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Child Welfare Caseworker Education and Caregiver Behavioral Service Use and Satisfaction with the Caseworker

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Abstract

Social work has long been identified with child welfare, and research has generally found that child welfare caseworkers with a social work degree are better prepared than aseworkers with other degrees. Little knowledge exists though about the relationship between caseworker professional background and caregiver behavioral health service use or their satisfaction with the caseworker. Using data from the National Survey of Child and Adolescent Well-Being, we found no significant relationships between having a social work degree and caregiver use of services or satisfaction with the caseworker. More research is needed to clarify how caseworker characteristics, including professional preparation, influence child welfare outcomes.

Keywords

child welfare workers; behavioral health service utilization; client-worker relationship; workforce issues

INTRODUCTION

Permanent caregivers of children in the child welfare system often experience mental health and substance abuse problems that can negatively affect their parenting (Chaffin, Kelleher, & Hollenberg, 1996; Connell, Bergeron, Katz, Saunders, & Tebes, 2007). Use of behavioral health services can decrease maltreatment risk (DePanfilis & Zuravin, 2002). Researchers investigating service use by caregivers have focused predominantly on their characteristics and those of their children (Kolko, Selelyo, & Brown, 1999; Libby et al., 2007). However, Stiffman and colleagues found that provider characteristics explained more variance in

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service use than did client variables (Stiffman, Pescosolido, & Cabassa, 2004). Findings from two recent studies have pointed to the role that caseworker characteristics and organizational practices play in the identification of caregiver need for behavioral health services. Caseworkers were more likely to identify caregiver depression when the agency incorporated standardized mental health assessments during the investigation process (Chuang, Wells, & Aarons, 2014), and caseload size was negatively associated with the identification of depression and substance abuse in caregivers involved with child welfare (Chuang, et al., 2014; Chuang, Wells, Bellettiere, & Cross, 2013). These findings imply the need to begin studying caseworker characteristics and other contextual variables that affect caregivers' use of behavioral health services, and satisfaction with the caseworker and services, as well as other child welfare outcomes.

Caregivers do or do not use services within the context of interactions with social service professionals and community organizations (Hohmann, 1999; Pescosolido, 1992). Yet, little is known about what contextual variables influence caregiver service use or the factors that affect their satisfaction with the caseworker. Contextual variables exist at many levels, including caseworker characteristics, the nature of the caseworker-client relationship, supervisory and management support of caseworkers, and organizational openness to reform and strengths-based practices. Community characteristics include availability and accessibility of behavioral health services and other informal and formal supports for families. The professional background of the child welfare case manager is one contextual variable. Whether and how the professional discipline and training of the child welfare caseworker influences outcomes are in need of further study. Evidence suggests that child welfare workers with social work training are more likely to have the complex skill set needed to develop relationships with parents and to facilitate their use of behavioral health services (e. g., Ryan, Garnier, Zyphur, & Zhai, 2006). Previous research has found that social workers have generally positive attitudes toward supporting caregivers engaged with the child welfare system with addictions, and optimism about caregivers' ability to care for their children (Adams, 1999). Historically, scant attention has been given to how caregivers perceive child welfare services and the factors that affect their satisfaction with services. To our knowledge, no studies exist that examine the relationship between caseworker professional background and caregiver service use or caregiver satisfaction with the caseworker. The current study addresses this gap by examining whether caregivers whose child welfare caseworkers have degrees in social work are more likely to use needed behavioral health care and whether they are more satisfied with the caseworker.

LITERATURE REVIEW

Social work is the profession most closely identified with child welfare (Popple & Vecchiolla, 2007; Zlotnik, 2003). In recent years, concerns about the lack of a professionally prepared and competent child welfare workforce in the US have led to federally funded training collaborations between schools of social work and public child welfare agencies which have created "new bonds" between these two fields (Zlotnik, 2003). Evaluations of Title IV-E and other specialized child welfare training programs in schools of social work have generally shown positive outcomes, including increased knowledge and competence and higher retention (Auerbach, McGowan & LaPorte, 2007; Barbee et al., 2009; Fox,

Miller, & Barbee, 2003). Folaron and Hostetter (2006) found that social work knowledge and skills were a better match for child welfare case management than were related human service and social science disciplines. Child welfare services, though, are also provided by case managers not trained as social workers, including those with degrees in sociology, psychology, business, criminal justice, theology, physical education, music, and chemistry, among others (Ellett, Ellis, Westbrook, & Dews, 2007).

