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Project Summary Report

CHILD WELFARE TRAINING GRANTEES			
PROJECT	Interdisciplinary Training for Child Welfare Workers and Supervisors		
GRANT PRIORITY AREA	Child Welfare Training Projects		
PROJECT DIRECTOR	Dr. Loring Jones		
AGENCY	San Diego State University		
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START DATE	9/30/98	END DATE	9/30/00
PROJECT DESCRIPTION Specifically, the project has three primary objectives: <ol style="list-style-type: none"> 1. Develop competency based curriculum aimed at building knowledge, attitudes and skills to strengthen the capacity of child welfare staff for collaboration with community-based agencies to provide services to at-risk families to prevent child maltreatment and prevent the recurrence of such problems for children reunified with their families. 2. Provide training in domestic violence intervention, substance abuse, and mental health for child welfare practitioners and community based providers which facilitates interdisciplinary collaboration and practice. 3. Field test collaborative training and evaluate its application; (e.g. number of trainees, perceived usefulness, knowledge acquisition, skill development, and attitudinal changes). 			
PROJECT ACCOMPLISHMENTS <ul style="list-style-type: none"> ▶ Conducted five focus groups with community groups/agencies to gain input on curriculum design prior to training. ▶ Developed curriculum based on focus group comment. Curriculum consists of 5 one day (6 hours) modules that are taken as a single course. This curriculum package is available as a product of the project. ▶ An evaluation instrument was developed and employed in the project. The instrument is available for dissemination. ▶ The curriculum package had been offered in six separate occasions. A total of 192 workers attended the trainings. ▶ Evaluations have shown high consumer satisfaction with the training, consumer gains in knowledge and skill concerning collaboration and the content areas, and increased collaboration by project participants. 			

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INTRODUCTION

This report describes the experience of the Interdisciplinary Child Welfare Training Program (ICWTP) which was funded in response to Priority Area 3, *“Training for Child Protective and Child Welfare Staff for Collaboration with Community-Based Agency Efforts and Services to Prevent the Incidence and Recurrence of Child Abuse and Neglect and to Prevent the Re-abuse of Children Reunified with Families to Prevent Re-entry into Foster Care.”* The ICWTP was a successful collaboration between the San Diego State University School of Social Work (SDSU-SSW), The Public Child Welfare Training Academy, and the Children's Services Bureau (CSB) of the San Diego County Health and Human Services Agency. The ICWTP applied and field tested an *Interdisciplinary and Collaborative Training Model* developed through previous collaborations. The previous model had focused on training students from social work and other professions. The current project applied the training model to practicing professionals. The training occurred through the Public Child Welfare Training Academy (PCWTA) at SDSU. The PCWTA provides training for public child welfare workers in the five county southern California region.

OBJECTIVES

Specifically, the project had four primary objectives:

1. Develop competency based curriculum aimed at building knowledge, attitudes and skills to strengthen the capacity of child welfare staff for collaboration with community-based agencies to provide services to at-risk families to prevent child maltreatment and prevent the recurrence of such problems for children reunified with their families.
2. Provide training in domestic violence intervention, substance abuse, and mental health for child welfare practitioners and community based providers which facilitates interdisciplinary collaboration and practice;
3. Field test collaborative training and evaluate its application; (e.g. number of trainees, perceived usefulness, knowledge acquisition, skill development, and attitudinal changes);

4. Institutionalize the application of this interdisciplinary and competency based curriculum through an ongoing training program for public child welfare workers (the SDSU Public Child Welfare Training Academy, PCWTA).

These objectives contained several tasks in the development of an educational program for child welfare practitioners. These tasks were completed by the ICWTP implementation team and included the following:

1. Develop specific interdisciplinary and collaboration competencies and curriculum on domestic violence, substance abuse, and mental health;
2. increase collaboration with disciplines that impact child welfare;
3. develop an interest in interdisciplinary practice;
4. trainee recruitment and selection, orientation, progress, and evaluation process;
5. integrate the collaborative child welfare competencies into the Public Child Welfare Training Academy curriculum;
6. and empower staff to work effectively together to provide better results for children and families.

THE NEED FOR COLLABORATIVE TRAINING

Overview–The Macro Perspective

Like other large urban areas, San Diego has hundreds of service organizations targeting a specific categorical need. Effective communication and integration of services is lacking. Potential users of services often find services hidden and inaccessible. The existing service system is inefficient in its use of resources. Of the 900 million dollars spent on services in 1993 less than 3% went to prevention, and the bulk of the remainder went to a relatively small group of multi-problem families. An example of this problem can be found in prevention services. The CPS hotline received 75,000 in 1993. Only about a third of those calls were deemed serious enough to warrant entry into the service. However, 30% of those cases that did not enter CPS were re-referred to CPS within one year

(Ross, 1994). If preventative services were available some of these families might have avoided system entry. Families in crisis need to wait until their situation becomes acute enough to meet criteria for CPS entry. The local human service organizations, each operating within the narrow confines, are unable to meet many of the needs of an increasingly diverse population.

These problems have not gone unnoticed. In 1990, the San Diego County Board of Supervisors created a task force to develop a model for integrated services countywide. The model developed by the task force was a fundamental shift in focus from crisis intervention to prevention. One outcome of the shift in focus was the collaborative planning initiative *New Beginnings*. This school-based initiative brought together child serving agencies on behalf of at-risk into a *single service entity* in order to reduce service fragmentation. This program is the model for the development of the *Healthy Start Initiative* by the State of California. The idea of these preventative programs is that if families require services, but do not fit CPS criteria they would be referred to other County or community service providers. Referrals and subsequent services offer an opportunity to stabilize at risk families and keep them from entering (or re-entering) the child protective service system.

Despite good intentions these programs fall short. Funds are presently insufficient to meet demands for even crisis programs, and workers lack the training to engage in effective collaborative practice. The ICWTP met part of that unmet need by providing training for workers on collaboration.

The Micro-Perspective

Case managers are often faced with difficult decisions regarding the removal of children and provision of services because of the uncertainties of prognosis. Furthermore, substance abuse

issues are often presented in tandem with mental health and/or domestic violence issues, resulting in confusion about appropriate ordering of services. Appropriate substance abuse treatment programs for families dealing with substance abuse are in short supply.

An additional layer of complexity is added when these issues are present in cases that become part of the court system. *Domestic violence* and substance abuse problems may be prosecuted in court, affecting the availability of the parents for treatment. Mental health problems may be subject to civil proceedings that interfere with or complicate child protection cases. Furthermore, juvenile court judges, who must make the ultimate decisions regarding the disposition of children and reunification plans and services, may be poorly informed about the dynamics of these problems. Social workers who appear in court must be prepared to explain their decisions to the court if their efforts are to be realized.

Public child welfare programs have been subject to intense public scrutiny in recent years, often in conjunction with the deaths or injuries of children in placement, or with disruption of families that might have been preserved. These incidents often reflect the pressure of caseloads that are rapidly increasing in numbers and acuity while resources are diminishing. Frequently however, workers who have committed serious practice errors are poorly trained in the legal requirements and complex skills associated with child welfare practice. In several states, child protective services agencies have been found by the courts to be deficient in observing legal and professional practice standards. Consent decrees agreed to by states and counties have included requirements for upgrading child welfare staff (Grossman, Laughlin, & Specht, 1992).

Rarely is social work the only human service profession called upon to address complex psychosocial problems, such as those associated with family violence, drug abuse, and mental illness.

Thus, in addition to mastering the knowledge, skills and attitudes unique to social work, the social worker must also possess knowledge about and respect for what other professions have to offer us as partners in service delivery, and be skilled in interdisciplinary communication and collaboration.

In social work, interdisciplinary collaboration has been an intrinsic and fundamental, albeit not always cherished, component of practice. Despite the importance of collaboration, social work educators have offered minimal training in the development and maintenance of effective collaboration in education and practice (Andrews, 1990). The need for interprofessional collaboration is likely to be felt more keenly when social work is conducted in "host" settings such as hospitals, treatment facilities, mental health agencies, and within the court system. Although social work traditionally has been the primary profession in public child welfare, the prevalence of domestic violence, substance abuse and mental health problems in the typical child welfare caseload requires effective collaboration with professionals from other disciplines within and across service agencies.

Collaboration takes many forms, such as consultation, referral and teamwork. The latter form is of greatest relevance to effective delivery of services to families within the child protection system who are affected by problems of domestic violence, substance abuse and mental illness. Thus, many communities, counties, and states are moving toward collaborative models of service coordination which cannot be developed and implemented without parallel cooperation among the disciplines involved (Baglow, 1990; Chadwick, 1996; and Knitzer & Yelton, 1990).

Some of the identified benefits of a collaboration approach include the following: more accurate assessments, especially of complex cases; more creative and effective interventions; less fragmentation and duplication of services; fewer cases being overlooked; reduced traumatization of children; less contamination of the evidence gathered; less role confusion, enhanced interprofessional

communication, greater advocacy and emotional support for clients, improved ability to influence public policy, enhanced ability to overcome professional stereotypes, increased professional development and working environments, and a greater sense of accomplishment among the professionals involved (Andrews, 1980; Berg-Weger & Schneider, 1998; Karuza, Calkins, Duffey, and feather, 1988) .

Team approaches to child abuse assessment have been used successfully by both hospital-based teams (e.g. physicians, nurses, social workers, psychologists) and community-based interagency teams (e.g. law-enforcement-social worker teams conducting joint child interviews) over the past ten years (Kaufman, Johnson, & McLeery, 1992). Collaboration has also been demonstrated to be a successful secondary intervention for high-risk parents in preventing child abuse. Such programs provide team designed psychosocial intervention which involve intense contact, support, and community services (Schoor, 1989 & Holden, Willis, & Corcoran, 1992).

Interdisciplinary teams have also demonstrated their utility in providing consultation to child welfare practitioners, who can draw from their varied areas of expertise when needing to make assessments and treatment plans for high risk families.

