Engaging Families in Child Welfare Services: An Evidence-Based Approach to Best Practice

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Successfully engaging clients in the helping process is a critical task for child welfare practitioners. Drop-out and noncompliance rates in child welfare services are high and lead to high rates of removal of children from their families and to eventual termination of parental rights. Although no known interventions guarantee treatment compliance, this review of the empirical literature delineates critical components of engagement in child welfare services. Effective engagement strategies, including service components and caseworker qualities and behaviors, are identified as contributing to the positive case outcomes of treatment compliance, family preservation, and placement prevention. The unique needs of neglectful parents are also examined, with recommendations for practice.

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Child welfare programs cannot claim high success rates with current treatment populations. Rigorous experimental tests of intervention effectiveness are difficult, given many constraints on evaluations: High drop-out rates preclude posttests; mandated treatment prohibits the use of equivalent control groups; poorly specified treatment models are difficult to replicate; and standardized outcome measures are often developed and normed on populations unlike those beset by low income, inadequate housing, low literacy, and so forth. Contributing to the scarcity of effective public child welfare models is the absence of many controls often found in laboratory intervention research (Weisz, Weiss, & Donenberg, 1992). Effective models for the treatment of child maltreatment do exist (although models are better specified for child abuse than for child neglect), but they require strict adherence to model parameters (Cohn & Daro, 1987; Henggeler & Borduin, 1990; Kluger, Alexander, & Curtis, 2000).

Client drop out is problematic, not only for evaluators but for treatment itself. Client drop-out rates for therapeutic services range from 35% to 70% (Kazdin, 2000; Mueller & Pekarik, 2000), with higher rates among clients receiving involuntary or court-ordered services (Rooney, 1992). Because many child protective service agencies serve only court-ordered clients, referring voluntary clients to other agencies, client drop out and retention are significant issues, often ignored in the specification of treatment models.

For parents receiving child welfare services, the timely completion of treatment is part of a specified service plan. Noncompliance with that plan can result in the removal of children and their placement in foster care and, ultimately, termination of parental rights. Uncooperative parents may not be offered services (Jones, 1993), whereas cooperative parents are less likely to face court proceedings (Karski, 1999) or removal of their children and placement of their children in foster care (Atkinson & Butler, 1996; Jellinek et al., 1992).

Completing this picture is the recent shift to shorter time frames for serving families and their showing improvement, before moving on to the termination of parental rights. The Adoption and Safe Families Act of 1997 (ASFA; P.L. 105-89) reduced the amount of time agencies have (from 18 months [P.L. 96-272; 1980] to 12 months) to show a reduced likelihood of maltreatment in a family. If agencies cannot show family improvement by the 12th month of services, courts begin proceedings to terminate parental rights.

This reduction in the time the "treatment window" is open is intended to be a safeguard for children's healthy development in a permanent and family-like setting. The reduction is also intended to be sensitive to a child's developmental needs for safety and a timely and permanent disposition of his or her case. The reduction is furthermore intended to limit the amount of time during which agencies can intrude into the private lives of families. This reduction to a 12-month period to improve child safety was based on a small body of research on models that have achieved safety within 12 months with this population (Henggeler & Borduin, 1990). Those service models that have shown good outcomes for children and families often have voluntary clients, rather than families mandated by courts to public child welfare agencies. For instance, an effective home-based service model for troubled adolescents (Brunk, Henggeler, & Whelan, 1987) has had great difficulty in producing similarly good outcomes with families experiencing child maltreatment.

The majority of child welfare agencies across the country are currently operating under some form of settlement agreement or court disposition resulting from class action lawsuits regarding the poor oversight of child welfare cases. Most agencies have limits on the size of caseloads that child welfare caseworkers can carry. These limits can also, however, contribute to a reduced treatment window for helping an individual family, in that the number of case closures needs to match the number of incoming cases.

For caseloads to remain at a steady size, the number of case closures must be equal to the number of new cases in any given period. As new cases continue to come into the agency—and public agencies are not able to refuse serving families found to abuse or neglect their children—case closures must happen at a rate equal to case openings, regardless of the level of family difficulties. Treatment developments must therefore keep pace with the changing constraints on agencies and their service populations.

