailored Design Methodology for mail surveys have yielded response rates of 30-50% (Dillman, 2000; Kaplowitz, Hadlock, & Levine, 2004; Stevanovic & Rupert, 2004). A similar mail survey utilizing social workers to make placement decisions yielded a response rate of 60% (although in this particular study social work supervisors allowed structured time for workers to complete the questionnaire and collected and returned the questionnaires, contributing to the high response rate) (Britner & Mossler, 2001).

There are several nonexclusive possible explanations for the lower than anticipated response rate, including; respondent lack of personal connection to the questionnaire, detail of the questionnaire, lack of incentive, respondent confusion about study eligibility, and postal problems. In previous studies with higher response rates (i.e., Kaplowitz et al., 2004; Stevanovic & Rupert, 2004) the research question directly concerned the respondent (specifically psychologist burnout and college student's knowledge about clean water). Therefore, the respondents did not have to think hypothetically or consider anything outside of their personal experiences. Perhaps the lack of personal connection and "homework" required of potential respondents (i.e., reading the vignette, thinking hypothetically about placement options, answering several

hypothetical questions) in the present study contributed to the lower than expected response rate. It is also likely that the detailed nature of the questionnaire contributed to the response rate. Although the entire study was pilot tested to take between 10-15 minutes to complete, one respondent noted on the questionnaire that it took 45 minutes for her to complete. It might have been useful to include a question asking the respondents the amount of time required to complete the study, but this question was not asked of the participants.

Although the present study did not utilize an incentive, researchers often implement a reward or compensation for completing a mail survey (Church, 1993; King & Vaughan, 2004). Church conducted a meta-analysis of studies that compared incentive and non-incentive (control) response conditions. Incentive conditions documented an average increase in response rate of 13.2% compared to control conditions. The meta-analysis also compared types of incentive structures (i.e., monetary vs. nonmonetary and initial mailing vs. contingent on returned response), and results indicated that only incentives provided with the initial mailing of the survey instrument had a significant impact on response rates. Given budgetary constraints it would have been impossible to include an up-front incentive with the present survey, and the most likely incentive method would have been entry into a lottery system contingent on returning the survey. However, given the results of the meta-analysis documenting a lack of positive impact on response rates utilizing this methodology, and the anonymity issues it would raise, it was decided that incentives would not be worthwhile to include in the study framework.

It is possible that some participants might have been confused about their eligibility for participation in the study. Although the cover letter stressed that no experience in child welfare decision making was necessary, perhaps some respondents discarded the questionnaire once they saw the vignette and study themes. Finally, postal problems and problems with the NASW address list might have contributed, in a small way, to the response rate. Sixteen (1.6%) studies were returned to sender due to address or postal problems. In addition, several respondents contacted the study coordinator to note that they never received the study. These participants were then sent a new study, but it is unknown how many other potential participants might not have received the study.

#### *Future Research*

The respondent's data yielded several interesting pieces of information. Evidence suggests that the social workers in this study primarily utilized clinical factors and problem behaviors when making placement recommendations (as opposed to demographic or previous placement factors). This important finding contradicts some of the other research on client demographics and placement decisions that utilized retrospective chart reviews (Glisson et al., 2000; McMurtry & Lie, 1992). Although none of the experimentally manipulated variables influenced placement decision, the variables were related to the respondents' views of service delivery. Experience played little role in placement decision.

Future research should continue to assess decision making in child welfare. A more qualitative approach to understanding the methodology that child welfare professionals utilize when making placement decisions would be useful. The use of an interview format and more open ended questions could provide a further window into the collective minds of the individuals behind the placement decision. As discussed in previous sections, questions could be asked about particular relevant cases or idiosyncratic experiences that may influence decisions. Information should be gathered about the child welfare professionals training in decision making, previous experiences making decisions, and how much feedback they typically receive after decisions are made. Perhaps the field as a whole should focus more on providing feedback regarding clinical outcomes after placement or treatment decisions so that professionals can learn from their experiences and past decisions.