The vast pool of topical and change-process knowledge needed by the various professionals involved in child welfare practice consists of segments unique to each discipline. Some of the knowledge is borrowed from disciplines other than one's own, and some belonging to the common body of knowledge about family life and child rearing that everybody "owns." Lines among these domains of knowledge are hard, if not impossible, to draw, causing uncertainty and sometimes conflict about what constitutes appropriate use of this conglomerate of knowledge.

Special care in use of borrowed knowledge is called for when selecting cases for

multidisciplinary or interdisciplinary collaboration. In both forms of collaboration the professionals involved agree upon shared case goals, but in the former they act independently but parallel to one another to arrive at these goals, while in the second approach the professionals work collaboratively as an interdisciplinary team in order to arrive at shared case goals. Collaboration is distinct from other forms of collective actions that many people may believe constitutes collaboration.

These choices and their collaborative implementation require more than acquired cross-disciplinary knowledge; they require development of a collaborative attitude and skills in interdisciplinary communication and collaboration. This three-fold interplay between knowledge, attitudes and skills acquisition was the focus of ICWTP. Project activities, which were guided by several specific conceptual and pedagogical principles and models to be briefly presented below, in describing our approach to the project.

The positive act of interdisciplinary training on professional practice is documented in a 1985 study (Harbaugh, Casto & Burges-Ellison, 1987) in which 196 students and professionals from eight disciplines identified training benefit as (1) an easier transition from professional school to practice, (2) greater use of interdisciplinary treatment approaches, (3) more effective client care and, (4) greater use of referral sources. Other studies cite increased cooperation between agencies and greater participation in interprofessional activities as benefits of interprofessional education (Edelstein et al, 1990; Snyder, 1987; Spencer, 1987). Similarly, Kolbo and Strong (1997), in their national survey of the use of multidisciplinary teams, found initial and ongoing training of new members and teams as the most frequently mentioned strategy for "overcoming turf issues," language barriers, role confusion, misconceptions about the function and value of other disciplines, and other obstacles to

successful implementation of treatment plans (Kolbo & Strong, 1997, p. 70).

RESULTS AND BENEFITS DELIVERED BY THE PROJECT

The major need that this program met was the development of a cadre of child welfare practitioners and community professionals with the ability to respond effectively to complex family problems of child abuse and neglect resulting from substance abuse, mental illness, and domestic violence.

The project met this by offering a specialized child welfare educational training to 192 child welfare workers and community workers. Tables 1 through 5 describes those workers.

Table 1
Description of Trainees Job Titles
Frequencies and Percentages Reported
(N=192)

<u>Primary Job</u>	<u>Frequency</u>	<u>Percentages</u>
Administrator	11	5.7%
Supervisor	25	13.0%
Professional Staff	97	50.5%
Planner/Organizer	6	3.1%
Paraprofessional	4	2.1%
Other	15	7.8%
Student	17	8.9%
Missing/Unknown	17	8.9%
% With Staff Training Responsibilities	99	51.6%

*Percentages rounded for this report

Table 2
Trainees Field of Practice
Frequencies and Percentages Reported
(N=192)

<u>Field of Service</u>	<u>Frequency</u>	<u>Percentages</u>
Child Protective Services	68	35.4%
Substance Abuse	24	12.5%
Family Services	24	12.5%
Domestic Violence	17	8.9%
Mental Health	15	7.8%
Community Organizing	7	3.6%
Juvenile and Adult Corrections	6	3.1%
School Social Work	4	2.1%
Other	9	4.7%
Missing	18	9.3%

*Percentages rounded for this report

Table 3
Field of Highest Degree
Frequencies and Percentages Reported
(N=192)

<u>Profession</u>	<u>Frequency</u>	<u>Percentage</u>
Social Work	58	30.2%
Psychology/counseling/MFT*	67	34.9%
Sociology & Criminal Justice	11	5.7%
Substance Abuse	8	4.2%
Other Professional Program (mph, law, MD, Clergy, etc.)	7	3.6%
Education	5	2.6%
Other	3	1.6%
None or left blank	33	17.2%

**Percentages rounded for this report

*Marriage and Family Therapy

Table 4
Educational level of Trainees
Frequencies and Percentages Reported
(N=192)

<u>Profession</u>	<u>Frequency</u>	<u>Percentage</u>
Doctorate	8	4.2%
Masters	92	47.9%
Graduate Student	13	6.8%
BA/BS	32	16.7%
Undergraduate Student	12	6.3%
AA	8	4.2%
Some College	16	8.3%
HS Diploma	2	1.0%
Left Blank	3	1.6%

Table 5
Demographic Description of Trainees
Means and Percentages Reported
(N=192)

	<u>Frequency</u>	<u>Percentage or Mean</u>
<u>Age</u>		Mean=42.96 (sd=14.52)
<u>% Female</u>	139	72.4%
<u>Ethnicity</u>		
African-American	25	13.0%
White	86	44.8%
Asian Pacific Islander	15	7.8%
Hispanic	40	20.8%
Mixed Race	8	4.2%
Other	10	5.2%
Left blank	4	2.1%

Thirty six of the trainees (18.5%) were supervisors or managers. The proposal in response to the request for proposals (RFP) called for training 15 managers and supervisors. Over one-half of the trainees had staff development responsibilities. They were an experienced group who had on average 17.99 years experience, and 47% had at least a masters degree. Twenty-eight percent of trainees had a professional license. The high number of trainees who were supervisors/managers/and trainers suggest this program will have impact beyond the funded period. Workers from under-represented groups received preference for training slots. Over one-half of the trainees were minorities.

Trainees were drawn from a wide variety of fields. Thirty-five percent were Child Protective Service Workers with the rest drawn from a wide variety of service settings.

Other products included developing a set of *interdisciplinary collaborative competencies* for work with substance abuse, domestic violence, and mental health problems. The attached curriculum document includes these competencies, the training model, curriculum, exercises, and guide to use of the curriculum. This document also represents our institutionlization of the curriculum at the PCWTA. The document will also be the focus of our dissemination efforts.

APPROACH

Overview

The project built upon the interdisciplinary training model developed for the *Interdisciplinary Child Welfare Training (ICWT) Project*, which was based upon our prior work in the *Child Abuse Interdisciplinary Training Program (CAIT)*. The project trained 6 cohorts (192 workers) in interdisciplinary collaborative practice training, as well as in the content areas of domestic violence, substance abuse and mental health as they relate to public child welfare.

Training Issues and Strategies

While a variety of training opportunities are available to social workers and supervisors, including on-site, in-service continuing education, agencies have often met with little success in achieving uniform training goals for staff. There are a number of reasons for the inability to reach all workers. First, social workers and their supervisors often carry high case loads; time spent in training results in less attention to the demanding cases they manage. Second, workers often have little incentive to attend training courses. There may be no observed benefit from the time spent, including the lack of acknowledgment or reward for the workers effort. Third, the training may be seen as irrelevant to the actual work the staff is handling. Fourth, training by academics may be seen as "ivory tower" and not in touch with the realities of day-to-day practice. Fifth, workers may have

attended a sufficient number of trainings to conclude that the presentations were not stimulating or *engaging*.

The project employed a variety of incentives and other strategies to ensure attendance and participation. First, we provided payment for continuing education units. Second, training was provided in comfortable surroundings with meals provided. Third, the training modules were designed to meet qualifications for 30 hours of continuing education credit for MFCCs, LCSWs, Nurse Practitioners, and Alcohol and Drug Abuse Counselors as required by the California Board of Behavioral Sciences.

Fourth, the course was taught in a highly interactive manner, focusing on the integration of knowledge into practice and including the participation from other professions so that the experience built collaborative relationships. This relationship building, in turn, enhanced self-respect and respect for other professions as it built on an understanding of how each profession plays a role in helping families. Because the course was interactive, and focused on problem solving among the participants, the complaints that the training is academic, not relevant to practice, or not stimulating was absent. We also utilized trainers who have strong practice backgrounds to further ensure relevance.

CURRICULUM DEVELOPMENT

Curriculum development occurred through a process that included community resources and expertise in the content areas and integrates that knowledge into an interdisciplinary perspective. The Public Child Welfare Training Academy at the SSW trainers conducted trainings in the areas of domestic violence, substance abuse and mental health. These trainers played an integral role in curriculum development, consulting with the Investigators regarding relevant competencies and appropriate content to be covered in the training modules. Focus groups consisting of child welfare

workers, community service providers and clients were conducted to further develop the competencies and to gather suggestions for training delivery. Their role in the development of curriculum is discussed in the next section.

FOCUS GROUPS

The principal investigators on this project used their own experiences and the relevant literatures to develop a broad outline of program content. They recognized, however, that any training on such a complex topic as this would need to be tailored to the specific needs of service providers in the target community. The focus group process was chosen as an efficient way to gather broad-based but specific data on appropriate training content and delivery methods. Focus groups emerged as a research method in the social sciences in the 1940's. They were initially most frequently used in the military and in the marketing profession, but recently have been increasingly used in the human services as well (Kreuger, 1994). For example, four schools of social work and Child Protective Services in Texas used focus groups to help develop a statewide CPS training institute (Urwin and Haynes, 1998).

We conducted five focus groups with 52 participants. The purpose was to provide program planners with feedback on curriculum needs of the service community. The service providers were expected to give us data on specific curriculum content needed by agencies, the format of training, and ideas of how to attract their workers. The groups were conducted by a two person facilitator team. The group participants were chosen purposefully. We developed a comprehensive list of interested parties from among various program directories. Potential participants were contacted by mail with a follow-up phone call. In advance of the sessions, participants were mailed both the focus

group questions and a summary of the proposed outline and the objectives of the five sessions. The focus groups were augmented by interviews with several county staff who were heavily involved with training in interdisciplinary collaboration, including a CPS trainer, the County's director of community initiatives, the director of a local collaborative children's mental health initiative, and a group of county mental health trainers.

