Services for Child Maltreatment: Challenges for Research and Practice

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With the shrinking funds for child welfare allocated primarily to investigation and foster care, prevention and treatment services for child maltreatment (CM) are increasingly nonexistent, inaccessible, or inappropriate. Prior research on help-seeking and service utilization has given scant attention to maltreating and at-risk families, who pose special challenges for service delivery for several reasons: maltreating families often do not recognize the development of problems in the parenting relationship; even if problems are recognized, the stigma associated with child maltreatment makes families reluctant to seek help; and service providers and client families often have different beliefs about what services are needed. A review of the literature on help-seeking and service utilization among populations at risk, in light of the social context of child maltreatment, suggests that research to identify specific parental concerns is needed in order to link prevention and treatment services to other services devised to meet clients' perceived needs. In addition, longitudinal research is needed to focus on the effects of social networks on the use of formal services and on the links between utilization of formal and informal services.

Although reports of child maltreatment (CM) have steadily increased over the last decade, a growing body of literature suggests that services to maltreated children and their families are increasingly nonexistent, inaccessible, or inappropriate. What accounts for this failure in services, and what research

This research was supported by a grant from the National Institute of Mental Health (R24-MH53623), Children's Mental Health Services Research Center, Charles Glisson, Principal Investigator. The authors are grateful to the anonymous reviewers who offered useful comments on an earlier draft of this paper.

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is needed to guide future efforts? These questions are addressed in a three-part discussion which considers how and why child welfare services are inadequate; relevant research on help-seeking and utilization of services, especially among poor and minority families; and future directions for CM research and practice.

Child Welfare Services: Challenges and Limitations

The evidence suggests that most children and families who are investigated by child welfare agencies do not receive supportive services designed to preserve the integrity of the family and prevent placement in foster care. While foster care is an important service for children who cannot safely remain in their homes, both legislative guidelines and professional standards require that all “reasonable efforts” be expended to keep families together before placement is considered. Yet, such supportive services are often absent. For example, in a study of 169 cases investigated by thirty-nine social workers, Meddin and Hansen (1985) found that three-fifths (59.7%) of the children and families received no services during the investigation. Similarly, Salovitz and Keys (1988) found that 55.8% of the cases investigated in New York State in 1987 were closed without services; moreover, this statistic was comparable with the previous five years. Of course, it should be noted that some cases are not substantiated and services are not provided because maltreatment did not occur and the families do not need services. Often, however, needed services are not provided.

While several recent studies have revealed that children in state custody have significant mental health problems (Glisson, 1996; Thompson & Fuhr, 1992), mental health services often are not provided (Glisson, 1996). For example, Glisson (1996) found that in his sample of children in state custody in Tennessee, 52% had psychosocial problems in the clinical range but records documented mental health services for only 14%. (Services may have been delivered elsewhere and not documented in agency records). Trupin and colleagues (1993) found that half of a sample of 191 children in the child protective services (CPS) system were seriously emotionally disturbed (SED); although protection was provided at a high rate for the sample as a whole, needed mental health services were not. Specifically, the researchers found that “case management and foster care were the services most frequently provided,” while “family support groups,...outpatient treatment, and school-based treatment and diagnostic services” were the “area[s] of greatest unmet
need” (p. 350). In a study of children’s mental health service use across service sectors, Burns and colleagues (1995) found that child welfare and juvenile justice “provided mental health services to relatively few children in the sample” (p. 152).

Two additional studies not only provide evidence of the relative lack of services for children in foster care, but also identify the characteristics of those children who do receive services. In a study of 1,352 children entering foster care in San Diego County, Blumberg and colleagues (1996) found that only 17.4% of the children received public mental health services while in foster care (and only 16.2% had received such services prior to entering foster care). Older children were more likely to receive mental health services and received more episodes and more intensive services (e.g., inpatient rather than outpatient). Males, children not placed for neglect as the primary reason, and those with more severe problems (according to DSM diagnoses) also received more services. Given the low rate of 17.4% receiving public mental health services, it is particularly noteworthy that California is one of the richest states in terms of mental health resources; moreover, there is no reason to believe that children in foster care in California need services any less than foster children in other states.