Research on intensive family preservation services has found program success to be predicted by a family's early cooperation and engagement in services (Berry, 1992; Kinney, Haapala, & Booth, 1991; Lewis, 1991). Given shortened time frames in which to involve families in services, and the importance of the family's engagement in contributing to positive case outcomes, a delineation of strategies that enhance family cooperation and engagement is an important task.

Components of Services That Engage Families in Treatment

Services can only be effective when clients fully participate in them. Littell and Tajima (2000) distinguished between two constructs of client participation: collaboration and compliance. In collaboration, a client participates in both treatment planning and agreement with treatment plans; both can also be influenced by caseworkers and by agency practices. Client compliance consists of such behaviors as keeping appointments, completing tasks, and cooperating with caseworkers and others. Most literature in child welfare practice comments on client compliance, although we propose that client collaboration is the construct of most importance to client engagement.

For clarity, we have embraced the standard of effective intervention delineated by Carr and colleagues (1999), who stated that an intervention is deemed effective by stakeholders, including the agency, client, and policymakers, when it

- Helps to create changes in lifestyle, not just behavior;
- Includes practical and relevant interventions; and
- Strives for long-term changes.

Social service agencies and workers are responsible for embracing these standards. When these standards are implemented on every agency level, treatment collaboration and compliance are likely to increase. It should be emphasized, however, that many discrepancies exist in the literature regarding service structures as they relate to successful outcomes. Our purpose here is to outline briefly the strengths of various programs as they relate to effective client participation and collaboration.

Immediate and Home-Based Interventions

Most social service agencies have an established system for service delivery. Many studies rule out other factors for successful outcomes, while finding that elements of the service structure affect treatment effectiveness. Widely cited intensive family preservation services programs have shown success in preventing out-of-home placement in 40% to 95% of participating families (Fraser, Pecora, & Haapala, 1991; Schuerman, Rzepnicki, & Littell, 1994). These home-based programs aim to provide alternatives to out-of-home placement, as well as to provide links to community supports, so that families can be self-sustaining for longer periods of time.

Conflicting research on the success of intensive family preservation services reveals that this service structure may not be effective for all families all of the time. As a system of service delivery, however, the home-based programs show great strengths in maintaining family participation in the intervention process (Fraser et al., 1991; Kinney et al., 1991). Intensive family preservation services, such as the Homebuilders program (Fraser et al., 1991; Kinney et al., 1991), claim that their successes directly relate to their service structure by:

- Contacting clients immediately (2 days or less) once a referral is made,

- Providing services in the home to teach practical skills in the setting where they will be used,
- Emphasizing skill building over therapeutic insight, and
- Emphasizing delivery of concrete services.

Studies of consumer satisfaction with services received have identified many of these same components as particularly helpful. A study of problem families with multiple problems (Benvenisti & Yekel, 1986) found consumers to rate caseworkers most helpful when they

- were willing to help and to be with the family,
- were supportive and nonpunitive,
- listened to clients and encouraged them, and
- provided concrete services.

Family preservation caseworkers seek to engage the family and to instill hope early in the intervention (Kinney et al., 1991). Workers provide understanding and emotional support by listening to and helping families define the problem and set their own goals for treatment. Huszti and Olson (1999) reinforced this practice. They emphasized the importance of educating families about the pending case issues during the initial interview process, in addition to modeling appropriate parent/child interventions during subsequent sessions.

Given the short duration of services, most family preservation programs do not emphasize the truly "soft services" of psychological individual or family counseling. For example, Whittaker, Schinke, and Gilchrist (1986) instead focused on the teaching of specific life skills. This form of soft services is especially applicable in short-term interventions, during which emotional support from agency workers is available only for a finite period, usually two to three months. The skill building that occurs will continue to support and reinforce positive family interaction in the long run, after formal services have ended.