Groups were held in different regions of the county in order to insure a proper representation. Participants included direct service and management personnel from many County and community-based programs as well as community leaders involved with current collaboration initiatives. One group was held for managers of one of the County's Children's Services regions to gather data from a management perspective.

At the group sessions, participants were asked the following question and instructed to write their responses on a questionnaire form: "Given your understanding of the objectives and content of the five modules, list for each module:"

- ▶ "The top five subjects I and/or my staff need to know more about; and
- ▶ the top five subjects that other professions/disciplines need to know about my discipline."

This last question was based on the expectation that each training series would have staff from child protective services and providers in the areas of domestic violence, substance abuse, and mental health, and that there would be variation in learning needs based upon a participant's discipline or profession. The researchers then asked participants to suggest any important items or areas missing

from the curriculum, keeping in mind that sessions needed to be one day per subject. Members shared their individual responses and the group prioritized them.

Other questions asked regarding the training design and delivery included:

1. What would be the best format (full days, half days; consecutive days, spread out over several weeks)?
2. What would be the most effective teaching methods for delivering the training (lecture, role playing, case discussions, etc)?
3. Considering staff levels, what would be the best way to group sessions (i.e., with workers and supervisors at the same or separate sessions)?
4. Do you have any other suggestions which would help make the project more useful to you?

Groups were taped and transcribed. Each group took about 90 minutes to complete. Eight to fifteen participants attended each session. Facilitators recorded notes on poster paper that were displayed to participants. The audio tapes and poster notes insured accuracy of our transcription of participant comments.

After a focus group was completed, a transcript based on notes and audio record was produced. A coding scheme which allowed us to reduce the data into content units for analysis was developed. Content units are defined as any statement or idea into the data. Data was then coded into specific categories and recurring themes. Content was selected for the curriculum according to the frequency mentioned across the five groups. Below is a listing of curriculum content that should be included in trainings that were identified by the five groups. Subheadings describe consistent themes

identified from the groups. Specific requested content is listed under subheadings

I. Collaboration

A. Basics of Collaboration: Getting Started

- Definitions
- Roles in collaboration
- Purpose and function
- Benefits
- Expectations
- Principles
- Barriers
- Opportunities
- Beginning a collaboration
- Selecting partners for collaboration
- What to do after you get started
- Logistics and organization

B. Communication among Partners

- Boundaries
- Conflict resolution
- Consensus building
- Participation
- Confidentiality
- Cultural issues
- Team building
- Effective meetings
- Trust building
- Mutual respect

C. Using and Maximizing Resources

- Learn how the service system operates
- What resources are available

D. Consumers: Listening and Getting Them Involved

- Involving consumers as participants
- Understanding the priorities of low income families
- Cultural issues

II. Domestic Violence

A. Definitions and Basics

- Epidemiology of domestic violence
- Differences from others forms of violence and family assault

Differentiation: Distinguishing between different levels of violence
Causation
Batterers and their belief systems (including women)
Dynamics; why women stay

B. Assessment Skills

Initial assessment
Impact on children
Pregnancy and risks
HIV and risks
Lethality Assessment

C. Intervention

How to bring up the subject of domestic violence
Empirical successful models of working with domestic violence
Working collaboratively with everyone involved
Safety planning
Controversies about treatment (and our own biases)
Court mandated vs. Voluntary treatment
CSB reporting
Temporary restraining orders

D. Resources and Systemic Issues

Barriers to use of services
Other agencies involved and their approaches
County and state laws
Safe houses/confidentiality
Court process

III. Mental Health

A. Cultural Definitions and Assessments

Societal influences and definitions of mental health
Workers values and mental health
How other cultures define mental illness
Differential assessment and treatment

B. Assessment

Assessment skills
Discussion of labeling
ADHD
Abnormal development
Normality and development
Psychopathology
Family systems-how effected

C. Resources

- Availability
- Access rules
- HMO's

D. Treatment: Medications and Alternatives

- Basic pharmacology
- Interaction among drugs
- Treatment of substance abusers

E. Treatment

- Differential treatment
- What is treatable
- Suicide prevention

IV. **Substance Abuse**

A. Basics on Substance Abuse

- Costs of various drugs
- Lingo/language
- Paraphernalia
- Drugs of choice by population
- Alcohol
- Abuse of legal drugs
- Causation and effects
- Disease vs. Behavioral Model
- Drugs-health impacts; including HIV
- Cultural definitions and issues
- Definitions-use, abuse, addiction
- Lifestyles of substance abusers

B. Resources

- Availability of treatment
- Access rules

C. Treatment

- Successful empirical models/modalities
- Holistic assessment
- Dual diagnosis
- Court mandated vs. Voluntary
- Treatment of non-abuser
- Family intervention
- Denial
- Relapse

Twelve step
Recovery, life after....early stages

D. Family and Child Impacts

Effect on child by type of substance
Family dynamics
Effect on the extended families
Adolescent and teens
in-utero exposure

The data gathered during the focus groups generally validated the overall strategy and objectives of the project as outlined in the funding proposal, reassuring the implementation team that the design was relevant and would not need major changes. Nevertheless, the focus groups provided suggestions on content and training design which would not otherwise have been considered. For example, regarding skills necessary for collaboration, effective meetings, trust building, and logistical considerations were noted as key skills which may have otherwise been left out of the training design. Also, while the original design included attention to cultural factors, the focus groups emphasized the importance of this subject, prompting augmentation of this part of the curriculum. As might be expected, themes emerged regarding suggested content in the areas of domestic violence, substance abuse, and mental health. In addition to cultural factors, the areas of definitions, assessment, intervention methods, and available community resources were noted in each area. This provided clarity on specifics which should be included, and led us to address resources in two ways: having all participants provide their business cards and program summaries to be compiled, copied, and distributed to all participants; and including internet resources in each session.

Participants provided specific and helpful suggestions on the training design and factors which may enhance interest and attendance. For example, free meals, continuing education credits, and a

pleasant training site were seen as effective marketing tools. All of these were used, and demand was so great that each training series had a waiting list. Suggestions were also offered regarding ways to identify participants and other professions to invite (e.g., school and justice system personnel).

Lessons Learned from the Focus Groups

- **The focus groups provided community input that enriched the curriculum described in the original proposal.**

The focus group process used here was a very useful augmentation to the original program design, which was based primarily upon the relevant literature and the principal investigators' knowledge of the community and its needs. Certainly we could have delivered a very adequate training program, but the data from the focus groups provided specific detail and suggestions on content which may not have been included otherwise. One frustration which the process highlighted was the wide range of knowledge and skills which were seen as necessary for effective interdisciplinary collaboration. The priority-setting process used during the focus groups helped narrow down possible subjects and reminded all that one training series, even one taking five days, cannot give participants all available knowledge and skills.

A literature is developing regarding interdisciplinary and collaboration competencies (some cited above), and the focus group findings may be of use to others designing such training programs. Of course, any training design should be based on locally identified needs and goals, and findings such as those here should not be adopted without consideration of local situations. The areas listed above can nevertheless be used to stimulate or focus thinking in another context. More important, perhaps,

is the example of the successful use of the focus group methodology. This can be replicated by trained researchers (see Krueger, 1994, Greenbaum 1993, and Templeton, 1994 for guidelines on methods and procedures) for any training content, and can be expected to result in more relevant and complete content than would otherwise be provided.

▸ **The focus group process also seemed to serve an energizing and marketing function.**

It built awareness of the upcoming training program in the child welfare community and enabled many service providers to get a better feel as to how the sessions would be conducted. Those who later attended the sessions included some focus group participants and many staff from their agencies, although we cannot definitively say that the focus groups were a key factor here. Another dynamic which may have operated is the notion from research on decision making philosophies in management which suggest that people are more supportive of decisions or programs in which they had a decision making or input role. More specifically, one model (Miles, 1975) suggests that getting input should not be done only to develop “buy in,” but also because it will lead to a better product. Staff on this project believe that this operated here. The training as ultimately delivered was better due to the input received at the focus groups.

▸ **Designing training provider input gave the trainers and their work added credibility.**

There were times during the sessions when a trainer would introduce a subject by noting that it had come up during a focus group, underlining the importance of it from a provider’s perspective. Since three of the five trainers were academics, albeit with significant practice experiences, this may

have further reassured participants that they were not getting just *theoretical content* devised in the proverbial ivory tower.

- ▶ **The focus group process enabled participants to become acquainted with the faculty who would conduct the training.**

Some in the community did not have contact with faculty from the School of Social Work for many years, and some remembered past faculty who were seen as out of touch and unresponsive to community input. The positive reactions to this series of groups suggested that views of the school were changing in a positive direction.

The findings from this process may have relevance to others in two areas: the specific content areas suggested for interdisciplinary training in child welfare and the process of using focus groups in training design.

- ▶ **Finally, the process can serve a useful function in building relationships between the university or training institute and the community, and among community members who become involved in the process.**

CURRICULUM FINE TUNING

The curriculum was evaluated after each cohort and upon completion of the entire course. Feedback from the evaluation process was used to modify the *curriculum* as appropriate to improve the *delivery* of future trainings.

THE OVERVIEW OF THE CURRICULUM

The *curriculum* is discussed in detail in the attachment. This section of the report provides an overview. The curriculum is based upon the *Interdisciplinary Training Model for Collaborative*

Practice (IT Model) developed at SDSU-SSW by an interdisciplinary group (Davis, Litrownick, and Weinstein, 1997). The IT Model's overall purpose was to develop and institutionalize a competency-based, interdisciplinary education program for preparing students from a variety of disciplines for child welfare practice. The main objectives of the project were to help students : (1) gain interdisciplinary knowledge in the topical area of child maltreatment and protection, and (2) develop attitudes and communication skills conducive to effective collaboration. Specific exercises were developed dealing with issues presented by the presence of domestic violence, substance abuse and mental health problems in child welfare cases. (See attached curriculum document).