Risley-Curtiss and colleagues (1996) studied children entering foster care in Baltimore between April 1989 and June 1991. All children received a health screening (including mental health) upon placement and a more comprehensive assessment within 60 days, and appropriate referrals for services were made at both assessments. At the screening assessment, 87.4% had at least one identified physical health problem, and almost 70% had at least one mental health problem or serious risk factor. For the referrals made at the first assessment, the researchers calculated “completion rates,” that is, the percentages of children who received the recommended service by the time of the second assessment sixty days later. The findings showed a completion rate of .61 for problems described as urgent (e.g., evidence of strep throat, suicidal ideation), .39 for problems described as not urgent but important (e.g., evidence of possible scoliosis, sexual activity without contraception), and .28 for problems described as routine (e.g., needs eye exam). For mental health referrals, specifically, the completion rate was .56 for “urgent” problems and .29 for “nonurgent” problems. It is striking that despite high need, a large proportion of children did not receive recommended services even though qualified health care providers gave referrals, services were paid for by Medicaid, and a Federal consent decree had been issued based on inadequate attention to health problems.
Reasons for lack of services

What accounts for the dearth of services provided to maltreated children and their families? To a great extent, the lack of services is a result of the evolution of child welfare policy, funding, and resource allocation over the past quarter century. During the 1970s, the passage of mandated child abuse reporting laws and efforts to educate the public resulted in large increases in reports, with the numbers doubling between 1983 and 1993 (GAO, 1995). Despite modest increases in total funding for child welfare, increased spending for investigation and foster care has resulted in fewer and fewer resources to provide preventive and rehabilitative services for these troubled families (Pelton, 1990). States' emphasis on foster care, at the expense of other services, is largely a consequence of federal funding guidelines through which states receive matching dollars for their foster care expenditures regardless of the amount spent, while funds for treatment and prevention are capped at a fixed amount. Discontinuity in service delivery and lack of services for many families have been inevitable consequences of this series of events (Kamerman & Kahn, 1990a; Salovitz & Keys, 1988).

Service delivery is generally separated from the investigation process (Kamerman & Kahn, 1990a; Meddin & Hansen, 1985; Salovitz & Keys, 1988), at least in part because reports of maltreatment may not in fact be accurate. Nevertheless, a protracted time frame for conducting investigations and a delay in providing services can result in the loss of a significant opportunity for effecting change, in addition to excess trauma for families. Moreover, the primary service often provided is placement “rather than a mix of services for the family system” (Meddin & Hansen, 1985, p. 181), and when other services are provided they are often inappropriate or inadequate (Kamerman & Kahn, 1990a; Meddin & Hansen, 1985). Citing Florida statistics from the late 1980s, Crittenden (1992) noted that the state spent almost four-fifths of its funds for dependent children on investigation, prosecution, and out-of-home placement, while only 15% was spent on supervision and treatment and 4% on prevention.

With limited funding, CPS focuses its attention on the most urgent cases, leaving few resources for other troubled families. Supportive services and treatment options for multi-problem families or families with more chronic problems (often related to poverty) are quite limited in many jurisdictions. Likewise, there are few services for out-of-control children and for latency and early adolescent children (Kamerman & Kahn, 1990a; Crittenden, 1992).
Organizational factors in child welfare agencies, often related to funding shortages, also contribute to service discontinuity and lack of services: high caseloads, mandated worker deadlines, reduced qualifications of staff, staff turnover, and inflexible organizational boundaries and funding streams (Kamerman & Kahn, 1990a; Knitzer & Yelton, 1990; Salovitz & Keys, 1988; Trupin et al., 1993).

Services also may not be provided because specific needs related to different types of maltreatment are hard to match within the limited resources of a specific community. For example, the focus of treatment services for maltreating parents has gradually shifted away from a pathology-deviance focus to a focus that emphasizes promoting parental competence and reducing family stresses (Wolfe & Wekerle, 1993). Physically abusive parents may need behavioral training in appropriate discipline, along with methods of controlling anger, while the needs of neglectful parents are likely to be quite different and to relate to deficits in caretaking skills and information (Wolfe & Wekerle, 1993). Moreover, neglect is often more pervasive and less responsive to intervention than abuse, embedded as it often is in a chaotic and dysfunctional environment (Erickson & Egeland, 1996).