Research about the effects of social work training on child welfare case management has yielded a mix of positive and null results. Lieberman, Hornby, and Russell (1988) surveyed child welfare workers about how well prepared they were to perform child welfare tasks. Respondents with a master's degree in social work (MSW) had higher perceived preparedness scores overall, whereas those with a bachelor's in social work (BSW) had higher scores than did respondents with a bachelor's degree in a non social work field. Findings from another study suggest that professionally trained social workers are better prepared to work with families with multiple needs and to develop plans for permanent family placement, compared to workers without a social work degree (Albers, Reilly, & Rittner, 1993). Dhooper, Royse, and Wolfe (1990) examined how professionally prepared social workers performed on several measures (quality assurance scores, a state merit test, supervisor ratings, commitment to social work values, and perceived preparation), compared to state social service employees without social work degrees. Overall, professionally prepared social workers scored significantly better on these measures than did the other employees. Finally, Ryan, Garnier, Zyphur, and Zhai (2006) found that children with a MSW social worker spend significantly less time in foster care, compared to children with non-MSW social workers, although MSW status did not affect reunification. Other studies have not found any benefits from having a social work degree. For instance, Perry (2006) found that the performance scores of case managers with a social work degree did not significantly differ from those with other degrees. And, in a multi-state sample of child welfare workers, having a social work degree did not predict a strength based practice approach (Douglas, McCarthy, & Serino, 2014).

The social work curriculum includes content directly relevant to use of needed services and other positive outcomes. Social workers have knowledge of community resources (Scannapieco & Connell-Corrick, 2003) and have been trained in how to make effective referrals. In their examination of social work and other human service/social science disciplines, Folaron and Hostetter (2006) found that social work was more likely to include content on referral to appropriate services, engagement of individuals and families, cultural sensitivity and competence, assessment models, assessment of functioning, intervention planning, collaboration skills, as well as other content areas. Such content has relevance to a number of child welfare outcomes, including two that are the focus of this study. Knowledge and skills related to referrals, assessment, intervention planning, and collaboration are important to enhance caregiver use of behavioral health services. Knowledge and skills related to client engagement and cultural sensitivity should impact how satisfied clients are with the services provided by their caseworkers.

Recent studies have shown that caregiver use of services targeted toward their needs (for example, parents with substance abuse problems use substance abuse services), as well as

more general services (for example, parenting classes, counseling) results in a higher likelihood of reunification (Choi, Huang, & Ryan, 2012; D'Andrade & Nguyen, 2014). Similarly, the role of the client-professional relationship in attaining outcomes is well established in psychotherapy, and at least one study has shown it is related to outcomes in child welfare (Lee & Ayon, 2004). However, little is known about the provider factors that affect either caregiver use of services or their satisfaction with services (Alpert, 2005). Satisfaction has several dimensions, including agreement with the services offered by the caseworker, collaborative decision-making, and the degree to which the caseworker is respectful of the parent and family.

This study sought to address these gaps in the literature by addressing the following questions. Compared to caregivers whose child welfare caseworkers do not have a degree in social work, are caregivers whose caseworkers have a MSW: 1) more likely to use needed behavioral health care? 2) more satisfied with the caseworker?

METHODOLOGY

Study Design

Data were drawn from the second Child Protective Services (CPS) cohort of the National Survey of Child and Adolescent Well-Being (NSCAW), a study of children in the U.S. child welfare system (Dowd et al., 2006). A two-stage stratified design was used to sample children in 81 primary sampling units (PSUs) within 83 counties throughout the U.S (Dolan, Smith, Casanueva, & Ringeisen, 2011). Within the PSUs, children were randomly sampled from all maltreatment investigations or assessments that closed between February 2008 and April 2009. Among those interviewed were children, their current caregivers, and child welfare caseworkers. Interviews were conducted at baseline, or shortly after the initial child welfare investigation or assessment (Wave 1, with first interviews conducted between March 2008 and September 2009), and at 18 months (Wave 2).

Sampling weights within NSCAW accounted for differential selection probabilities as well as potential bias resulting from survey non-response and thus yield approximately design-unbiased and consistent estimates for the corresponding population quantities (Dowd et al., 2010). Analysts can thus derive an almost nationally representative sample of families who have had encounters with the child welfare system, excluding the non-participating states. The original data collection was approved by RTI International's IRB. Analyses for the current study were approved by the IRB at the University of North Carolina at Chapel Hill.