The IT Model

The IT model distinguishes between four levels of instruction regarding the functioning and content of interdisciplinary and cross-system training:

Level I: Exposure to interdisciplinary and cross-system content (Material presented in Part I of curriculum).

Level II: Exposure to individuals from other disciplines and systems (e.g. instructors and fellow from multiple disciplines in the classroom).

Level III: Interaction with individuals from other disciplines and systems (e.g., classroom discussions of issues raised).

Level IV: Problem solving with individuals from other disciplines and systems (e.g., instructors and students from multiple disciplines and systems engage in problem solving with one another).

Objectives and Content

- Knowledge ----> Levels I through IV
- Attitudes —> Levels II through IV
- Skills —> Level IV

The Model focuses on knowledge of one's own and other disciplines and cross-systems, attitudes towards collaborative practice, including respect for and awareness of what each discipline and service system has to offer, and on skills in interdisciplinary communication and collaboration. Collaborative training, as proposed in this project, has the objectives of helping social workers to gain interdisciplinary knowledge, attitudes, and skills to allow them to communicate and collaborate effectively in their work with families who present problems of domestic violence, substance abuse and mental health.

As indicated above knowledge may be acquired at all four levels of interdisciplinary training; attitude development at Levels II through IV, while skills development is most likely to occur at Level IV's when trainees engage in active and planned problem solving with members from disciplines other than one's own. The proposed training program exemplifies training at Level IV.

The participants from social work and other disciplines, necessary for Level IV training consisted of practicing professionals (community mental health and substance abuse providers, domestic violence advocates) who were grounded in their respective disciplines. While the other disciplines are not the focus of the training, their presence in the classroom are deemed necessary to help the public child welfare workers practice interdisciplinary collaborative skills. Contact with other professionals also allowed workers to fully consider and understand the roles, responsibilities, and approaches of other professions with whom they must collaborate in order to serve their clients appropriately.

Level IV training requires the participants to engage in collaborative problem solving in order to experience the different perspectives of the disciplines and to learn to communicate effectively and to maximize the professional input of each member of the problem solving team. Specific exercises were developed dealing with issues presented by the presence of domestic violence, substance abuse and mental health problems in child welfare cases.

Competencies for training were drawn from the list developed by the California Social Work Education Center CalSWEC. The list was developed by a culturally and racially diverse committee representing faculty, public social services, and the nonprofit sector. Competencies represented the skills and knowledge necessary for child welfare practice.

Additional material from *Partners for Success* (PFS) was included. PFS is a two-day training program to enhance and encourage participation of San Diego community service providers and educators in community based service partnerships. The purpose of the partnerships is to encourage family-focused approaches and collaboration strategies to strengthen children and families within their communities. Curriculum for this project was developed by the Georgia Academy (1995) with input from a local implementation team. Curriculum was piloted in the Spring of 1996. Based upon evaluation data from these pilot sessions, the curriculum was modified in September 1996.

PLANNING AND COORDINATION ACTIVITIES

The Investigators for the proposed project served as the primary team responsible for the planning and coordination of activities. They were responsible for gathering and reviewing materials currently in use by the Public Child Welfare Training Academy meeting with current substantive trainers, running focus groups as mentioned in the Curriculum Development section and determining the final content and format for the training modules. The team engaged providers from existing collaboratives and community based organizations who deal with these populations, inviting them to participate in the focus groups as well as in the training sessions.

EVALUATING TRAINING OUTCOMES

A quasi-experimental design was used to test both the impact of interdisciplinary training, and trainee acquisition of knowledge and skills during training. Attitudinal change and use of collaborative skills (behavioral) was also assessed. A pretest that assessed basic knowledge and

skills regarding interdisciplinary practice, domestic violence, substance abuse, and mental health was also administered. The instrument is included in Appendix A. This instrument was given to project participants prior to the start of training. A post-test was given to all participants at the conclusion of the training. A follow-up telephone interview was completed approximately six months after the training. This interview was completed with the first five training cohorts. A little over half of the trainees in the first five training cohorts completed the follow-up interview. This interview allowed us to test for retention and transfer of learning.

The attitudinal and behavioral portion of the instrument was based on an instrument developed by Harbert, Finnegan and Tyler (1997). It consisted of 15 items that assessed trainees strength of agreement/disagreement on a six point scale, with a series of statements about their beliefs and behaviors regarding collaboration. These were summed into a scale that is reported in Table 6. The alpha coefficient for the scale was .5017.

The knowledge and skills segment of the instrument was developed from the competencies described in the curriculum section. The scale consisted of 13 items where the trainee provided a summary of workers perception of learning in the content areas. Trainees indicated that on a six point scale their belief that they were knowledgeable or could perform the competency described in the statement. These were summed into a scale that is reported in Table 7. The alpha coefficient of the scale was equal to .84 which indicated strong reliability.

A vignette was also used. The vignette allowed us to examine the application of learning. Vignettes are sometimes called "scenarios," "scripts," or "simulations," and are short descriptive statements of a situation. Contained within the vignette is an event that the trainee is asked to evaluate. The trainee answered a series of questions about the vignette. The responses

were assumed to represent their attitudes, opinions, or how they might behave in a practice situation (Azjen & Fishbein, 1988).

The vignette was an actual case obtained from the supervisor of the Family Violence unit at the local public child welfare agency. This unit is a collaborative effort with the probation department that specializes in domestic violence intervention. Members of the CSB Family Violence Unit and the YWCA Domestic Violence Research and Training Institute Unit assisted the researcher in editing the vignettes into its final form (see Appendix A), and in developing an accompanying scoring key for the vignettes. The trainers contributed material about substance abuse and mental health to the vignette. Respondents were asked to read and evaluate the incident described in the vignettes. Workers specified three interventions they would initially use with the family described in the vignette.

Vignettes have been criticized as a means of investigating intended behavior because they present limited information in an unrealistic way. One cannot examine actual behavior. While behavioral intentions are not the same as actual behavior, they have been found to be significant predictors of actual behavior in a number of studies across a broad range of behavior (Azjen & Fishbein, 1988). The vignette tested participants ability to apply learning. The trainee answered questions about the vignette which tested their knowledge and measure their practice skills in the above referenced areas.

Finally, the utility of each session was assessed in two ways. An instrument was developed by our trainers to assess the specific content presented in the workshops. Participants were to rate the relevance and satisfaction with content presented. We also used the Public Child Welfare Training Academy's evaluations to assess consumer satisfaction with training (See Appendix B).

Project staff also developed an instrument to assess trainee satisfaction with specific exercises and learning in each session. This last instrument was useful in *fine tuning* the curriculum since it provided us with *specific information* about training content and activities. (See Appendix C).

An additional aspect of our evaluation was that respondents were asked to identify specific things they had learned. Data from this instrument were used to refine training strategies.

Findings

Table 6
COLLABORATIVE ATTITUDES
Pre, Post, & Follow-up Test
(Comparison of Pre-test to Follow-up)

<u>Statement</u>	<u>Pre-test</u> Mean & SD (N=119)	<u>Post-test</u> Mean & SD (N=119)	<u>Follow-up</u> Mean & SD (N=52)
1. I work on at least one collaborative or cooperative community project.	4.66 (sd=1.46)	4.68 (sd=1.59)	4.92 (sd=1.36)
2. Limited opportunities exist for me to work collaboratively with other social agencies.	2.42 (sd=1.32)	2.50 (sd=1.44)	2.65 (sd=1.40)
3. Social agency leaders in San Diego encourage collaborative efforts as a means of tackling problems and needs of San Diego residents.	4.42 (sd=1.21)	4.19* (sd=1.16)	4.06 (sd=1.16)
4. Generally, other social service agencies value the range of services provided by my agency.	4.67 (sd=.96)	4.46** (sd=1.13)	4.50 (sd=1.20)
5. Generally, other organizations have many unrealistic expectations about what my organization can achieve relative to the needs of the community.	3.83 (sd=1.30)	4.20*** (sd=1.16)	4.13 (sd=1.31)
6. Generally, with some exceptions, I highly value the full range of services provided by social agencies in San Diego.	4.70 (sd=.91)	4.92* (sd=.87)	5.80 (sd=7.23)
7. With some exceptions, the accomplishment of social services provided by other organizations in San Diego, are well below what I think they should be able to achieve.	3.29 (sd=1.17)	3.33 (sd=1.18)	3.33 (sd=1.21)
8. I believe the benefits gained by collaboration in the solutions to improve San Diego's residents' well-being will outweigh costs such as loss of autonomy or "turf".	5.04 (sd=.90)	5.29**** (sd=.96)	5.08 (sd=1.11)
9. I clearly understand my role and responsibilities as a member of a collaborative.	4.61 (sd=.88)	5.19**** (sd=.76)	5.24 (sd=.72)
10. I believe that I know when to seek compromises or consensus, when I am working in a small group.	4.88 (sd=.76)	5.20**** (sd=.59)	5.18 (sd=.56)
11. I frequently receive referrals from other social service agencies.	4.23 (sd=1.40)	4.61*** (sd=1.34)	4.62 (sd=1.42)
12. I frequently make referrals to other agencies.	4.99 (sd=1.08)	5.14 (sd=1.08)	5.27 (sd=1.03)
13. Generally, I have the resources I need to serve my clients.	3.80 (sd=1.31)	3.97** (sd=1.31)	3.98 (sd=1.11)
14. I think clients would benefit from increased cooperation among agencies.	5.55 (sd=.70)	5.69* (sd=.62)	5.63 (sd=.63)

15. I frequently meet with other social service agency personnel to plan service activities.	3.36 (sd=1.37)	3.70** (sd=1.20)	3.94 (sd=1.32)
Collaboration Scale Score	51.31 (sd=6.50)	58.22**** (sd=7.00)	65.90 (sd=31.32)

- 6=strongly agree....1=strongly disagree
 - Collaboration Scale Scores equals (items 6+8)-(items 1+2+3+4+5+7+9+10+11+12+13+14+15)
- p<.001****
P<.01 ***
P<.05 **
P<.10 *

The Paired T- Test was used to examine differences at pre and post test in Tables 6, 7, & 8. No attempt was made to do the follow-up interview with the last training cohort since not enough time had elapsed between their post-test and the end of the grant to conduct the follow-up. Tests of significance were not completed between the pretest and the follow-up since the “N” declined from 119 to 52. Significant differences were found on the overall collaboration scale between the pre and post test with an increase in scale score at the follow-up. This finding indicates that workers feel more positive about collaboration after training. Significant change in the expected direction were noted on five items. A scan of the means at follow-up found the change in mean scores between pre and post test was still evident at the follow-up. On one other item positive change was noted, but only at the level approaching significance. Trainees appeared to have become more positive in their attitudes toward other social service agencies, and to report an increase in resources available to serve clients after training. However, they did not appear to think the training improved other agencies views toward their agency. They also reported they more clearly understand their role and responsibilities as a member of a collaborative, and being able to seek compromises and consensus after training.