Indeed, the technologies for addressing specific types of child maltreatment are not well developed, and may require individualized approaches to families’ unique circumstances, problems, and strengths. The ecological model of maltreatment (Belsky, 1984), the most frequently cited model for explaining child maltreatment, hypothesizes that maltreatment results from a complex mix of societal, community, and personal factors; one would expect such factors to require equally complex methods of intervention. Clearly, the effective delivery of services in this way would be labor-intensive and expensive. Heretofore, resources have not been available to develop or to deliver services in this way.

**Inappropriate services**

One consequence of the limited availability of services is the assignment of families to inappropriate services. In some cases, inappropriate services are probably offered because nothing else is available. For example, generic “parenting classes” are often provided to large numbers of parents with a broad range of problems. Often, such a scatter-shot approach is an effort to provide services to many clients in the hope that “something will work.”

Reviews of successful services show variability in program intensity, duration, staffing, and structure, with families needing different types of pro-
grams based on their circumstances (Daro & McCurdy, 1994). Daro’s (1991) review found that in general, communities are most equipped to provide short-term help and least equipped to serve the families at high risk for severe maltreatment. Kamerman and Kahn (1990b) also noted that many families need long-term assistance, while only short-term help is available. Moreover, agencies are organized to provide help for single problems, while most families have multiple problems (Kamerman & Kahn, 1990b). While some parents require home-based services because they are too isolated to feel comfortable outside their homes, others benefit from group settings. First-time parents may benefit from more fundamental information about child care, while more experienced parents may simply need resources to reduce their stress. In general, it is agreed that comprehensive, multi-service interventions are needed to meet families’ individual needs (Wolfe & Wekerle, 1993), but many communities simply cannot offer the range and diversity of services that are needed. Indeed, communities with the greatest number of disadvantaged families tend to be the most lacking in community-based services (Daro, 1991).

Thus, for example, in an analysis of the Florida service delivery system, Crittenden (1992) found that “the range of services did not match the range of services needed by families. Because of the lack of appropriate services, workers were assigning seriously troubled families with deeply rooted, chronic problems to preventive or crisis-oriented services which were available” (pp. 26-27).

In some instances, the services offered are inappropriate from the client’s perspective. In a review of studies that examined client and worker perspectives on service needs, Pelton (1982) found that agencies tended to offer services that clients did not want. While agencies offered services designed to change the clients, the clients desired concrete advice, help with interpersonal problems, and material assistance.

Indeed, despite wide recognition of the role of chronic poverty in maltreatment (Garbarino et al., 1992), the services generally provided give inadequate attention to the relationship between deprivation and quality of parenting. In fact, the conditions of chronic and severe poverty create enormous obstacles to healthy parenting. Children suffer directly from material deprivation and indirectly through the stress, anxiety and depression experienced by their parents (Magura & Moses, 1984). In areas of concentrated poverty, families are socially isolated in dangerous neighborhoods threatened by drugs and violence (Garbarino et al., 1992). In such circumstances, parents may use harsh and restrictive parenting practices to protect their children from outside
influences, to prevent them from being apprehended by authorities (Garbarino et al., 1992), or to build “functional competencies” for surviving in a hostile environment (Ogbu, 1981). In light of pervasive and relentless social and economic pressures on poor families, interventions such as parenting education classes are likely to have little impact.

To complicate matters further, while clients may perceive services as inappropriate, workers are likely to cite factors related to the family as barriers to children’s receiving needed services. Specifically, in a study of CPS caseloads, Trupin and colleagues (1993) asked service providers “to identify any of 24 barriers to a child receiving a needed service” (p. 350). The results showed that 58% of the barriers cited were family-focused, while only 21% were system-focused (19% were child-focused). The most frequently cited barrier was “family’s lack of cooperation,” followed by “family’s misunderstanding of the child’s needs” and “family overwhelmed.”