Samples

Of the 5,872 children in the initial NSCAW cohort, 4,112 received some services from a child welfare agency, including case management; others did not receive services either because their cases were determined to be unsubstantiated or because agency staff determined that services were not required. In 1,167 of these 4,112 cases served by a CPS agency, service caseworkers also provided information about their educational background and services for families at wave 1 and/or wave 2.

Caregiver Service Use—The sample for each caregiver service use model was restricted on the basis of need for each respective type of service (i. e., individual mental health treatment, family counseling, and/or substance abuse treatment). Because of the difficulty identifying behavioral health problems for families engaged with child welfare, caregivers were identified as needing mental health services if their wave 1 (baseline) responses to the Composite International Diagnostic Interview--Short Form (CIDI-SF) indicated a major depressive episode within the last 12 months, or the child welfare investigative caseworker indicated that the caregiver had a serious mental health or emotional problem (Walters, Kessler, Nelson, & Mroczek, 2002). A total of 530 caregivers were identified as needing mental health services. Data on caregiver receipt of individual mental health treatment was available for 376 of these cases, and data on family counseling was available for 345 of these cases. Listwise deletion on the other variables included in the multiple regression reduced the final analytic samples for these models to 362 cases and 331 cases, respectively.

Caregivers were identified as needing substance abuse treatment if at baseline their scores on the Drug Abuse Screening Test (DAST-20) indicated a moderate to severe drug-related problem (Cocco & Carey, 1998), their scores on the Alcohol Use Disorders Identification Test (AUDIT) indicated at-risk for a drinking problem or hazardous alcohol use based on DSM-IV classification criteria (Reinert & Allen, 2007), or the investigative caseworker indicated that the caregiver was actively abusing alcohol or drugs. A total of 442 caregivers met these criteria. Data on caregiver receipt of substance abuse treatment was available for 304 of these cases. Listwise deletion on other variables reduced the final analytic sample for this model to 297 cases within 66 agencies.

Caregiver satisfaction—In the three models predicting caregiver satisfaction, we included 599 caregivers who were interviewed at wave 1 and who were working with a service caseworker at that point. In the model predicting perceived caseworker responsiveness, data were available for 535 caregivers. In the second model predicting caregiver dissatisfaction with caseworker services, data were available for 527 cases. Finally, in the model predicting caregiver perceived caseworker availability, data were available for 487 cases.

Measures

Dependent variables—Caregiver service use was measured through three binary variables, each based on wave 1 survey responses (i.e., approximately four months after the case transitioned from investigation to services). First, individual caregiver outpatient mental health service use was coded=1 if a caseworker indicated that the caregiver had received individual counseling, either at home or at the child welfare agency. Second, family counseling was measured through yes/no caseworker response about whether the family had been counseled together, either at home or somewhere else. Finally, substance abuse treatment was coded as having occurred if the caseworker reported that the caregiver had received substance abuse treatment as a result of a referral from the child welfare agency.

Caregiver satisfaction was measured using three binary variables, each collected at wave 1. The first variable reflected caregiver perceived caseworker responsiveness. This variable was

based on a three-item measure reflecting caregiver perceptions of the extent to which their caseworker (a) listened to their concerns, (b) treated them with respect and (c) did a good job of explaining problems or services to the caregiver (α=0.83); the variable was coded =1 if caregivers reported caseworkers as responsive in these areas either “Some of the time” or “All of the time.” The second caregiver satisfaction variable measured caregiver dissatisfaction with the services provided by the caseworker. Caregiver dissatisfaction was identified as present if caregivers responded “Agree” or “Strongly Agree” to the following measures related to services received: “Services should had been more helpful”, and “I should have been offered more services.” Finally, the caregiver satisfaction variable measured caregiver perceived caseworker availability. This variable was based on a three-item scale measuring the degree to which the caseworker (a) maintained contact with the caregiver, (b) involved him or her in meetings, and (c) involved him or her in decision-making (agr; =0.88). Caregivers were coded as satisfied with caseworker availability if on average they reported being “Satisfied” or “Very Satisfied” with caseworkers in those three areas.

Independent variables—The highest educational degree of child welfare caseworkers was measured through four separate binary variables indicating that the caseworker had: 1) a non-social work bachelor’s degree (referent category), 2) a bachelor’s degree in social work, 3) another master’s degree and, 4) a master’s degree in social work. This caseworker education variable was constructed from the survey wave in which the service caseworker was interviewed.