Table 7
TRAINEES PERCEPTION OF THEIR KNOWLEDGE AND SKILLS IN THE
CONTENT AREAS
Pre, Post, & Follow-up Test
(Comparison of Pre-test to Follow-up)

<u>Statement</u>	Pre-test Mean & SD (N=119)	Post-test Mean & SD (N=119)	Follow-up Mean & SD (N=52)
1. I can recognize the signs of drug and alcohol abuse in children and adults.	4.74 (sd=.93)	4.92** (sd=.81)	4.96 (sd=.84)
2. I can assess the impact of drug and alcohol abuse on families and children.	4.93 (sd=.89)	5.19*** * (sd=.74)	5.17 (sd=.68)
3. I know how to intervene in families where substance abuse is an issue.	4.51 (sd=.98)	4.98**** (sd=.89)	5.00 (sd=.71)
4. I understand the dynamics of family violence including intimate partner violence.	4.71 (sd=.99)	5.18*** * (sd=.67)	5.31 (sd=.64)
5. I can develop appropriate culturally-sensitive case plans for families and family members to address domestic violence.	4.25 (sd= 1.00)	4.96**** (sd=.65)	4.96 (sd=.95)
6. I can evaluate and incorporate information from others, including family members and professionals in assessment, treatment planning, and service delivery.	4.97 (sd=.81)	5.22*** * (sd=.62)	5.25 (sd=.84)
7. I know how to work collaboratively with other disciplines that are routinely involved with child welfare.	4.82 (sd=.82)	5.12*** * (sd=.72)	5.18 (sd=.65)
8. I understand the impact of adult/parental substance abuse on child development and family functioning.	4.98 (sd=.91)	5.33*** * (sd=.63)	5.42 (sd=.54)
9. I understand the impact of domestic violence on child development.	4.95 (sd= .80)	5.42*** * (sd=.59)	5.40 (sd=.57)
10. I understand the potential effects of child abuse and neglect in child/adult development and behavior.	5.11 (sd=.75)	5.42*** * (sd=.60)	5.44 (sd=.57)
11. I understand the process of the court system and the role of human service providers in relation to the courts.	4.49 (sd=1.16)	4.81*** * (sd=.99)	4.85 (sd=1.14)
12. I think I know what it takes to start and sustain a collaborative.	3.66 (sd=1.06)	4.59*** * (sd=.92)	4.52 (sd=.96)
Content Scale score	73.24 (sd=8.81)	80.05**** (sd=12.16)	82.36 (sd=16.15)

- Content scale score is a sum of the items.
 - 6=strongly agree....1=strongly disagree
- p<.001****
P<.01 ***

P<.05 **

P<.10 *

The overall scale score show a positive change in trainee perception of learning. Trainees reported gains at both the post-test and follow-up in all of the content areas. These gains are evidence of the perception of students that they are learned much in the training.

TABLE 8
COLLABORATION BEHAVIOR OF TRAINEES
Pre, Post, & Follow-up Test
(Comparison of Pre-test to Follow-up)

<u>Statement</u>	<u>Pre-test</u> <u>Mean & SD</u> <u>(N=119)</u>	<u>Post-test</u> <u>Mean & SD</u> <u>(N=119)</u>	<u>Follow-up</u> <u>Mean & SD</u> <u>(N=52)</u>
1. I frequently collaborate with domestic violence providers.	3.63 (sd=1.45)	4.03*** (sd=1.36)	4.31 (sd=1.50)
2. I frequently collaborate with mental health service providers.	4.28 (sd=1.17)	4.60** (sd=1.20)	4.67 (sd=1.20)
3. I frequently collaborate with substance abuse service providers.	4.26 (sd=1.26)	4.53** (sd=1.32)	4.67 (sd=1.29)
4. I frequently collaborate with protective service providers.	4.85 (sd=1.20)	5.72** (sd=8.91)	5.21 (sd=1.18)

• 6=strongly agree....1=strongly disagree

P<.01 ***

P<.05 **

P<.10 *

The above table documents the increase in collaboration after training. Trainees reported they are collaborating more with mental health, substance abuse, domestic violence, and child protective service workers at the post-test. This increase sustained itself at the follow-up. The actual vignette is located in Appendix A. Debbie is the victim in the vignette and Michael is the perpetrator.

Table 9
Responses to Vignettes
Percentages Reported
(N=152)

<u>Intervention</u>	<u>Pre-test</u>	<u>Post-test</u>	<u>Difference</u>
Domestic violence treatment for both Michael and Debbie	54.4%	13.8%	-40.6
Anger management training	32.2%	10.5%	- 21.7
Domestic violence treatment for Debbie	26.1%	41.8%	+15.7
Family counseling	25.6%	11.8%	-13.8
Police involvement	30.0%	42.8%	+12.8
Counsel parents to protect child(ren)	17.8%	7.2%	- 10.6
Counseling for both parents	15.0%	4.6%	- 10.4
Urge Michael to leave	7.8%	17.0%	+9.2
Shelter for mother & child(ren)	47.2%	39.5%	- 7.7
CPS involvement other than removal	19.4%	11.8%	- 7.6
Medical care for Debbie	12.8%	19.7%	+6.9
Domestic violence treatment for Michael	36.4%	43.1%	+6.7
Counseling for child(ren)	46.7%	52.9%	+6.2
Restraining order	8.9%	13.8%	+4.9
Safety Planning	38.5%	43.4%	+4.9
Substance Abuse Treatment	65.5%	60.6%	- 4.9
Parenting classes	13.9%	10.5%	-3.4
Remove child(ren)	17.2%	18.4%	+1.2

Workers were asked to read the vignette and provide 3 interventions for the family. At the pre-test interventions were coded and collapsed into 25 categories. The categories were used to code post-test responses. Categories were based on workers responses and represent the universe of suggested interventions by the workers. Qualitative analysis from the responses involved

identifying basic concepts and themes inductively from the worker's open-ended responses, going back and coding all responses within these categories. Responses were quantified in terms of frequencies. Coding for most categories was straightforward. To code for shelter care for Debbie, the respondent had to state explicitly in their response that they would refer Debbie to a shelter. Other responses called for more detailed rule making. For example, safety planning was identified as a frequent intervention. Respondents were credited with using safety planning if they included the term safety planning in their list of interventions, or they described a strategy that encompassed safety planning. This strategy could describe moving or making plans with the victim to move to place of safety such as a shelter, neighbors, or family members home. They could also describe a plan to remove the perpetrator from the home. If the workers provided any of these descriptions their response was coded as safety planning. Qualitative analysis involved identifying basic concepts and themes from open-ended responses that were then quantified in terms of frequencies. The qualitative part is heuristic in nature and is intended to assist in the description of practice. Table 9 provides a list of collapsed findings from a list of three interventions that each respondent said they would provide the individuals described in the vignette. Responses could be coded in more than one category. The table is assumed to provide a description of practice at the pre and post test with domestic violence.

The changes in greatest magnitude between the pre and post test were suggesting domestic violence for both Debbie and Michael (-40.6%), anger management (-21.7%), domestic violence treatment for Debbie only (+ 15.7%), family counseling (-13.8%), and police involvement (+12.8%). These findings suggest workers have changed from an assumption that both parties need treatment but attending to the victims needs. Most advocates for domestic violence victims believe conjoint treatment and anger management are ineffective methods of treatment. The involvement of police indicates attention to safety issues.

Forty-three percent of the sample would engage in safety planning at the post-test, an increase of 4.9%. Only 18.4% of the sample would remove the child as an initial intervention. This finding contradicts some in the domestic violence community claims that child protective service workers ignore women's safety issues and remove children in domestic violence cases. There was a decline in the number of workers who would have requested more CPS involvement. Most of the sample did not explicitly state that they would have opened a protective service case, but almost all respondents indicated they would have made a referral to another agency for service.

Also declining in popularity as an intervention between pre and post was conjoint counseling for the couple (-10.4%) and substance abuse treatment (-4.9%). Conjoint counseling and substance abuse treatment may be needed, but these interventions do not attend to immediate safety needs of the mother and children in the vignette. Those workers who would have counseled the parent to protect the child declined by -10.6 percent between the two tests. In order to be coded in this category, workers had to say they would counsel the parents to protect, or counsel the parents on the effects of domestic violence on children. Workers who listed "counseling parents to protect" as one of their first three interventions may not realize that the victims may be incapable of protecting their children until after intervention for the domestic violence. The lower percentage of social workers willing to open a protective service case may possibly explain their lower estimates of domestic violence in their caseload. The number of trainees who would have urged Michael to leave increased by 9.2%, and the percentage who would have sought a restraining order increased 4.9%. These last two items suggest more attention was given to worker safety after training.

We believe this last table provides evidence that workers after training are using best practices and paying more attention to safety issues of victims.