It must be noted that clients’ beliefs that the services offered are inappropriate does not necessarily mean that the clients could not benefit from those services. Yet if clients’ stated needs are not met and the services recommended are perceived as inappropriate, clients are less likely to accept and benefit from the recommended services. The practice principle of “starting where the client is” recognizes that attentiveness to the client’s emotional state and definition of the problem is crucial for establishing and sustaining a therapeutic relationship (Hepworth & Larsen, 1993). It follows that the provision of a service desired by the client may enhance the client’s willingness to accept other recommended services.

Creating services that are deemed appropriate (and thus sought and used) by potential clients requires consideration of another set of questions: Under what conditions are troubled families likely to seek and use services? How do social networks and informal sources of help affect utilization of formal services?

Help-Seeking and Service Utilization

Poverty, which is concentrated in many minority communities, is a strong predictor of child maltreatment (Jones & McCurdy, 1992; Courtney, 1995). This correlation does not necessarily imply that poverty causes child maltreatment, but most models of causation do include a number of extant factors, such as low educational levels, dense and unsafe housing, violent and unsupportive neighborhoods, and others (e.g., Belsky, 1993). Thus, from the vantage
point of preventing child maltreatment, the well documented under utilization of mental health and other social services by low-income and minority populations (Neighbors et al., 1992; Rogler & Cortes, 1993; Leaf et al., 1987) is cause for great concern. Efforts to understand utilization patterns, which heretofore have not focused specifically on maltreating families, have concentrated on the help-seeking process, on one hand, and barriers to service utilization, on the other.

*The help-seeking process*

Help-seeking is usually conceptualized as a process involving several stages, with each stage of the process influenced by factors such as social class, race and ethnicity, religious affiliation, gender, age and social networks (Gross & McMullen, 1983; Greenley & Mullen, 1990; Rogler & Cortes, 1993; Gourash, 1978; Wills & DePaulo, 1991; Green, 1982, 1995). While help-seeking models vary in detail, they generally agree that the process of help-seeking includes recognizing and defining a phenomenon as a problem, and deciding whether and from whom to seek help. The help-seeking process has also been summarized in the concept of "help-seeking pathways," which are defined as "the sequence of contacts with individuals and organizations prompted by the distressed person's efforts, and those of his or her significant others, to seek help as well as the help that is supplied in response to such efforts" (Rogler & Cortes, 1993, p. 555). Rogler and Cortes (1993) note that researchers often use the concept of pathways to explain the relationship between demographic variables and service use, but fail to study pathways directly.

Differences in help-seeking among ethnic groups and social classes may reflect cultural differences in recognizing and defining problems. Because problems are given cognitive and emotional meaning by the culture (Green, 1982, 1995; Kleinman, 1981; Rogler & Cortes, 1993), the processes of defining and resolving a problem are both personal and social events (Green, 1982, 1995; Mechanic, 1982). Moreover, how a problem is defined determines whether help is sought and where help is sought (Rogler & Cortes, 1993). Green (1982) notes "that the greater the cultural distance between the help seeker and the help provider, the greater the discrepancy in perception, labeling and response to a particular problem" (p.30). Perhaps in no other area of life might we expect greater variation between clients and service providers than in the area of parenting, particularly when it comes to discipline and standards of care. Is it any wonder, then, that clients and workers define
problems differently and have different expectations about what type of service is needed, as studies cited earlier reported? For many clients, social service agencies are professional subcultures that do not seem relevant to their needs, and indeed in some cases may seem hostile to those needs.

As Greenley and Mullen (1990) note, service utilization is the final stage in the help-seeking process; thus, much of what is known about help-seeking has been inferred from examining utilization patterns. Unfortunately, this primary focus on service utilization rather than on the help-seeking process affords little information on help-seeking among groups who, in terms of their demographic characteristics, are at risk of child maltreatment.