A number of caregiver, case and contextual factors known to be associated with caregiver likelihood of behavioral health service use and interactions with the child welfare system were included as covariates. On the basis that more mature parents might be more likely to use recommended services, caregiver age was included. We also accounted for caregiver gender (March & Cao, 2005). Based on previous findings from NSCAW data about caregiver race and ethnicity (Libby et al., 2006), separate binary variables were used for non-Latino African American, Latino and American Indian/Pacific Islander, with the referent group being non-Latino white. Three separate binary variables were used to measure caregiver health insurance status: self-pay, private, and other (e.g., military health insurance such as CHAMPUS or VA care), a factor found in previous research to correlate with service access (Stockdale, Tang, Zhang, Belin, & Wells, 2007). The referent group was public insurance (e.g., Medicaid or Medicare). We also ran models with and without caseworker years of experience, but found no significant effects on focal estimates, and thus omitted this covariate because it was missing for over 10% of cases.

The models also accounted for family attributes that prior research suggested might affect service use. Children were coded as having a behavioral problem if their total Child Behavior Checklist (CBCL) score was >=64, i.e., in the range at which clinical intervention was recommended by the instrument developer (Achenbach & Edelbrock, 1991). An ordinal measure of family risk for child maltreatment was used to account for a number of additional factors potentially related to caregiver behavioral health needs and use – e.g. history of domestic violence, child special needs, social support, and poverty (McCrae & Barth, 2008). Values for this measure ranged from 1 (low risk) to 3 (high risk). The most

serious type of child maltreatment was measured through three binary variables: physical abuse, sexual abuse, and neglect, with other types of maltreatment (i.e., emotional, lack of supervision, abandonment and moral, educational and medical/dental neglect) as the referent category.

Finally, three contextual variables were included in the regression models. First, a binary variable indicated that the child welfare agency was located in an urban area. Second, models predicting family counseling and individual mental health treatment included agency director perceptions of availability of mental health services for adults in the families they served using a 5-point Likert scale ranging from 1="Not at all" to 5="Very Adequate". Third, for the model predicting substance abuse treatment, the agency director's perceived availability of substance abuse treatment services was included to account for local provider availability and using the same 5-point Likert scale.

Analytic Approach

The NSCAW sample includes multiple families within each child welfare agency. The unconditional intraclass correlation coefficients for all six dependent variables indicated significant (>5%) variance across agencies in caregiver service receipt and satisfaction (Hofmann, 1997). However, because our focus was on estimating individual level associations (i.e., between caseworker factors and caregiver service use), all analyses were run as single-level logistic regression models; Stata 12.0's svy module (StataCorp, 2007) was used to account for the complex survey design of the data, including the clustering of caregivers within child welfare agencies.

Bivariate correlations among study variables, followed by tolerance checks for any correlations >.4 and post-estimation checks for individual variance inflation factors > 10 did not indicate any problematic multicollinearity. However, preliminary analyses indicated that case complexity, such as family risk level, differed across caseworkers' educational level; this finding raises the possibility that families served by caseworkers with social work degrees would be more likely to receive needed services not because of caseworker education, but instead because higher risk families had higher priority for service referrals. To test for the possibility of observed selection bias, analyses for the three models predicting caregiver behavioral health service use were rerun using propensity score greedy matching techniques (Guo & Fraser, 2009). Under this approach, caregivers were first matched on eight variables indicative of family risk, such as history of arrests or trouble paying for basic necessities. Logistic regression analyses were then conducted on the matched sample to examine whether caregivers whose caseworkers had social work degrees were more likely to use needed behavioral health care. Results from these propensity score adjusted models (available from the authors upon request) were consistent with the results obtained from the un-matched multivariate logistic regression models; hence, only the latter are reported in the Results section.

RESULTS

Characteristics of the Sample

Detailed summary statistics are provided in Table 1. Briefly, only a small proportion of caregivers reported receiving substance abuse treatment (26%). A higher proportion of caregivers reported receiving family counseling (54%) and individual counseling (63%). Most caregivers (77%) perceived their caseworker to be available and to be responsive (63%) to their needs. About a third (36%) of caregivers reported being dissatisfied with their caseworkers' services. Most caregivers were served by a caseworker without a bachelor's degree in social work (44%), followed by caseworkers with a bachelor in social work (27%), other master's degree (16%) and a master's in social work degree (13%).