LESSONS LEARNED

- **Interdisciplinary Training works best when there is a balanced mixture of professions represented in the classroom.**

Throughout the project we struggled with maintaining a balanced representation of the various professions. A balance classroom might have led to more sharing among the professionals in the classroom and more learning by participants. If we did this again, we would engage in more targeted recruitment. As indicated earlier in this document the benefits of interdisciplinary training are maximized when trainees engage in active and planned problem solving with members from disciplines other than one's own. Contact with other professionals also allowed workers to fully consider and understand the roles, responsibilities, and approaches of other professions with whom they must collaborate in order to serve their clients appropriately

Level IV training requires the participants to engage in collaborative problem solving in order to experience the different perspectives of the disciplines and to learn to communicate effectively and to maximize the professional input of each member of the problem solving team.

- **Interdisciplinary training works best with a professional mix of trainers in the classroom who can model skills.**
- **It takes time to help professionals break out of narrow confines of their discipline and work through the stereotypes that they had of other professions.**

This training was delivered in 5 modules over a five week period. Participants needed the several meetings to establish relationships with one another so they could begin to work through their misconceptions of one another.

- **Collaborative training for administrators might help reduce system barriers to collaboration.**

Trainees identified many system barriers to collaboration. These barriers are a limitation of training. Unless these barriers are overcome trainees can not make full use of their learning. Training administrators presumably means you may have people in the classroom who are in a position to reduce those barriers.

- ▶ **Targeting training in a small geographic region may allow for developing teamwork within that region.**

An unanticipated outcome of the training is that trainees reported establishing collaborative relationships amongst themselves which extended to their practice outside the classroom. Future training might look at a region and identify who works with whom and target them. On the other hand, we completed two of our courses that included workers from two counties. Trainees seemed to benefit from sharing differences in approaches to collaboration between the two counties.

- ▶ **Developing a common learning experience helped integrate the learning from the three content areas (domestic violence, substance abuse, mental health, and child protection).**

A common case was developed by the trainers. Trainees received additional information about the case at each session. The new material was related to the content area presented in the session. A portion of each session was devoted to solving problems suggested by the new materials.

- ▶ **Trainees worked in small groups during the training made up of a mix of professions involved.**

This group work allowed trainees to develop and practice collaborative skills by interacting with other professionals from other disciplines and service systems.

- ▶ **Developing curriculum and teaching strategies required the multiple trainings. We were able to design and redesign the curriculum until we believe “we got it right.”**

We learned the following from our evaluation that lead us to redesign the curriculum:

(1). *Make safety issues explicit.* Trainees frequently overlooked safety issues in the case which set them off on the wrong track in many of the courses. We could not rely on workers to “discover” the safety issues.

(2). *Collaboration skills were taught earlier in the training than was in the original design.* Our intent initially was to teach collaboration along with the other content. However, we found if we wanted the trainees to use collaboration skills in their case planning, collaboration skills had to be front loaded in the curriculum.

(3). *The use of teams of trainees was augmented by activities that required teams to interact with one another.* This interaction added richness to the case problem solving, and kept teams from being isolated.

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Appendix A

Appendix A contains the pre-and post test. Appendix B show some of the results from the use of the PCWTA consumer satisfaction form. Appendix C contains results from our own internally developed satisfaction form. this form allowed us to assess the effectiveness of specific teaching strategies so we could more finely tune our curriculum. The results from both instruments indicates high consumer satisfaction with the training.

Appendix B

Appendix C

Date: _____

**PUBLIC CHILD WELFARE TRAINING EVALUATION OF TRAINING
PRE/POST-TEST INSTRUMENT**

GENERAL DIRECTIONS

The pre-test/post-test is part of an effort to test the effectiveness of training that the Public Child Welfare Training Academy provides. This evaluation is simply a "pre-test/post-test" and not a test of your performance. The post-test may appear repetitive to the first test. It is designed to be so. In most cases you will circle the letter of the response you *think* is correct. In other cases you will fill in the blanks. It will take between 20 and 30 minutes to complete.

You are being asked to provide the last four digits of your social security number and your date of birth as identifiers. This request is made so that the Academy may link your responses to the pre-test which will be given at the conclusion of training. The use of these identifiers is to help you remain anonymous while enabling the Academy to gather useful evaluation information.

We will compare the data from the pre-tests with the data from the post-tests. This comparison information will enable the Academy to improve the Interdisciplinary Training.

There is some demographic data in this questionnaire. This data will help the evaluators interpret responses. It will only be used as group data. Personal identifying data will *not* be released to anyone including your employers. If any question makes you feel uncomfortable, you do not have to answer it.

Please ~~write~~ in the last four numbers of your social security number : _ _ _ _

Please ~~write~~ in your two initials (first and last name): _ _

Month and Day of Birth: _ _ / _ _

PRE-TEST INSTRUMENT FOR INTERDISCIPLINARY TRAINING FOR CHILD PROTECTIVE SERVICE
WORKERS & COMMUNITY BASED PROVIDERS

Directions: Read the following statements and tell me how strongly you agree with them. Circle the letter of the most appropriate response.

1. I work on at least one collaborative or cooperative community project.
 1. Strongly disagree
 2. Disagree
 3. Disagree somewhat
 4. Agree somewhat
 5. Agree
 6. Agree strongly

2. Limited opportunities exist for me to work collaboratively with other social agencies.
 1. Strongly disagree
 2. Disagree
 3. Disagree somewhat
 4. Agree somewhat
 5. Agree
 6. Agree strongly

3. The human services needs of my county's residents require substantially different solutions than currently exist.
 1. Strongly disagree
 2. Disagree
 3. Disagree somewhat
 4. Agree somewhat
 5. Agree
 6. Agree strongly

4. Social agency leaders in my county encourage collaborative efforts as a means of tackling problems and needs of my county's residents.
 1. Strongly disagree
 2. Disagree
 3. Disagree somewhat
 4. Agree somewhat
 5. Agree
 6. Agree strongly

5. Generally, other social service agencies value the range of services provided by my agency.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

6. Generally, other organizations have many unrealistic expectations about what my organization can achieve relative to the needs of the community.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

7. Generally, with some exceptions, I highly value the full range of services provided by social agencies in my county.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

8. With some exceptions, the accomplishment of social services provided by other organizations in my county are well below what I think they should be able to achieve.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

9. I believe the benefits gained by collaboration in the solutions to improve my county's residents' well-being will outweigh costs such as a loss of autonomy or turf.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

10. I clearly understand my role and responsibilities as a member of a collaborative.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

11. I believe that I know when to seek compromises or consensus when I am working in a small group.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

12. I frequently receive referrals from other social service agencies.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

13. I frequently make referrals to other agencies.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

14. Generally, I have the resources I need to serve my clients.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

15. I think clients would benefit from increased cooperation among agencies.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

16. I frequently meet with other social service agency personnel to plan service activities.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

17. I can recognize the signs of drug and alcohol abuse in children and adults.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

18. I can assess the impact of drug and alcohol abuse on families and children.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

19. I understand how to intervene with families where substance abuse is an issue.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

20. I understand the dynamics of family violence including intimate partner violence.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

21. I can develop appropriate culturally-sensitive case plans for families and family members to address domestic violence.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

22. I can evaluate and incorporate information from others, including family members and professionals in assessment, treatment planning, and service delivery.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

23. I know how to work collaboratively with other disciplines that are routinely involved in child welfare.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

24. I understand the impact of adult/parental substance abuse on child development and family functioning.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

25. I understand the impact of domestic violence on child development.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

26. I understand the potential effects of child abuse and neglect on child/adult development and behavior.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

27. I understand the process of the court system and role of human service providers in relation to the courts.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

28. I think I know what it takes to start and sustain a collaborative.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

29. I frequently collaborate with domestic violence providers.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

30. I frequently collaborate with mental health service providers.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

31. I frequently collaborate with substance abuse service providers.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

32. I frequently collaborate with protective service workers.

1. Strongly disagree
2. Disagree
3. Disagree somewhat
4. Agree somewhat
5. Agree
6. Agree strongly

33. I collaborate with other agencies in about _____% (estimate percent of your cases) of the cases in my caseload.

34. I collaborate with other professional disciplines (other than my own) in about _____% (estimate percent of your cases) of the cases in my caseload.

Vignette Directions. Please read the vignette below. I know the information given is brief, and you would have an opportunity to collect more data in your practice, but please try to answer the questions at the end of the vignette as you feel about the situation, and how you would act in practice.

Debbie and Michael

The CPS worker responded to a report of abuse at the apartment of Debbie Smith and Michael Madden. The family had one previous, but unsubstantiated report of child abuse. The worker found Debbie and her two small children at a neighbors house. Debbie was sitting on the floor crying. Both children appeared distressed, and had withdrawn and were rocking back and forth. The children were both clutching a stuffed animal. The older child was playing with small cars, smashing the cars into one another. When this child was asked to play quietly he shouted, "make me."

Debbie had a bruise on her forehead, and a small cut over her eye. The worker thought she

looked like she had been punched. The children did not have any visible marks. Debbie reported she had a fight with her fiance, Michael, and she had fled the apartment to avoid continued fighting. She denied that the bruise and cut were related to the fight, but were related to an earlier accident. She said there had been some shoving, but the fight had consisted mostly of shouting and name calling. Debbie said her children were fine, that they were not involved in the fight, and she would return home the next day when things had blown over.

The worker interviewed Michael and concluded he may be under the influence of drugs or alcohol. He acknowledged that he had been fighting with Debbie, but said he did not know what had happened during the fight. He said he and Debbie fought frequently, but he denied hitting her. Michael admitted pushing her in the past, and said he slapped once when she threw her engagement ring at him. He said things were bad at the home, because he had just been laid off from his construction job, and that things would get better when he was back working. The worker noted an unsheathed hunting knife on the TV. Michael has a previous conviction for assault on a co-worker.

Briefly tell me three to five things you would do with this family.