For example, studies that focus on utilization of mental health services may underestimate the actual help sought and received by poor people and minorities, who may be more likely to seek help for emotional and psychiatric problems from non-mental health specialists such as physicians and clergy (Leaf et al., 1987; Neighbors, 1985). African-Americans, in particular, are likely to utilize social networks as sources of informal help. Data from the National Study of Black Americans showed that most respondents used informal help only, or a combination of informal and professional help. In addition, the respondents in this study who had emotional problems were more likely than those with other types of problems not to seek help at all (Neighbors & Jackson, 1984). While relatively few respondents sought help from social service agencies, those with economic problems were the most likely to do so (Neighbors & Taylor, 1985). Other research suggests that African-Americans are more likely to use emergency services (Hu et al., 1991) and that low income and minority individuals often enter the mental health system by way of a referral or mandate from professionals in other institutions (Armstrong et al., 1984; Snowden & Chung, 1990).

The focus of much of the literature on service utilization, as opposed to earlier stages in the process of help-seeking, particularly limits our understanding of how maltreating families recognize and define problems in the parenting relationship. This is true because most such clients (at least those who do actually end up in the child welfare system) are mandated clients; other people (either professionals or lay observers) have recognized and defined the problems of these maltreating families, and whatever services they receive have been ordered by the court. Many families may have such problems but have not been reported, and thus little or nothing is known about how these unidentified families recognize (or fail to recognize) and define parenting problems.
How then do we learn whether mandated child welfare clients and unidentified maltreating parents have recognized problems developing in their parenting relationships with their children, their definitions and attributions of such problems, and why and how they have or have not sought help? The methods used in the limited services research available on this population have not been able to address these issues.

For all racial and income groups, social networks (which themselves reflect an individual's social class, race, and ethnic context) affect whether help is sought from formal or informal sources, and which formal or informal sources are used. Studies have found that network type (kin vs. friendship), network size and network density (the extent of independent contacts among the members of an individual's network) affect help-seeking in ways that are complex and not completely understood (Birkel & Reppucci, 1983; Powell & Eisenstadt, 1983). From their two studies of low-income populations, Birkel and Reppucci (1983) concluded that highly dense, kin-dominated networks that are in close proximity may discourage the use of professional help by serving as an alternative source of information and advice. In a study of pediatric medical care use, Horwitz and colleagues (1985) found that network size was positively related to pediatric care use, presumably because these networks were well-educated and were likely to be in favor of medical care. On the other hand, the tendency to make use of network members decreased utilization of pediatric care for minor medical problems, presumably because network members were serving as alternative sources of help. In general, these studies show that social networks can increase or decrease use of professional help, depending on the network members' values and availability to provide information and services.

Thus, certain social networks may decrease the likelihood that needed services are sought for parenting problems and maltreatment. Maltreating, and particularly neglectful, families are known to be socially isolated (Polansky, Ammons & Gaudin, 1985). Furthermore, as we noted earlier, families in areas of concentrated poverty are particularly isolated and may use harsh and restrictive parenting practices as an adaptation to their social and economic circumstances (Garbarino et al., 1992). If poor parenting styles are learned from older generations in these isolated families, maltreatment could be reinforced rather than challenged in the maltreating families' limited social networks.

Parents' demographic and personal characteristics are also correlated with helpseeking for their children. Compared to older mothers, younger mothers were found to have more inappropriate expectations for their children and to
rely more heavily on family and friends, who may be unreliable sources of information (Vukelich & Kliman, 1985); younger mothers were also found to make less appropriate use of pediatric treatment, and were more likely to delay treatment for their children (Turk et al., 1985). Hughes and Durio (1983) found that extended families had fewer developmental and childrearing concerns than single parents and that single parents were more likely not to consult anyone about childrearing concerns. Finally, Firestone and Witt (1982) found that parents who dropped out of a parent-training program were significantly younger and had lower IQs than the parents who completed the program.

Comparing mothers who used a family support program to those who had not, Telleen (1990) found that the mothers who sought formal help with parenting were experiencing significant behavioral problems with their children, perceived themselves as lacking competence in parenting, attributed their children's behavioral problems to their own parental behavior, had significantly higher stressors than a comparable sample of mothers in the community, and "had an expressed need for more social support in parenting and felt somewhat isolated in their parenting role" (p. 274). Telleen concluded that if the "need for support exceeds [the individual's] supportive resources, then he or she is more likely to seek help" (p. 275). Somewhat consistent with Telleen (1990), Raviv and colleagues (1993) found negative relationships between self-confidence and help-seeking on four issues among parents of adolescents.