Given that this was the first study utilizing the aforementioned clinical vignette and experimental manipulations, future research could also use this vignette in an effort to establish reliability and validity. Given the almost perfectly even split between respondents recommending community placement and those recommending residential services, the vignette would be appropriate to use in future similar studies involving decision making. Overall, the results of the present investigation provide evidence that social workers utilize clinically relevant information when they make placement decisions, and that their decision does not depend on demographic factors or the experience of the decision maker.

Table 11

*Findings Related to Research Questions and Hypotheses*

<u>Research Question</u>	<u>Hypothesis</u>	<u>Support</u>
1. Experimental variables will influence responses		Some
	1a) Race will influence placement decision	No
	1b) Race will influence clinical severity ratings	No
	2a) Foster care SES will influence placement decision	No
	2b) Foster care SES will influence clinical severity ratings	No
	2c) Foster care SES will influence service delivery ratings	Yes
	3a) SOC treatment will influence placement decision	No
	3b) SOC treatment will influence clinical severity ratings	No
	3c) SOC treatment will influence service delivery ratings	Yes
2. Experience will influence responses		No
3. Interaction of experimental variables & experience will influence response		No
	4) Interaction between experience and race	No
	5) Interaction between experience and foster care SES	No
	6) Interaction between experience and SOC treatment	No
Exploratory analyses. CANS variable ratings will influence placement decision		Yes

APPENDIX A:  
RECRUITMENT MATERIALS



## Introductory Letter

June 4, 2009

Dear Colleague:

Within the next week, you will receive in the mail a request to complete a survey for a research project that my students and I are conducting.

The survey, entitled "**Decision Making in Child Welfare**", examines how social workers make placement decisions within the child welfare system. We are sending the survey to a representative sample of members of the Illinois chapter of the National Association of Social Workers (NASW). Because one of the variables that we will assess is experience within child welfare, you are still eligible for the study even if you have limited experience in child welfare. In fact, many of the participants recruited for the study have indicated other specialties within social work and will have no experience in child welfare decision making.

I am writing in advance to alert you to expect the survey. I understand that your time is valuable and have tried to make the survey as easy to complete as possible. When you receive it, I hope you will be able to take some time to complete and return it.

Thank you for your time and consideration.

Sincerely,

Scott C. Leon, Ph.D.  
Assistant Professor of Psychology  
Loyola University Chicago

Jeffrey H. Sieracki, MA  
Doctoral Candidate  
Loyola University Chicago

## Cover Letter

June 11, 2009

Dear Colleague:

We are asking for your help in completing the enclosed survey entitled, "**Decision Making in Child Welfare.**" I will be conducting this study with a doctoral student in the psychology department. We are conducting this study as part of our ongoing effort to research how various factors influence placement decisions in child welfare.

We are sending the survey to a sample of members of the Illinois chapter of the National Association of Social Workers (NASW). As mentioned in the previous letter, one of the variables we are assessing is child welfare experience; therefore, you are still eligible for the study even if you have limited experience in child welfare. In fact, many of the participants recruited for the study have indicated other specialties within social work and will have no experience in child welfare decision making.

If you agree to participate in the study, you will read a brief clinical vignette and answer several questions about the vignette. In addition, you will also be asked demographic questions and questions about your professional experience. The entire study should take 5-10 minutes to complete. There are no foreseeable risks involved in participating in this research beyond those experienced in everyday life. Although there are no direct benefits to you from participation, the results will be helpful in understanding how placement decisions are made.

This is an anonymous survey. Please **do not** put your name or any identifying information on your survey. The surveys have not been coded in any way that would identify participants and, as an extra precaution, we will destroy return envelopes as surveys are received. All results from this survey will be summarized in aggregate form and will be presented in professional sources.