35. _____

36. _____

37. _____

38. _____

39. _____

The statements listed below *may or may not reflect best practice*. For each of the tasks listed, please fill out one of the two columns:

In your cases where a caregiver has a mental health problem, in approximately what percent of them did you complete (or help complete) each of the following tasks?	Percentage of cases – caregiver has a mental health problem (0-100)	Circle N/A (If not your job responsibility)
1. Uses a written or mental checklist of symptoms that may be “red flags” for mental health problems during your work with a family.	_____ %	N/A
2. Discussed with a client his or her underlying belief system about his or her mental health problem, including cultural perspectives or influences.	_____ %	N/A
3. Evaluated the effect that the mental health problem has on the caregiver’s capacity to form positive interpersonal relationships with his or her children.	_____ %	N/A
4. For caregivers taking medications for their mental health problems, obtained information from an outside source about side effects or effects of compromised compliance with those medications.	_____ %	N/A
5. Routinely asked the caregiver with mental health problem questions about medication side effects or other factors that might interfere with medications compliance.	_____ %	N/A
6. Shared a written relapse plan with others in the family’s formal and informal support network, including mental health professional.	_____ %	N/A
7. When referring the caregiver for mental health evaluation, requested specific information that could help you to evaluate the caregiver’s parenting and the child’s safety.	_____ %	N/A
8. Discussed with a client’s mental health provider the realities of child protective services and some of the constraints affecting the case, such as legal timelines.	_____ %	N/A
9. Designed a treatment plan that includes regular feedback and discussion of the case with the mental health provider.	_____ %	N/A
10. In the case plan, included specific plans to address other concrete needs that cause stress for the caregiver, such as housing and work issues.	_____ %	N/A

How did you work with your clients?

For each of the 10 tasks listed, please fill out one of the two columns:

If.....	If.....
...the task is within your professional role, and you could be the one to do the task	...the task would not be considered part of your professional responsibility
Then.....	Then.....
.... write a number between 0-100 to express about how often you completed or helped to complete the task for your AODA casescircle N/A

In approximately what percent of your substance abuse-related cases did you complete (or help complete) each of the following tasks?	Percentage of AODA cases (Number from 0-100)	Circle N/A (If not your job responsibility)
1. Assessed how a caregiver's substance use could directly affect the safety of the child(ren).	_____ %	N/A
2. Interviewed caregiver about his or her substance use, including triggers for use and patterns of use.	_____ %	N/A
3. Interviewed other family members about the caregiver's substance use.	_____ %	N/A
4. After making a referral, prepared the client for participation in treatment services.	_____ %	N/A
5. Wrote referral for AODA evaluation that requested information about triggers for substance use and patterns of use.	_____ %	N/A
6. Made contingency safety plans with a caregiver in the event of substance abuse relapse.	_____ %	N/A
7. In writing court conditions, considered whether abstinence was a necessary condition for this caregiver.	_____ %	N/A
8. Created a plan that took into account the whole family situation the caregivers' treatment and likelihood of relapse.	_____ %	N/A
9. At the time of referral of the caregiver for AODA treatment, established a plan for regular communication with substance abuse provider, including information needed.	_____ %	N/A
10. Used a non-confrontational style to motivate the client to make appropriate changes with regards to his or her substance abuse.	_____ %	N/A

If.....	If.....
...the task is within your professional role, and you could be the one to do the taskthe task would not be considered part of your professional responsibility
Then.....	Then....
...write a number between 0-100 to express about how often you completed or helped to complete the task for your domestic violence casescircle N/A

Please indicate what you did in practice. The statements listed below *may or may not reflect best practice*. For each of the tasks listed, please fill out one of the two columns:

In approximately what percent of your domestic violence-related cases did you complete (or help complete) each of the following tasks?	Percentage of DV-related cases (Number from 0-100)	Circle N/A (If not your job responsibility)
1. Verbally made clear to a child that s/he was not responsible for the violence that occurred.	_____ %	N/A
2. Shared with the child some of the information given by the mother about the violence that occurred in order to obtain corroborating evidence.	_____ %	N/A
3. Confronted a batterer about his responsibility to control his anger.	_____ %	N/A
4. Had regular communication with a domestic violence professional about a case.	_____ %	N/A
5. Considered which stage within the "cycle of violence" the family was in prior to conducting an interview with the victim.	_____ %	N/A
6. Wrote separate safety plans for the mother and children.	_____ %	N/A
7. Allowed a batterer to "vent" his feelings about the victim and the things she did that caused him to lose his temper.	_____ %	N/A
8. Worked with domestic violence professionals to create an intervention plan that addressed the case holistically, from both DV and CPS perspectives.	_____ %	N/A
9. Advocated for the batterer to participate in a short-term anger management program.	_____ %	N/A
10. Asked the victim specific questions about the typical pattern of violence within the household.	_____ %	N/A
11. Verbally reassured the victim that she is not responsible for the violence perpetrated by the batterer.	_____ %	N/A
12. During the assessment stage or earlier in a case, clearly determined whether or not domestic violence had occurred and its severity.	_____ %	N/A

Basic Demographics. Please circle the correct answer or fill in the blank. If a question does not apply to you, please write N/A. Answering the questions will help the Academy tailor to the needs of your families.

D1. Your Age: _____

D2. Your Gender:

A. female

B. male

D3. How do you describe your ethnic group?

A. African-American

B. White

C. Asian: _____
(write in your group)

D. Pacific Islander: _____
(write in your group)

E. Hispanic: _____
(write in your group)

F. Mixed: _____
(write in your group)

G. Other: _____
(please specify)

D4. What is your marital status?

A. Married and living with spouse

B. Separated

C. Divorced

D. Single

E. Domestic partnership (e.g. living with someone)

D5. Number of children you have: _____

D6. Which of the following best describes your highest level of education?

A. Have a doctorate or equivalent (medical, law, psychology, etc.)

B. Have a masters degree

C. Graduate student and have an undergraduate degree

D. Have an undergraduate degree

E. Currently an undergraduate

F. Have an associates degree

G. Finished high school or GED and some college

H. Finished high school but have not attended college

I. Not a high school graduate

D7. In what field is your highest degree? _____

D9. If you have a graduate degree, please indicate in what field you have an undergraduate degree: _____

D10. Which of the following best describes the primary responsibility of your current social services position ?

- A. Program administrator with responsibility for supervising supervisors
- B. Supervisor of line or support staff
- C. Professional staff: Line worker with direct contact with child and/or family
- D. Planner or organizer but not a supervisor or administrator
- E. Staff support such as staff development or researcher
- F. Paraprofessional
- G. Other
- H. Not applicable, this position is my first in social services

D11. How many years have you worked in social services? _____

D12. How many of those years in social services were spent working with children? _____

D13. Do you have a professional license such as an LCSW or MFCC?

- A. No
- B. Yes. Please indicate what type of license it is: _____

D14. Which best describes the primary population you work with in your practice? Choose only one.

- 1=Aged population and their families
- 2=Single adult (but not aged)
- 3=Children and families (includes teenagers and youth)
- 4=Teenagers and youth (but usually not families)
- 5=Primarily children (children under the age of 13, usually not families)

D15. Which best describes the field of service of your practice? Circle # of your response.

- | | |
|-----------------------------|---------------------------------|
| 1=Mental Health | 9=Juvenile Justice |
| 2=Child Protective Services | 10=Adult Corrections |
| 3=Adoption | 11=EAP... Business and industry |
| 4=Aging / Gerontology | 12=Substance Abuse Services |
| 5=Health | 13=Domestic Violence |
| 6=Family Services | 14=Other (Please specify) _____ |
| 7=Community Organization | |
| 8=School Social Work | |

D16. Do you have any staff training responsibilities at your agency?

- 1=yes
- 2=no

Appendix B

SOUTHERN REGION PUBLIC CHILD WELFARE TRAINING ACADEMY
 Summary of Participants Reactions to Training Presented 10/04/20
 120-01386

Training Title: Effective Interdisciplinary Work: Breaking Down the Barriers
 Trainer: Staff,

Item on questionnaire	N	Means	Standard deviations
1. As an overall evaluation, I think this class was excellent.	17	5.88	1.36
2. The content of the training appropriately addressed cultural issues and differences.	17	5.59	1.42
3. The course content was appropriate for my present skill level in this area.	17	5.94	1.39
4. The trainer did a poor job helping participants relate the course content and knowledge to the participants' job activities.	16	1.81	1.05
5. The content clearly matched the stated learning objectives.	16	6.00	0.97
6. The training content was interesting and well supported with examples, exercises, etc.	17	6.12	1.11
7. The trainer did not clearly demonstrate that he/she knows and understands how the concepts and issues of this training relate to child welfare practice.	17	1.82	1.33
8. The trainer arranged the content to make the most effective use of the allotted time.	17	6.00	1.06
9. The trainer demonstrated an excellent relationship with the participants by answering questions and responding appropriately to concerns raised.	17	6.12	1.11
10. The trainer made poor use presentation styles other than lecture. (i.e., a/v, handouts, overheads, group discussion, case examples, Q+A, tests, etc.)	17	1.59	0.87

Note: Means are based on a 1 (Strongly disagree) - 7 (Strongly agree) scale. A lower mean score for some of the items (i.e., 4, 7, and 10) are indicative of a positive reaction.

SOUTHERN REGION PUBLIC CHILD WELFARE TRAINING ACADEMY
 Summary of Participants Reactions to Training Presented 09/20/20
 120-01384

Training Title: Multi-Disciplinary Intervention with Substance Abuse
 Trainer: Hohman, Melinda

Item on questionnaire	N	Means	Standard deviations
1. As an overall evaluation, I think this class was excellent.	21	6.05	1.43
2. The content of the training appropriately addressed cultural issues and differences.	21	5.24	1.70
3. The course content was appropriate for my present skill level in this area.	18	5.89	1.18
4. The trainer did a poor job helping participants relate the course content and knowledge to the participants' job activities.	21	1.90	1.37
5. The content clearly matched the stated learning objectives.	21	6.24	0.89
6. The training content was interesting and well supported with examples, exercises, etc.	20	6.10	0.97
7. The trainer did not clearly demonstrate that he/she knows and understands how the concepts and issues of this training relate to child welfare practice.	21	1.67	1.53
8. The trainer arranged the content to make the most effective use of the allotted time.	21	5.86	1.20
9. The trainer demonstrated an excellent relationship with the participants by answering questions and responding appropriately to concerns raised.	21	6.57	0.68
10. The trainer made poor use presentation styles other than lecture. (i.e., a/v, handouts, overheads, group discussion, case examples, Q+A, tests, etc.)	21	1.95	1.40

Note: Means are based on a 1 (Strongly disagree) - 7 (Strongly agree) scale. A lower mean score for some of the items (i.e., 4, 7, and 10) are indicative of a positive reaction.