Multivariate Regression Model Results—Our results showed no significant differences in service receipt across caseworker education groups. Among the control variables, caregivers had higher odds of receiving family counseling when the most serious type of alleged maltreatment was sexual abuse rather than another type of maltreatment such as emotional maltreatment or medical/dental neglect. Type of maltreatment was not related to caregiver use of individual counseling services or use of substance abuse treatment. Race/ethnicity was related to use of counseling and substance abuse services, with Latinos more apt to receive mental health counseling and African Americans less likely to use mental health services but more apt to receive substance abuse treatment. Caregivers also had lower odds of using substance abuse treatment when their children scored in the clinical range on the CBCL. Finally, the availability of substance abuse treatment was related to the caregiver's use of substance abuse treatment.

Regarding caregivers' satisfaction with caseworkers, caregivers were more likely to perceive that their caseworker was available when the caseworker had a master's degree in a non social work field; this was the only significant finding in relation to caseworker education. Compared to clients who worked with non-BSW workers, clients who worked with non-MSW workers were 16.3 times more likely to perceive that their workers were available (OR=16.20, 95 CI=3.80–70.02). Female caregivers were more satisfied than male caregivers with their caseworker's availability. Those with any insurance other than Medicare or Medicaid were more highly satisfied with caseworkers' responsiveness than were those with Medicaid/Medicare. When the most serious type of maltreatment was sexual abuse, caregivers perceived caseworkers as less responsive.

DISCUSSION

Our findings are not consistent with those from other studies that have generally found more positive outcomes for families with a professionally prepared social work case manager. This may be due to examining different outcomes, study samples, and methodologies. Another possible reason for the null results is the unmeasured heterogeneity across agencies. Factors at the agency and community level can affect caseworkers' ability to establish relationships with families and achieve outcomes. For example, it is possible that unmeasured barriers to service access could mitigate potential benefits from social work preparation for facilitating use of these services. Many obstacles impede access and use of

behavioral health services, especially substance abuse treatment for women, including stigma, multiple individual and family problems, and lack of child care (Corcoran, 2001). This could mean that social work skills were generally not sufficient to overcome the situational barriers present.

It is not clear why clients perceived caseworkers with master degrees in a non-social work field as more available. If the agency identified those with master degrees in social work as more knowledgeable about child welfare and better prepared to take on some administrative tasks, then they may have had less time to spend with families. Another possibility is that master level social workers had more interest in providing clinical services that did not fit well with how the client perceived their immediate needs. This finding is in need of more investigation in future research.

Ellett and Leighninger (2007) aptly noted that a degree in social work does not necessarily make a competent child welfare case manager and that with appropriate training and experience individuals of other disciplines can become competent child welfare practitioners. It is not known whether the social workers in our study had received specialized training for child welfare practice. Not all social workers are prepared for child welfare practice, and it may be that a degree in social work makes a difference only when the curriculum includes specialized knowledge and skill development in child welfare. Given the close identity of child welfare with the social work profession and the Title IV-E resources that have been given to the preparation of social workers for child welfare practice, it is important to continue to study whether and how the professional education of the child welfare worker makes a difference in child and family outcomes.

It may be that social work training does not better prepare workers to work with high risk families with behavioral health needs compared to training in other fields such as psychology. Child welfare case managers work with a diversity of family issues, and the question of whether case managers with social work training are better prepared for child welfare practice may be too broad. NSCAW data do not specify what the type of non-social work masters degree was, thus limiting exploration of what other specific degrees may facilitate caregiver satisfaction with caseworkers. Future examinations may want to include what specific training has been provided related to child welfare skills and knowledge and link this specialized training to relevant outcomes. Future research can include variables that represent the reality of child welfare practice, including those related to the organization and neighborhood (Hartinger-Saunders & Lyons, 2013). Research that examines the role of the child welfare caseworker in facilitating behavioral health service use by caregivers in child welfare should also include information about the duration and intensity of services, as well as the relationship of the caregiver with the behavioral health counselor/therapist. Studies that include the relationship between therapist and caregivers, child welfare workers and caregivers, and child welfare and mental health professionals will help tease out the complex pathways of how caregivers access and use treatment services. Prospective designs that examine the qualities of the relationships in these multiperson networks and that include the perspectives of caregivers as well as professionals will shed light on what factors facilitate or hinder the use of treatment services.