Your participation is, of course, voluntary. If you do not want to be in the study, you do not have to participate. Even if you decide to participate, you are free to leave a question unanswered. If you are willing to participate, simply complete the enclosed survey and return it in the envelope provided. Return of a completed survey will constitute consent. If you have questions about this research study, please contact Dr. Scott Leon at (773) 508-8684 or sleon@luc.edu. If you have questions about your rights as a research participant, you may contact the Compliance Manager in Loyola's Office of Research Services at (773) 508-2689.

Thank you very much for your help with this project.

Sincerely,  
Scott C. Leon, Ph.D.  
Assistant Professor of Psychology  
Loyola University Chicago

Jeffrey H. Sieracki, MA  
Doctoral Candidate  
Loyola University Chicago

## Reminder Postcard

June 24, 2009

Last week a survey entitled "Decision Making in Child Welfare" was mailed to you. If you have already returned this survey, please accept my sincere thanks. If not, I would appreciate you taking the time to do so at your earliest convenience. If you did not receive a survey or are unable to locate a copy, please email me at [sleon@luc.edu](mailto:sleon@luc.edu) or call me at (773) 508-8684 and I will mail you another copy today. Thank you for your help.

Scott C. Leon, PhD, Assistant Professor of Psychology  
Jeffery H. Sieracki, MA, Doctoral Candidate  
Loyola University Chicago  
6525 North Sheridan Road  
Chicago, IL 60626

APPENDIX B:

THE VIGNETTE AND QUESTIONS RELATED TO THE VIGNETTE

## The Vignette

**Please read the clinical vignette and complete the enclosed questionnaire based on the information presented in the vignette. Then mail the questionnaire to us in the enclosed self-addressed, stamped envelope. You do not need to send the vignette back to us.**

### **Clinical Vignette**

#### **Instructions**

Suppose you are a social worker with the Illinois Department of Children and Family Services (DCFS). You will be working to formalize a placement decision for Shawn Wilson, a 10 year old **Caucasian** (*African-American*) male with an extensive history of disruptive behavior and involvement in the child welfare system. Please note that this is a hypothetical child welfare case and is not meant to resemble a specific child. Based on the following information you have at your disposal, you will make an assessment of Shawn's situation that will allow you to recommend a placement that you believe will best meet his needs. The choices for placement options are (1) remaining in the community and receiving community-based services or (2) a residential placement.

#### **Current Situation and Brief History**

Shawn is a 10 year old currently in substitute care under the auspices of DCFS; Shawn was taken into custody three years ago. He has been living in the home of his foster parents, Jason and Tiffany Peters, for about one year. However, his frequent disruptive behavior has made it difficult for his foster parents to continue caring for him. Shawn demonstrates severe acting out behaviors both at home and in the community. He began to have frequent temper tantrums during both school and home when it was time to transition to another setting. He would kick, scream, and yell during these episodes. His school staff has been unable to manage Shawn during these episodes and he has kicked and bit several staff members. Tiffany is typically called to settle Shawn down, although this strategy has not always been effective. Shawn has been expelled from an after-school program due to frequent altercations with several other children. He has become increasingly defiant at home, and he is becoming more physically and verbally aggressive. When he is punished (sent to time out or unable to play video games) he argues, cries, and attempts to fight with his foster parents. The fighting is usually verbal although he did push his foster mother once resulting in her losing her balance and falling. After one particular fight with his foster parents, Shawn responded by running away from the home. His parents found him several hours later in another part of town crying and alone. His foster parents also discovered him intentionally hurting an injured stray cat by repeatedly hitting it with a board. When confronted, Shawn indicated that he has done this to other animals in the past. Shawn attends a local school and is in the fifth grade. His grades are average to below average. His teachers say that Shawn is a bright

child who does not seem to apply himself. His teachers also report that over the past month Shawn's behavior has become more oppositional and verbally and physically aggressive toward her and the other students in the class. On three occasions he has gotten into trouble for pushing and kicking other students on the playground during recess. Furthermore, he reports that he has nightmares of his early environment (e.g., dreams of being scared because his biological mother has not come home), and that he cries uncontrollably several nights per week. In the past, Shawn has been diagnosed by his therapist as having conduct disorder, oppositional defiant disorder, and attention deficit/hyperactivity disorder.