Appendix C

SESSION 1 FEEDBACK
Mean & Standard Deviation Reported

Content	Value	Enjoyment
Definitions & types of collaboration	4.97 (sd=.83)	4.44 (sd=1.08)
Image exchange	4.92 (sd=1.23)	4.83 (sd=1.78)
Team building & team effectiveness criteria	5.06 (sd=1.00)	4.91 (sd=1.04)
Case discussion	5.38 (sd=.76)	5.16 (sd=.96)
Overall		
Facilities		5.32 (sd=.75)
Food & refreshments		5.30 (sd=.85)
Facilitation	5.47 (sd=.57)	5.31 (sd=.79)
Objectives	Achievement	
1. Can create opportunities for collaboration with other work units and related agencies.	4.78 (sd=.98)	
2. Has beginning skills in how to work collaboratively with other disciplines that are routinely involved in child welfare issues.	4.78 (sd=.85)	
3. Is familiar with the knowledge base and values that underlie effective collaboration.	4.89 (sd=.74)	
4. Has a preliminary understanding of the client and system problems from the perspective of all participants in a multidisciplinary team.	5.05 (sd=.78)	
5. Is aware of team dynamics that support and undermine the achievement of team goals.	5.05 (sd=.97)	
Overall Impression	Percentages	
Excellent	21.6%	
Very Good	43.2%	
Good	21.6%	
Fair	10.8%	
Poor	0%	

SESSION 2 FEEDBACK
Mean & Standard Deviation Reported

Content	Value	Enjoyment
Video: Intro to DV	5.66 (sd=.53)	5.21 (sd=1.30)
Didactic/video: Assessing Dangerousness	5.68 (sd=.53)	5.36 (sd=.99)
Case study exercise	5.46 (sd=.67)	5.03 (sd=1.14)
Video: Profile of victim	5.73 (sd=.45)	5.30 (sd=1.16)
Safety planning	5.71 (sd=.46)	5.52 (sd=.71)
Safety planning role plays	5.40 (sd=.87)	5.15 (sd=1.04)
Overall		
Facilities		5.34 (sd=.76)
Food & refreshments		5.31 (sd=.96)
Facilitation	5.73 (sd=.52)	5.59 (sd=.81)
Objectives	Achievement	
1. Develop understanding of the role culture plays in understanding the dynamics of domestic violence.	5.19 (sd=.94)	
2. Understand the dynamics of family violence, including spousal abuse, and develop appropriate culturally sensitive interventions for families and family members to address these problems.	5.48 (sd=.77)	
3. Develop an understanding of how exposure to domestic violence affects children.	5.55 (sd=.67)	
4. Accurately assess risk in families where there is domestic violence, and develop strength-based interventions to protect victims.	5.45 (sd=.71)	
5. Develop an understanding of the importance of multi-disciplinary cross-systems interventions in protecting victims of domestic violence.	5.33 (sd=.87)	
6. Develop knowledge of community resources for families where there is domestic violence.	4.95 (sd=1.06)	
Overall Impression	Percentages	
Excellent	64.3%	
Very Good	23.8%	
Good	4.8%	
Fair	0%	
Poor	0%	

SESSION 3 FEEDBACK
Mean & Standard Deviation Reported

<i>Content</i>	<i>Value</i>	<i>Enjoyment</i>
What is addiction?	5.28 (sd=.99)	5.03 (sd=1.02)
Environmental and cultural aspects of AOD use	4.77 (sd=1.35)	4.85 (sd=1.35)
Assessment	5.25 (sd=1.06)	5.23 (sd=1.10)
Treatment	5.10 (sd=1.13)	5.09 (sd=1.10)
Practice vignettes	4.92 (sd=1.40)	5.07 (sd=1.30)
Working with CSB/DV	4.71 (sd=1.12)	4.86 (sd=1.14)
Case vignette discussion	5.29 (sd=1.15)	5.21(sd=1.30)
	4.96 (sd=1.02)	4.78 (sd=1.24)
	4.16 (sd=1.07)	4.57 (sd=1.17)
	4.93 (sd=.96)	4.87 (sd=1.06)
	5.33 (sd=1.00)	5.48 (sd=.99)
Overall		
Facilities		5.46 (sd=.89)
Food & refreshments		5.32 (sd=1.04)
Facilitation	5.44 (sd=1.16)	5.43 (sd=1.00)
Objectives	Achievement	
1. Define the differences between substance use, abuse, and dependency utilizing DSM-IV criteria.	5.00 (sd=1.04)	
2. Describing alcohol and other drug use patterns and cultural practices.	4.68 (sd=1.14)	
3. Recognizing and assess for dependency.	5.13 (sd=.84)	
4. Describe the different kinds of substance abuse treatment, and how treatment level is determined utilizing the Patient Placement Criteria-2.	4.68 (sd=1.29)	
5. Apply the PPC-2 in practice vignettes.	4.84 (sd=1.07)	
6. Understand substance abuse issues involved with working with the Child Welfare and Domestic Violence systems.	4.41 (sd=1.28)	
7. Apply the above knowledge and skills to a sample case vignettes.	4.98 (sd=.92)	
Overall Impression	Percentages	
Excellent	48.9%	
Very Good	34.7%	
Good	12.2%	
Fair	2.0%	
Poor	0%	

SESSION 4 FEEDBACK
Mean & Standard Deviation Reported

Content	Value	Enjoyment
Risk & vulnerability: Impact of multiple risk factors	5.45 (sd=.71)	5.22 (sd=.87)
Relationship of risk factors & psychiatric diagnosis	5.51 (sd=.64)	5.34 (sd=.73)
Exercise: Name that tune	5.14 (sd=1.07)	5.58 (sd=.65)
Exercise: A second look at the children	5.29 (sd=.71)	5.17 (sd=.82)
Looking beyond the label	5.43 (sd=.77)	5.31 (sd=.76)
Exercise: Cross systems response to mental health issues	5.38 (sd=.89)	5.34 (sd=.84)
Brainstorming & networking	5.39 (sd=.97)	5.35 (sd=.82)
Overall		
Facilities		5.47 (sd=.60)
Food & refreshments		5.55 (sd=.65)
Facilitation	5.59 (sd=.57)	5.64 (sd=.58)
Objectives	Achievement	
1. Understand the potential effects of child abuse, neglect, & domestic violence on child/adolescent development and pathology.	5.13 (sd=.99)	
2. Understand the impact of adult/parental substance abuse on child development and family functioning.	5.10 (sd=.99)	
3. Develop ability to recognize developmental delay and disruption in daily functioning in children and youth exposed to violence.	5.36 (sd=.81)	
4. Increase knowledge of how to access mental health resources and services for children and families.	4.90 (sd=.98)	
5. Increase skills and abilities in collaborating across systems to improve service delivery to children and families who require mental health services.	5.10 (sd=1.07)	
Overall Impression	Percentages	
Excellent	52.5%	
Very Good	35.0%	
Good	7.5%	
Fair	2.5%	
Poor	0%	

SESSION 5 FEEDBACK
Mean & Standard Deviation Reported

<i>Content</i>	<i>Value</i>	<i>Enjoyment</i>
Win as much as you can	5.07 (sd=1.33)	5.41 (sd=1.22)
Role clarification	4.84 (sd=1.07)	4.63 (sd=1.41)
Effective meetings	4.89 (sd=1.34)	4.92 (sd=1.47)
Cultural competency	4.96 (sd=1.04)	4.69 (sd=1.35)
Case discussion	5.07 (sd=1.10)	5.07 (sd=1.27)
Team effectiveness critique	5.04 (sd=1.37)	4.96 (sd=1.51)
Starfish story	5.19 (sd=1.33)	5.04 (sd=1.49)
	5.00 (sd=.63)	4.90 (sd=.74)
	4.89 (sd=1.54)	5.00 (sd=1.58)
Overall		
Facilities		5.55 (sd=.87)
Food & refreshments		5.41 (sd=.95)
Facilitation	5.63 (sd=1.01)	5.66 (sd=.90)
Objectives	Achievement	
1. Understand the strengths and concerns of diverse community groups to enable work with community members to enhance services for families and children.	5.00 (sd=1.02)	
2. Aware of the barriers that undermine collaboration and ways to address them.	5.07 (sd=1.02)	
3. Can evaluate and incorporate information from others, including family members and professionals, in assessment, treatment planning, and service delivery.	5.29 (sd=.81)	
4. Knows how to access and work collaboratively with key community agencies.	5.11 (sd=1.09)	
5. Can use role clarification, action planning, and meeting management to enhance collaborative problem solving to improve service delivery.	5.15 (sd=.95)	
Overall Impression	Percentages	
Excellent	44.8%	
Very Good	27.6%	
Good	13.8%	
Fair	0%	
Poor	0%	



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December 15, 2000

To: National Clearinghouse on Child Abuse and Neglect Information
Attention: Cathy Overbaugh
Caliber Associates
10530 Rosehaven Street
Fairfax, Virginia 11030

From: Loring Jones
Principal Investigator
Grant No. 90CT0038—Submission of Final Project Report
Interdisciplinary Training for Child Welfare Workers and Supervisors

Re: Final Project Report, Section 426 grants

Enclosed please find two hard copies of the Final Project Report and Training Curricula for the above referenced grant. This material is also sent on disk.