In considering what is known about help-seeking among low-income, minority, and otherwise "at risk" populations, it is important to reiterate that the existing research has focused on voluntary help-seeking, whereas many services provided or needed for child maltreatment (or parenting problems preceding CM) are mandated. In fact, child welfare has historically faced the difficult challenge of providing family support services in the context of a system that investigates and reports abuse as well as provides services (Pelton, 1990). Thus it is important to distinguish between voluntary programs with a preventive focus (such as the Healthy Families programs sponsored by the National Committee for Prevention of Child Abuse, and the various family support programs) and public-sector child welfare services, which tend to be mandated for those with substantiated cases of child abuse and neglect.

Recent reviews of empirical research indicate modest short-term success for voluntary programs in improvement of child-rearing skills and other indicators of risk for maltreatment (Wekerle & Wolfe, 1993; Wolfe & Wekerle, 1993; Daro, Jones & McCurdy, 1993). There is less evidence for
long-term effectiveness, although at least one very intensive program of home visiting has shown long-term evidence of improvements on a number of fronts (Olds et al., 1997). (All of these programs use reports of maltreatment as outcomes, allowing for the possibility of undetected and/or unreported abuse).

There is less evidence about the effectiveness of the public child welfare system. Kamerman and Kahn's (1990b) national study found no services provided for unsubstantiated cases, and most provided only to the approximately 5% involving severe abuse. The vast majority of troubled children and families with multiple problems receive nothing. Other studies suggest that the families least likely to receive services include those who are the most difficult to reach and possibly most in need (Bryant, 1993) and those who would benefit from early intervention (Wekerle & Wolfe, 1993).

Experimental studies comparing "regular" child welfare services with intensive programs for family preservation (to avoid out of home placement) or for reunification of families underscore the need for more services for all maltreating and at-risk families. For example, Fraser and colleagues (1996) found higher rates of reunification in an experimental vs. a control group, and suggested that "relatively brief and intensive family-centered services can significantly affect reunification rates" (p. 335). Furtermore, Rzepnicki and colleagues (1994) found that Illinois families in a family preservation program (called "Family First") received more services and were more satisfied with the services they received than families in the control (or "regular" services) group.

Research also suggests that at least some maltreating families establish positive relationships with CPS workers. For example, in the study just cited (Rzpeckni et al., 1994), the Family First parents were more satisfied with their relationship with their caseworkers than parents in the regular services group. Further, in a follow-up survey of Iowa parents investigated for maltreatment, most respondents rated their workers favorably on scales of worker attributes and behaviors, and nearly three-fourths rated the services they received as good or excellent (Frycr et al., 1990). Although the response rate in this mail survey was low (26%), cases of substantiated abuse and recidivism were overrepresented in the sample, which would be likely to bias the findings toward more negative perceptions of workers (Fryer et al., 1990). Thus the high proportion of favorable ratings of workers in this study is somewhat encouraging.

However, despite some exceptions, the relationships between mandated clients and their service providers often involve resistance and hostility due to conflicting interests, cultural differences and/or disparate definitions of the
situation of the respective parties (Cingolani, 1984; Horejsi, Craig & Pablo, 1992). Such resistance is understandable in light of many clients’ negative perceptions of the child welfare agency and their fear of its power over their lives (Magura & Moses, 1984; Diorio, 1992). In a qualitative study of a sample of clients of a large public welfare agency, Diorio (1992) found that the subjects were overwhelmed by fear, felt vulnerable to the caseworker’s perceptions and authority, and believed that the caseworkers misused their power and ignored clients’ rights. Further, in the survey of Iowa parents investigated for maltreatment cited above (Fryer et al., 1990), over a fifth of the respondents believed that their workers’ judgments about them were not accurate. Such research suggests that the attitudes and actions of agency personnel, including workers’ use of authority, affect the likelihood of engaging mandated clients in appropriate services (cf. Hutchison, 1987; Horejsi, Craig & Pablo, 1992). In any case, in light of the different circumstances surrounding the agency contacts of voluntary and involuntary clients, the literature on voluntary help-seeking has limited relevance for our understanding of mandated service utilization.