### **Foster Parent Family Background**

The Peters family consists of father Jason (age 43), mother Tiffany (age 41), and their two biological children, ages 15 and 12. Shawn is the third foster child Jason and Tiffany have taken in over the past five years. He has been at the home for approximately one year. **The Peters family resides in an upper-middle income neighborhood, in a single family home.** (*The Peters family resides in a lower-income neighborhood, in government subsidized housing.*) They receive financial support from DCFS in exchange for their role as foster parents. **Shawn currently attends the same private school as his older foster siblings.** (*Despite this support, due to Jason's unemployment the Peters family often has great difficulty meeting the monthly rent.*)

### **Biological Family Background**

Shawn's biological mother is currently in treatment for drug and alcohol dependence. Although parental rights have not been terminated, she has not had contact with her son for three years. According to the DCFS caseworker report, at removal from the home it was indicated that Shawn, and his younger sisters, age 6 and 4, were neglected by their biological mother. The whereabouts of his biological father are unknown and Shawn has not had any contact with his biological father since birth. Due to the current situation, a return to the biological mother is not currently an option at this time.

### **Current and Previous Treatments**

Shawn has been assigned a DCFS caseworker since the time he entered the child welfare system three years ago. He has been attending weekly individual psychotherapy since this time. The sessions primarily focus primarily on addressing his anger issues and his oppositional behavior. The therapist reported that Shawn demonstrated progress initially, but that improvement has stalled over the past couple of months. **In addition, Shawn receives coordinated services through the Illinois wraparound program. Through the wraparound program, he has received afterschool tutoring, a mentor, and family respite services. A team, consisting of the caseworker, the therapist, Mr. and Mrs. Peters, and his teacher, meet on a monthly basis to collaborate and coordinate services. They update his treatment plan and goals every six months.** (*Shawn does not receive any additional services besides the individual therapy.*)

## The Questionnaire

**The Survey Should be Completed Anonymously  
Please Do Not Write Your Name on Any Portion of This Document**

1. What do you think is the most optimal placement option for Shawn? (choose one)
- Community-based treatment (i.e. remaining in the Peters home or transferring to another foster family)
  - Residential-based treatment (i.e. a milieu-based service providing setting)

2. Using a 0-100 scale, indicate the need that Shawn has for a residential versus a community placement.

0-100 rating: \_\_\_\_\_

\_\_\_\_\_

0 community

50

100 residential

3. What else would you need to know before making this placement decision?

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**Instructions**

**Based on the vignette, please rate Shawn on the following items. Circle the number that you believe best represents his current situation.**

**10 CANS Questions**

**(see Appendix C for items utilized and Appendix D for example)**

**Lastly, please answer a few questions related to your demographics and experience:**

1. Age: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Race (circle one):

African-American/Black

Asian-American



Biracial/Multiracial  
 European-  
 American/Caucasian  
 Latino/a  
 Native-American  
 Other: \_\_\_\_\_

4. What area of the state do you practice in?  
 Chicago city limits  
 Chicago suburbs  
 Rockford Area  
 Western Illinois/Quad Cities  
 Central Illinois (Peoria, Springfield)  
 Southern Illinois  
 St. Louis region  
 Other: \_\_\_\_\_

5. Most advanced degree (circle one):  
 BA/BS undergraduate  
 MSW/MA masters level  
 PhD/PsyD doctoral level  
 Other: \_\_\_\_\_