Treatment in family preservation services focuses on modeling of life skills, such as teaching parenting and practicing with

family members the constructive communication and negotiation skills that will contribute to a more positive and less abusive family environment. These positive communication skills foster a respectful and empathic working relationship, in addition to improving parenting skills. Workers assess parenting and communication skills, help parents and children to identify nonpunitive methods of interacting, and model and practice positive interaction. These skills apply not only to parent and child interaction. The same skills also help families to interact more productively with landlords, doctors, teachers, social workers, neighbors, relatives, and others who contribute to the support or stress in the family's social environment. The model is nonpunitive and nonblaming.

Broadly Focused Case Management

Some studies show strong effects in areas of family need that can be met by flexible and concrete service delivery. For example, Huz, McNulty, and Evans (1996), in a study of intensive case management services in New York, showed declines in "unmet needs" when families received intensive case management services. Focused primarily on children, their study reported that children received significantly more recreational, medical, and educational services between baseline and discharge. Overall family functioning, however, showed few significant changes with intensive case management.

The family preservation model of services recognizes the important role of concrete resources in the support of families. First, families who improve their communication skills and increase the self-esteem of their members will continue to be stressed by their physical environment if they cannot provide for the basic needs of their children, such as housing, food, and medical care. A systems perspective recognizes the importance of these physical and environmental resources to family well-being. Therefore, assistance and the provision of concrete resources can reduce ac-

cumulation of stress, thereby positively affecting the ability to effectively participate in both services and family life.

Second, Kinney and colleagues (1991) indicated that provision of concrete resources helps to establish rapport between the caseworker and the family by showing an understanding of their concrete needs and then applying a direct and real solution. Caseworkers in intensive family preservation systems often help families to fix broken windows, shop for food, request furniture, access car repairs, and so forth. These "hard services" improve the impoverished circumstances of families as well as the physical environment. The assistance also provides an opportunity to model these repair, shopping, or negotiation skills so that families can learn to do them on their own. Indeed, in a study of the client and agency characteristics predicting client participation or collaboration in family preservation services program, Littell and Tajima (2000) found that programs that provided a wide range of concrete services had higher levels of client collaboration, as reported by their caseworkers.

A common criticism of social service agencies is that, to make difficult decisions easier, they simplify their services to a "single operating principle" (Besharov, 1998). This single operating principle often changes with child welfare trends. Service systems, however, have not "trended" to a system of flexible service delivery. Marcia Robinson Lowry is quoted as arguing, "Never have these systems acknowledged the fundamental principle that the circumstances of individual children and families vary, as should responses to those circumstances" (Besharov, 1998, p. 124). Broadly focused case management services should, therefore, be flexibly fashioned to meet the individual needs of the family.

A Family Focus

Another form of service structure that has received much attention since the 1980s is the family-focused service agency. Many agencies are currently moving, or have recently moved, toward

family-focused services, because of the long-term results more likely to be produced when the entire family system is affected. Agencies with a family focus target more needs within the client system than do services that focus primarily on the child.

Those therapeutic services for children that successfully engage parents as well as children are more likely to retain clients than those that do not engage the parents (Smith, Oliver, Boyce, & Innocenti, 2000).

Family group conferencing is a recent addition to many agencies' family-focused service repertoire. Research on family group conferencing emphasizes the inclusion of the entire family as the core component of intervention success (Connolly & McKenzie, 1999; Sieppert, Hudson, & Unrau, 2000; Swain & Ban, 1997). This research points to several themes common to successful family group conferencing programs:

- Use the strengths of a widely defined family group;
- Promote decisionmaking based on the family's needs, as well as the needs of children involved; and
- Allow for the cooperation of parents and workers in the planning process.

Anecdotal evidence indicates that these programs contribute to family engagement and cooperation in service planning and case dispositions (Jackson & Morris, 1999; Ryburn & Atherton, 1996; Thomas, 2000). More evidence must be gathered, however, before this approach is adopted with confidence.

Caseworker Characteristics

Other factors in agency services also help result in the engagement and success of clients. These factors are embedded in the personality and professionalism of the therapist or worker. An agency's interventions and strategies must be flexible to target individual child and family needs, but an agency's caseworkers are the key reflection of the agency philosophy and approach to practice.