Another limitation of the help-seeking and service utilization literature is that studies have tended to focus on a particular service arena (such as medical or mental health services) rather than examining help-seeking directed toward a variety of formal and informal sources for a wide range of problems. An important exception is the National Study of Black Americans, which examined help-seeking from both formal and informal sources for various types of problem (Neighbors & Jackson, 1984; Neighbors & Taylor, 1985). However, the NSBA did not explicitly examine parenting practices, and it used a national probability sample of Black Americans; thus, the similarities and differences between the help-seeking patterns of this national sample and a sample of families of all races at high risk of child maltreatment are unknown.

**Barriers to Service Utilization**

Barriers have been conceptualized in terms of four factors (Stefl and Prosperi, 1985): availability (awareness of the existence and location of services); accessibility (ability to get to services); acceptability (including whether stigma is attached to services in one’s social network); and affordability (financial costs and time taken from work). In a study of community mental health need and utilization in a rural area, Stefl and Prosperi (1985) found that groups at greater risk (i.e., having higher need) also perceived more barriers to service. Moreover, among those who had used services within the
past year, the most important barriers to potential future utilization were affordability (specifically, cost of services) and availability (not knowing that services are available or where they are located).

Beginning in the 1960s, the community mental health movement has sought to lower the barriers to service, particularly among high risk populations. Specifically, by increasing their visibility, accessibility, and affordability (through sliding scale fees), community mental health centers have enhanced knowledge and utilization of services (Greenley & Mullen, 1990). Nevertheless, barriers to service persist and are greater for poor and ethnic minority populations. For one thing, mental health service providers, sometimes including those of minority status themselves, are not always sensitive to cultural differences, and may not understand or appreciate the role of informal helping and support networks among minority populations (Hoberman, 1992).

Moreover, the barriers to service utilization for families of maltreated children are particularly daunting. To begin, the stigma associated with child maltreatment decreases the likelihood that parents will acknowledge "symptoms" in their childrearing practices and come to define themselves at risk, or guilty, of maltreatment. Even if parents recognize that they have a problem, the stigma associated with child maltreatment, along with a fear of losing custody of their children, will further discourage seeking help, at least from formal services.

Further, given that child-rearing standards, discipline practices, and perceptions of maltreatment vary in complex ways across social class and ethnic groups (Daro & Gelles, 1992; Giovannoni & Becerra, 1979), there is likely to be disagreement between middle-class professionals and mostly low-income clients on these issues. These differing perspectives may contribute to the problem, noted earlier, of clients believing that the services offered are inappropriate. Indeed, research suggests that dropout rates even in voluntary prevention-oriented programs are high among high-risk and low income populations (Birkel & Reppucci, 1983). This may indicate that the services are not perceived as useful or relevant to these clients, particularly in light of competing needs and interests, or that accessibility (e.g., transportation) is a barrier.

Daro and Gelles (1992, pp. 528-529) have defined three types of families with respect to their likely responsiveness to programs to prevent maltreatment. "Consumer families" are aware of their limitations in parenting knowledge and skill and are the most receptive to preventive efforts. "Dependent families" are unaware of their need for services or of how to obtain help; reaching these families requires more intensive effort. Finally, "resistant
families” have “serious functional problems,” and have not been reached successfully by preventive efforts or treatment programs (Cohn & Daro, 1987). Both lack of accessibility of services and families’ lack of response to existing services contribute to the failure of prevention efforts with resistant families (Daro & Gelles, 1992).

While the community mental health movement of the 1960s and 1970s sought to increase availability of services, the managed care movement of the 1990s may be limiting utilization of medical and mental health services, which places a greater burden on low-income clients. Since low-income communities already have fewer resources for all types of health and social services, the managed care trend may increase the barriers of service availability and affordability for the most vulnerable populations.