6. How many years have you worked in the social work field: \_\_\_\_\_

7. How many years have you worked at your present job: \_\_\_\_\_

8. How many years, if any, have you worked in child welfare? \_\_\_\_\_

9. Specialization (circle one):  
 Child/Family Welfare  
 Health  
 Adult mental health  
 Child mental health  
 School social work  
 No specific specialization  
 Other: \_\_\_\_\_

10. How often do you make child welfare placement decisions? (circle one):  
 It is a major part of my job  
 Occasionally or I have made decisions in the past  
 I have never made a placement decision

11. Roughly how many child welfare placement decisions have you made in your (a) career: \_\_\_\_\_  
 (b) the past year: \_\_\_\_\_

12. Do you work for Illinois DCFS:  
 Yes  
 No  
 No, but previously for \_\_\_\_\_ years

**Thank you for your participation!**  
**Please return completed survey in self-addressed stamped envelope**

APPENDIX C:  
THE CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)

*The Child and Adolescent Needs and Strengths with the items utilized in study*

*bolded*

- A. Problem Presentation
  1. Psychosis
  2. Attention Deficit/Impulse Control
  3. **Oppositional Behavior**
  4. **Antisocial Behavior**
  5. Substance Abuse
  6. Adjustment to Trauma
  7. Situational Consistency of Problems
  8. **Temporal Consistency of Problems**
- B. Risk Behaviors
  1. Danger to Self
  2. **Danger to Others**
  3. Elopement
  4. Sexually Abusive Behavior
  5. Social Behavior
  6. Crime/Delinquency
- C. Functioning
  1. Intellectual/Developmental
  2. Physical/Medical
  3. Family
  4. School/Day Care
- D. Care Intensity & Organization
  1. **Monitoring**
  2. **Treatment**
  3. Transportation
  4. Service Permanence
- E. Caregiver Capacity
  1. Physical
  2. **Supervision**
  3. **Involvement with Care**
  4. Knowledge
  5. Organization
  6. Residential Stability
  7. **Resources**
  8. Safety
- F. Strengths
  1. Family
  2. Interpersonal
  3. Relationship Permanence
  4. Education
  5. Vocational
  6. Well-being
  7. Spiritual/Religious
  8. Creative/Artistic
  9. **Inclusion**

## Child and Adolescent Needs and Strengths (CANS) - Examples

**ANTISOCIAL BEHAVIOR (COMPLIANCE WITH SOCIETY'S RULES)**

*These symptoms include antisocial behaviors like shoplifting, lying, vandalism, cruelty to animals, and assault. This dimension would include the symptoms of Conduct Disorder as specified in DSM-IV.*

- 0 This rating indicates a child with no evidence of behavior disorder.**
- 1 This rating indicates a child with a mild level of conduct problems. Some antisocial behavior in school and/or home. Problems recognizable but not notably deviant for age and sex and community. This might include occasional truancy, lying, or petty theft from family.**
- 2 This rating indicates a child with a moderate level of conduct disorder. This could include episodes of planned aggressive or other anti-social behavior. A child rated at this level should meet the criteria for a diagnosis of Conduct Disorder.**
- 3 This rating indicates a child with a severe Conduct Disorder. This could include frequent episodes of unprovoked, planned aggressive or other anti-social behavior.**

**INVOLVEMENT**

*This rating should be based on the level of involvement the caregiver(s) has in planning and provision of mental health and related services.*

- 0 This level indicates a caregiver(s) who is actively involved in the planning and/or implementation of services and is able to be an effective advocate on behalf of the child or adolescent.**
- 1 This level indicates a caregiver(s) who is consistently involved in the planning and/or implementation of services for the child or adolescent.**
- 2 This level indicates a caregiver(s) who is only somewhat involved in the care of the child or adolescent. Caregiver may consistently visit individual when in out-of-home placement, but does not become involved in service planning and implementation.**
- 3 This level indicates a caregiver(s) who is uninvolved with the care of the child or adolescent. Caregiver likely wants individual out of home or fails to visit individual when in residential treatment.**

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## VITA

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The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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