A recent study found that approximately 20% of graduates from specialized bachelor of social work child welfare education programs leave after four years of child welfare employment (Barbee et al., 2009). This was largely due to stressful work conditions and lack of supervisory support. Supervisory support is especially important early in caseworkers' careers and predicts retention in the agency as well as retention in the child welfare field (Chenot, Benton, & Kim, 2009). Thus, agencies must not only hire professionally trained caseworkers, but also work to retain them. Studies have shown that professionally preparing social workers for child welfare work results in employees ready to "hit the ground running" (Fox et al., 2003, p. 80). The effects of specialized preparation may even out over time as these workers are confronted with the challenges and complexities of child welfare practice and as non social work prepared workers gain on the job experience and training. Initiatives to train workers as well as retain workers are needed. An example of such an initiative is collaboration between child welfare and a social work program to provide clinical supervision for MSW's employed in child welfare (Giddings, Cleveland, Smith, Collins-Camargo, & Russell, 2008). Giddings and her colleagues (2008) noted that social work practice in child welfare has been constrained to fit the focus on case management, ultimately meaning that the benefits of specialized training may be washed out if workers are not allowed to use their professional skills.

NSCAW is unique in its national depiction of families engaged in the US child welfare system and remarkable in the range of stakeholders who were interviewed. At the same time, use of secondary data presents several limitations to this study. The difficulties of collecting data from all potential sources manifested in retaining relatively small subset of cases in final samples. The standard errors may be higher because the models have less information to estimate the parameters due to missing data. Similarly, using caseworker reports of service use as we did is not as valid as using billing data or clinical records would have been. NSCAW data also did not indicate the specific types, intensity, duration, or quality of services. We believe that given both the early stages of this research stream and the many barriers to service entry, the current study's focus on whether caregivers received any treatment in each respective area was appropriate. However, the extent to which these services met caregiver needs remains unknown. We also could not ascertain the degree type of case managers who did not have social work degrees, or control for the amount of ongoing training and supervision that case managers received subsequent to entering the child welfare workforce.

In summary, it is important that child welfare managers and administrators not only work to recruit well-prepared case managers, but to also implement practices to retain them. Future research can examine administrative policies and practices that enhance the professional development and retention of child welfare case managers. In the future, it would be informative to move beyond simply asking whether a social work degree results in improved outcomes, and also describe whether the curriculum included child welfare relevant content and an internship in a child welfare agency. Information about the quality and content of ongoing training and supervision is also important to obtain, as case managers can develop skills and knowledge with experience and time. As noted, there are also other factors that can influence outcomes and it will be important to be attuned to them in future research.

CONCLUSION

Significant questions remain as to whether the human and financial resources invested in social work preparation results in better health outcomes for children and families, as well as how to develop supportive agency cultures in child welfare that support the hiring, training, and retention of qualified workers. We hope this study will encourage other researchers to continue exploring how caseworker characteristics, including professional preparation, influence the client-worker relationship, use of needed services, and other child and family outcomes.

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Table 1

Weighted Descriptive Statistics for Permanent Caregivers Receiving Services from a Child Welfare Agency and by a Service Caseworker

	Mean/%	(S.E)	Range
Dependent Variables			
Caregiver use of family counseling services	54		0–1
Caregiver use of individual counseling services	63		0–1
Caregiver use of substance abuse treatment	26		0–1
Caregiver perception of caseworker's responsiveness	63		0–1
Caregiver perception of dissatisfaction with caseworker's services	36		0–1
Caregiver perception of caseworker availability	77		0–1
Service Caseworker Education			
Other bachelor's degree [Referent]	44		0–1
Bachelor's degree in social work	27		0–1
Other master's degree	16		0–1
Master's degree in social work	13		0–1
Caregiver Characteristics			
Caregiver age in years	34	13.06	18–84
Caregiver gender: female	85		0–1
Caregiver gender: male [Referent]	15		0–1
Caregiver race/ethnicity			
White [Referent]	59		0–1
African American	9		0–1
Latino	20		0–1
American Indian, Pacific Islander	12		0–1
Type of caregiver health care coverage			
Public (e.g., Medicaid, Medicare) [Referent]	50		0–1
Self-pay	29		0–1
Private	18		0–1
Other insurance type	3		0–1
Characteristics of the child welfare case			
Child has a clinical score in the Child Behavior Check List (CBCL)	32		0–1
Risk scale for the family (1–3)	2.71	0.04	1–3
Most serious type of child maltreatment			
Physical abuse	19		0–1
Sexual abuse	7		0–1
Neglect	31		0–1
Other type of abuse [Referent]	43		0–1
Contextual variables			
Child welfare agency located in an urban area	59		0–1

	Mean/%	(S.E)	Range
Availability of mental health services per agency director report	3.04	0.22	1–5
Availability of substance abuse services per agency director report	3.33	0.22	1–5