Caseworker Qualities

Much research has coupled treatment success with the empathy, trust, and rapport established between a caseworker and his or her clients. These qualities are not typically factors inherent in the overall service structure of an agency; rather, they are found in the worker representing the social service agency (Lazaratou, Vlassopoulos, & Dellatolas, 2000; Menahem & Halasz, 2000).

Caseworker Behaviors

A review of research on service effectiveness with involuntary clients (Rooney, 1992) identified caseworkers' behaviors, rather than their qualities, that are most successful in influencing the treatment adherence or compliance of clients. Rooney summarized the resulting treatment recommendations as follows:

- Make a specific request rather than a vague one,
- Seek overt commitments from clients to comply,
- Provide training in performing the task,
- Supply positive reinforcement of the task,
- Choose tasks that require little discomfort or difficulty, and
- Ensure client participation in the selection and design of tasks (p. 88).

These behaviors exemplify the qualities of empathy, trust, and respect noted above, as manifested in cooperative, mutually agreed on task design and completion. This mutual process is what helps to ensure the engagement of clients who are often mistrustful, having experienced little empathy and trust in their prior service history.

Research in this area reveals that a therapist/caseworker can influence the process of client engagement and compliance by increasing the amount of time spent in direct contact with clients. MacLeod and Nelson (2000) cited research in which a strong correlation was found between worker contact hours and family stability. They state that "interventions which were more intense, requiring a greater number of hours, resulted in fewer children

being removed from their homes because of concerns about child maltreatment" (pp. 1130–1131). In a similar assessment of intensive case management services, Werrbach and Harrod (1996) showed a positive correlation between total case manager hours and a child's score on the function assessment inventory. Although the issue of contact hours might be seen strictly as an agency-level contributor to the engagement process, individual workers should consider how they structure services by integrating direct contact hours into the treatment plan.

Other factors, such as the type of treatment chosen and the clarity of goal setting, can be useful in the successful engagement and treatment of clients. For example, Littell and Tajima (2000) found fewer child removals and fewer recurrences of child maltreatment when parents were involved in treatment planning in intensive family preservation services. Traglia, Pecora, Paddock, and Wilson (1997) recommended the following practice principles in determining whether an intervention program is successful in engaging families:

- Are the goals and guidelines mutually agreed on by all involved parties, and are they clearly stated?
- Is the consumer making sound decisions and taking personal responsibility for the consequences for these decisions?
- Is the practice focus on expected results?
- Are the staff and clients committed to working together?

Most researchers agree that treatment goals should be met to consider an individual intervention successful. Few researchers, however, consider the elements of the treatment process themselves as important contributors to treatment compliance. In 1997, the U.S. Department of Health and Human Services (U.S. DHHS) issued a report that emphasized evaluation of change during the treatment process with neglectful families. Such evaluation should take place on two levels: changes in conditions and behaviors that originally caused maltreatment, and progress made by the

client to achieve set tasks and goals. A formal evaluation in the midst of treatment, rather than at case closure, is also helpful in discussing familial perceptions of goal achievement (U.S. DHHS, 1997). A formal evaluation is not only empowering for families, it serves as a motivator for tasks and goals not yet achieved.

A study by Lazartou and colleagues (2000) examines the relationship between therapy type and compliance. The study results support previous research stressing the importance of family-focused services. Their study found greater compliance (77.8%) in parental counseling than in psychotherapy (38.8%) or specialized therapies (57.3%). Thus, their argument is that knowledge is power: i.e., through parental or family therapy, help and support are extended from the caseworker, and the direct result is treatment compliance. If these factors are combined with a caseworker's responsibility to offer clear goals (Traglia et al., 1997) and with cognitively, socially, and emotionally appropriate interventions (Huszti & Olson, 1999), engagement and successful outcomes increase.