Green’s (1995) model of help seeking explicitly includes knowledge of community resources as a step in the help-seeking process, and lack of availability (not knowing that services exist or their location) has been identified as one important barrier to service utilization (Stefl & Prosperi, 1985). What is unknown, however, is exactly how knowledge of community resources affects help-seeking from both formal and informal sources. When troubled families do not utilize formal services, is it because (a) services are scarce in their communities, (b) they are unaware of community resources, (c) they prefer informal help, or (d) they seek no help at all, either because they do not perceive a problem or because they fear stigmatization? The research to date has not addressed this question.

**Future Directions for Practice and Research**

Noting the limitations and challenges of the child welfare system, analysts have already offered a number of recommendations for greater effectiveness. Services should be locally based (Kamerman & Kahn, 1990a), include school-based mental health services (Burns et al., 1995), provide continuity of care (Kamerman & Kahn, 1990a), reflect cross-system collaboration (Knitzer & Yelton, 1990), and take into account the social ecology of the target families (Crittenden, 1992). In addition, a number of authors are calling for greater “cultural competency” and research on cultural competency in work with clients of varying racial, ethnic, socioeconomic, and regional backgrounds (Orlandi, Weston & Epstein, 1992; Cross et al., 1992; Blank et al., 1994).

These general recommendations, based on analysis of major gaps in service delivery systems, are important, but more is needed to address the specific
problems of maltreating and at-risk families. Pelton (1990), for example, advocates the creation of a public child welfare agency that not only provides comprehensive services at no charge to families in need, but is also completely separate from the investigative functions and foster care system. This new public agency would be charged with delivering child welfare services “that parents with child welfare problems want and need” (p. 25) and might reduce the stigma ordinarily associated with services for child maltreatment.

However, this still leaves us with the question of how services should be devised to attract and treat families with child welfare problems. Consideration of the foregoing review of the literature on help-seeking and service utilization, in light of specific challenges for service delivery to families at risk of child maltreatment, suggests the following agenda for practice and research:

1. As we have seen, two of the obstacles and challenges to service delivery in child welfare are the resistance of mandated clients and clients’ perceptions that the services offered are inappropriate. To overcome resistance and gain clients’ interest, services to prevent CM may need to be linked to other kinds of services that at-risk families are likely to seek voluntarily, such as services to meet material needs. Indeed, a tight linkage is needed between income assistance and services not just for maltreatment, but also to support parenting and prevent maltreatment. Building such a linkage between income support and parenting services is particularly important now because the Temporary Assistance to Needy Families (TANF) program provides income assistance for such a short time. Offering parenting support services as a routine part of TANF might reduce the stigma (since at-risk families would not be singled out), engage families who otherwise might not seek services, and prevent maltreatment from occurring.

At the same time, research is needed to determine the specific concerns parents have about childrearing at each stage of a child’s life. Then, rather than trying to convince parents that they need the services being offered, child welfare agencies could gain the confidence of troubled families by offering the services that match clients’ stated needs and interests.

Indeed, if families are to be encouraged to seek services, clearly those services should be appropriate to their needs, both in terms of particular types of maltreatment involved and the families’ circumstances. More research, and in particular more sophisticated research to develop treatment technologies, must address this issue, even as current services needed by maltreating families (such as income support, education, and child care) should be expanded to meet the need.
2. As we saw earlier, our knowledge of help-seeking among high risk and maltreating families is limited in part because research has failed to consider informal help-seeking together with formal service utilization. At the same time, research has not linked the study of barriers to utilization of formal services with the study of help-seeking from informal sources. Future studies of high risk and maltreating families must focus on the whole picture: utilization and barriers to utilization of formal services, along with use of informal sources of help, for problems in all life sectors. An important question for this research is whether and how help-seeking for parenting differs from help-seeking for other problems.

Clearly, longitudinal research is needed to examine the range of services from which high-risk families seek assistance, as well as the ways in which social networks (informal sources of help) encourage or discourage help-seeking from formal services. Such research can provide information on maltreating families who never recognize their problems, those who recognize a problem but seek no assistance, and those who seek assistance outside the formal services system. Only such longitudinal research can make it possible to place services where they are most accessible and acceptable to at-risk families, thus reducing the incidences and negative consequences of families' being mandated to accept services in an adversarial relationship.

References


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