Caseworker Training and Credentials

Research findings are contradictory regarding the relationship between treatment compliance and the level of education and experience of individual clinicians and caseworkers. For instance, Mueller and Pekarik (2000) assessed the drop-out and satisfaction rates of 230 clients in private and public therapeutic clinics. Univariate tests were used for data collected from workers and clients, and the therapist's higher educational degree was found to be associated with the consistent attendance of clients. Of the responding caseworkers, 62% reported that they had a doctoral degree in psychology, and 25% reported that they had a master's degree in psychology or social work. Other research, however, has found that practitioners with bachelors degrees are effective in preventing out-of-home placement in home-based programs (Corcoran, 2000). Apparently, intervention location and technique may be at least as important as educational degree.

The Special Problem of Child Neglect

According to the National Incidence Study of Child Abuse and Neglect, the incidence of physical abuse increased 45% from 1986 to 1993, whereas the incidence of neglect increased 100% in the same period (Sedlak & Broadhurst, 1996). Many service models, including the family preservation service models mentioned above, report much greater success with physical abuse than with neglect.

Given the time limitations in child welfare legislation and managed care, it is especially important to determine methods of quick engagement and treatment compliance for neglectful families. According to a 1997 report from the U. S. DHHS, nearly 41% of children in the child welfare system are in out-of-home placement for at least 18 months. Without quick engagement and effective treatments once families are engaged, these children experience unstable and lengthy care. The incidence of termination of parental rights among these families will likely increase significantly in the near future.

Unique Needs of Neglectful Families

Of the interventions and treatment strategies available to parents who are served by child welfare agencies, many are targeted for both abuse *and* neglect. However, patterns of abuse and neglect are influenced by entirely different factors, and interventions should regard these differences appropriately.

Substance Abuse. No other factor causes more difficulty for treatment compliance than parents who are addicted to drugs and alcohol. The addictive nature of these substances is so powerful that poor parenting, unemployment, mental incapacitation, and homelessness become interconnected with the addiction itself. A national study (U.S. DHHS, 1997) found that substance abuse was the presenting problem in 26% of child neglect cases alone. In families that neglect children, alcohol and crack/cocaine are

the primary drugs, followed by methamphetamines and marijuana (Bartholet, 1999).

Engagement and retention of addicted mothers in substance abuse treatment programs are difficult at best (Eliason, Skinstad, & Gerken, 1995; Ingersoll, I-li, & Haller, 1995; Nelson-Zlupco, Kauffman, & Dore, 1995). Littell and Tajima (2000) found that substance-using parents in intensive family preservation services have significantly lower levels of collaboration with their caseworkers. These deficits are moderated, however, when the caseworker has a master's degree. Another program for substance-abusing mothers enhanced client participation by using a formal, signed treatment contract; goal setting; and a strength-based approach to encourage constructive relationships with caseworkers. A graduation ceremony was held to present certificates of completion (Plasse, 2000).

Most practitioners, policymakers, and researchers in the field passionately espouse one of two positions regarding parents who abuse substances. Either they advocate for amending legislation, such as ASFA, to account for the length of time it takes for parents and caretakers to recover from these addictions (Glisson, Bailey, & Post, 2000), or they advocate for speeding up the child placement process because of the high drop-out and relapse rates for parents in drug treatment programs (Besharov, 1998). Regardless of which position one takes, the issue remains: Until parents are capable of maintaining a substance-free and sober lifestyle, they are considered incapable of adequately parenting their children.

Poverty. Poverty is often associated with abuse and neglect for the obvious reason that impoverished environments create severe stresses for parents and caregivers (Besharov & Laumann, 1997; Lindsey, 1994; Pelton, 1989). Coupled with poverty, unemployment is the presenting problem for nearly 34% of neglecting caregivers (U.S. DHHS, 1997). In a rigorous study of out-of-home placement decisions for children, Rossi, Schuerman, and Budde

(1999) found that when families had some form of family income, family preservation services were more likely to be offered and/or recommended. If families showed no family income, however, children were much more likely to be placed in out-of-home care.

One may argue that children are not removed from the care and custody of their parents strictly because they are poor or unemployed. If resources appear to be scarce, however, and the living conditions for children in poverty do not appear as if they will quickly change, then children are more likely to be placed out of the home (Lee & Goerge, 1999). Once children are removed, many social service agencies or courts require proof of consistent employment, among other things, for family reunification to occur. Employment is, therefore, considered a corollary parenting skill that should not be ignored in the treatment array of services. Thus, if joblessness is a reason for child placement, it must be a target of intervention.

Mental Illness. A study of five home-based programs in six different states revealed that nearly 56% of out-of-home placements for children involved both parental substance abuse and concurrent mental health needs/problems (Menahem & Halasz, 2000). For these families, not parental compliance but mental instability was the presenting problem for treatment (Menahem & Halasz, 2000). Mental illnesses are clearly a barrier to treatment compliance, especially considering that parents may or may not intentionally comply, given the severity of their mental illness.

Effective Intervention Strategies

Current interventions are designed and implemented specifically for the treatment of neglectful families. Empirical support for these interventions might be limited to a single study, and some short- and long-term outcomes are missing from the data. Nevertheless, social service workers have found these techniques useful for their focus of service, and many offer successful outcomes; hence, they are included here.

In-Home Services. In Cohn and Daro's (1987) review of programs targeting child neglect, a combination of services was found to be the most successful in alleviating familial neglect. The services provided included family counseling, in-home casework and counseling, and skill development for jobs both in and out of the home. Given the range of problems in neglectful families, services must be more comprehensive and longer lasting than in physically abusive families.

Many in-home health programs are emerging as a preventative measure for treating families deemed to be at risk of child neglect (Gaudin, 1993; Holden & Nabors, 1999; Singer, Minnes, & Arendt, 1999). In-home services range from medical to clinical care, depending on the agency focus. Holden and Nabors (1999) examined one such program in New York for at-risk families with infants. This program combined in-home nurse visitation and case management for the first two years of the child's life. Long-term results from this program show that at 15-year follow up, the overall rate of child neglect was lower in the treatment group receiving in-home services.

Despite the success of this particular home health study, criticisms still exist of home-visiting programs used as the sole answer to the problem of neglect. Because the early intervention home health program is preventive in nature, it does not necessarily offer an appropriate response to current crises that might exist in a family that is abusing and neglecting children who are present in the home. Hence, families who chronically neglect their children, as much of the current research suggests, will need to be in multiple, intensive programs throughout their lifetime (Yuan & Struckman-Johnson, 1991).

Early Intervention Through Early Childhood Programs. Early childhood programs offer many of the same benefits, and often target the same populations, as in-home nurse visitation programs. These early intervention programs generally focus on the

children at the developmental stages of ages 2 through 5. The programs may be offered through child care agencies, parenting classes, or in-home service agencies, although the majority are offered in day treatment centers. Gaudin (1993) reported that

> Child care programs for [maltreated] children with specially designed therapeutic activities to provide stimulation, cultural enrichment, and development of motor skills and social skills, have proven to have a significant impact on the child's functioning, and the prevention of repeated maltreatment by parents. (p. 42)

Examples of existing programs include Families First (Detroit), The Family Center (Philadelphia), The Center for the Advancement of Mothers and Children (Cleveland), and Head Start (nationwide).

Concrete Services. As noted above, meeting the immediate needs of families in the engagement process cannot be overemphasized. Families of neglect often experience a number of barriers to engagement, including inadequate housing, poverty, unemployment, and lack of transportation. Meeting these needs is of utmost importance if long-term behavioral change is expected. Research shows that families of all types who receive simple and effective services at the beginning of their treatment relationship are more likely to build and maintain a relationship with caseworkers (Lewis, 1991). Therefore, if treatment goals are quickly established, work progresses more quickly.

Concrete services should include, as standard in the intervention plan, both formal and informal helping resources. These services include alleviating the barriers to engagement, i.e., housing, employment, transportation, and childcare. Gaudin (1993) stressed that the "successful mobilization of outside resources to meet the family's identified priorities helps to overcome the family's hopelessness, resistance, and distrust of professional

helpers" (p. 34). Any intervention that targets neglect and does not offer concrete services may miss the root of the problem. Other practitioners contend that programs claiming to work with children and families from backgrounds of neglect should openly address their intent to set long-term goals and to expect long-term treatment.

Behavioral Parent Training. Behavioral parent training focuses on teaching and reinforcing positive parental behaviors that will subsequently influence the children. This training may take place in a small group, in an agency setting, or in the home, but most of these behavioral strategies are concrete and problem-focused. Some multisystemic programs focus both on parental management of behavior and on appropriate responses to the child's needs (Corcoran, 2000). Criticism of this type of intervention is that behavioral parent training does not necessarily result in increased stimulation for the neglected child. Rather, the child's behavior, or the parent's behavior, is better *managed* by this training; nurturing and emotional bonding does not necessarily follow. Successful outcomes, however, are noted in some studies, e.g., an 83% reduction rate in out-of-home placement for families who participate in this training (Corcoran, 2000). Parent training that is especially effective with this population goes beyond parenting behaviors to address parental coping with multiple forms of family stress, including financial and other adult problems (Griest & Forehand, 1982; Patterson, Chamberlain, & Reid, 1982).

Family-Focused Approaches. Family preservation strategies have come under intense scrutiny. Research reveals poor results in effectiveness of this approach with neglectful families (Berry, 1994). Gaudin (1993) asserted that traditional, one-on-one counseling, in a formal office setting, is typically ineffective with families of neglect. He cites studies by Polansky and colleagues (Polansky, Ammons, & Gaudin, 1985; Polansky, Gaudin, Ammons, & Davis, 1985; Polansky, DeSaix, & Sharlin, 1972) advising, instead, assertive interventions that emphasize:

- Reassigning role tasks within the family,
- Establishing of better parent/child boundaries,
- Improving in clear communication between family members, and
- Reframing dysfunctional perceptions by parents and children.

Strengthening Support and Community Networks. Many interventions mentioned above are most effective when caseworkers establish a trusting and empathetic relationship with their clients. Although these skills are important, they do not necessarily help families to become self-sufficient in the long run (DePanfilis, 1999). Equally important, therefore, is helping families to build and to maintain support networks outside the professional working relationship.

Formal, community-based practices differ in the connections that they provide. Typically, support networks include key stakeholders from public and private agencies, schools, clergy, universities, as well as children and their families. A support team might also be created or strengthened by using members of the client's family and close neighbors or friends (VanDenBerg & Grealish, 1996).

An example of this type of community-based intervention is the Social Network Intervention Project developed by Gaudin, Wodarski, Atkinson, and Avery (1997) in Georgia. The Social Network Intervention Project comprises a four-step process of case management:

- Making assessments and targeting existing needs/supports;
- Identifying barriers to involvement, such as the lack of a phone, transportation, or childcare;
- Setting goals (e.g., facilitating needed concrete services, enhancing parenting and professional skills, and increasing social networks); and
- Intervening on various levels: personal, mutual, volunteer, neighborhood, and social.

Program evaluation revealed that the Social Network Intervention Project improved both parenting adequacy and overall attitudes about parenting. The Social Network Intervention Project also aided in increasing support systems, while decreasing unrealistic parental expectations of children (Gaudin et al., 1997).

Conclusions and Recommendations

This review of engagement strategies and behaviors that contribute to positive case outcomes has identified several promising practices in child welfare. Most notably, caseworker and agency behaviors, rather than qualities, appear to be the most important in the engagement of clients in child welfare services. Although empathy and respect are certainly important in building a working relationship, these qualities are best communicated through clear and concrete behaviors between the caseworker and client. These behaviors include: setting of mutually satisfactory goals, providing services that clients find relevant and helpful, focusing on client skills rather than insights, and spending sufficient time with clients to demonstrate skills and provide necessary resources. These practices, when applied in a supportive and nonpunitive manner, help to engage clients in treatment and, perhaps, decrease the number of families experiencing the termination of parental rights because of noncompliance with agency goals. These practices may also prevent the placement of children in out-of-home care and may promote family reunification when such placements occur.◆

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