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A SOCIAL WORKER'S PERCEPTION OF THE MEDICALLY AT-RISK (MAR) PROGRAM

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Corina Chavez
Lilia Razo
June 2010

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ABSTRACT

Children involved in child welfare often suffer from a plethora of health problems. This study seeks to evaluate social workers' perception of the Medically at-Risk (MAR) program that has recently been implemented in San Bernardino, Children and Family Services for children with special health care needs through a quantitative/qualitative questionnaire. Social worker's perception will be determined by their awareness, knowledge of qualifications, ability to identify symptoms, and training and education about the MAR program. It is expected that this study will enrich the field of social work through improving services to this population by social workers.

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We would like to express our sincerest gratitude to Children and Family Services of San Bernardino County for giving us the opportunity to conduct the study and for their courteous assistance and support.

DEDICATION

To the wonderful ladies who taught me everything I know: my Mama, and sisters Melissa, Lorena, and Inez. And of course to the little women who have big shoes to fill and I'm sure they will Lea and Isabel.

-Corina

I would like thank my mom and dad for always be supportive and encouraging me to follow my dreams. I love you! To everyone that believed in me, thanks.

-Lilia

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CHAPTER ONE

INTRODUCTION

Problem Statement

In the United States, more than half a million children enter the child welfare system each year (Donaldson, 2009). In September 2006 alone, there were 510,000 children who were in the child welfare system (Child Welfare Information Gateway, 2009). Children involved with child welfare services are more likely to suffer from serious health problems such as malnutrition, failure to thrive, delayed growth, neurological problems, infections, vision and hearing impairments (Child Welfare League of America, 2009). These children are also more likely to suffer from emotional disturbances, psychiatric disorders, learning, and developmental disabilities (Child Welfare League of America, 2009).

Furthermore, over 50% of infants who were involved with child welfare services, referred to as Children and Family Services (CFS) in San Bernardino, suffer from at least one mental, physical, or learning disability (Dicker & Gordon, 2004). Reasons why children in child welfare are more likely to suffer from more disabilities than children not involved in child welfare vary from parental drug use to environmental conditions. Environmental factors these minors are exposed to may increase the chances of a disability; these factors include poor nutrition, lack of or poor medical care and/or prenatal care, unsanitary and poor living conditions, exposure to toxins such as drugs or lead, poor supervision, and/or lack of developmental supervision. Drug use has become a problem in our society in recent years and is evidenced in the amount of children born who were drug exposed in utero. An estimated 350,000 to 739,200 infants were exposed to illegal substances each year (as cited in Siefert, Schwartz, & Ortega, 1994). Furthermore, an estimated 80% of drug-exposed children of untreated mothers were placed in foster care before their first birthday (as cited in Siefert, Schwartz, & Ortega, 1994; Child welfare League of America, 2009). Exposure to drug use in utero further places children at-risk of developing a disability.

About twenty percent of children involved in the child welfare system have a disability that classifies them as medically fragile (Child Welfare League of America, 2009). The terms medically fragile or special needs are used to describe individuals who suffer from a medical condition, or those with a disability that requires specialized care (Holen, 2009). Medical knowledge and technology have advanced in recent years increasing the chance of survival for children with severe medical problems and complications. Children with special needs often depend on a caregiver to assist them to have their basic needs met; this dependency can often put a child at risk of abuse or neglect because, they are less able to articulate the fact of abuse, unable to differentiate between appropriate and inappropriate physical contact (whether it be violent or sexual), more dependent on others for assistance or care, therefore, more trusting, since dependency and trust often translate into compliance and passivity. Children with special needs are often reluctant to report instances of abuse for fear of losing vital linkage to major care providers (Garfinkel, 1986).

Many people are involved in caring for children with special needs including medical specialists, occupational therapists, home health care nurses as well as other community resources (e.g. special education schools, regional centers, etc.) that provide services to this population. In Children and Family Services, a special "team" will work together to provide effective services to children with special needs and/or their families. The team consists of professionals from various fields intended to meet the varying needs of each child. This ensures that the child receives all medical, emotional, and educational services. A special needs child is assigned a regional or a special health care needs social worker to coordinate appropriate services depending on the program the child qualifies for. (These qualifications will be explained further in the chapter). A Public Health Nurse is also assigned to the case to oversee the child's special medical needs. Along with the child's caretaker, the team works to find a case plan that fits the child's needs and coordinate these services.

There are two programs that are offered to special needs children in San Bernardino County, Children and Family Services: Special Health Care Needs (SHCN) program and Medically at-Risk (MAR) program. (Each program will be discussed in detail later in the chapter). The programs ensure that children with special needs receive appropriate services and supervision. The MAR program was created in the aftermath of the SHCN program's exclusions. The MAR program receives no additional funding, which causes concern of whether special needs children are receiving adequate services and having their needs met.

Children with disabilities often require additional assistance such as the use of technological assistance, medication, and various other accommodations (Donaldson, 2009). Social workers must be prepared both emotionally and professionally in order to work with children who have medical conditions as they do require extra care, supervision, and support. Meeting these children's extraordinary needs demand optimal work from social workers, public health nurses, and caretakers. Compounded with the systematic barriers that inhibit or delay services (i.e. lack of funding, lack of specialized services, weak relationships between child welfare and disability services) achieving such needs is difficult (Lightfoot & LaLiberte, 2006). With the lack of funding for programs such as MAR, preparedness with training and education for social workers comes into question.

Social workers fulfill an essential role in the life of special needs children. Social Workers are to advocate, protect, and ensure that these children are provided with a safe permanent home. Social workers should also refer children to resources and programs that specialize in this population. For example, these children depend on social workers to find them specialized services such as therapy, support groups, and medical attention. Social workers should have knowledge about medical conditions, psychiatric disorders, and disabilities that children have. Appropriate training, education, and knowledge of existing resources, policy, and laws that affect this population are important for social workers in order to address these children's needs.

A Public Health Nurse (PHN) will also play a crucial role in a child's life. The PHN will have many responsibilities such as reviewing services, supporting both social worker and family, assessing children, and determining best case plans. A public health nurse has the most medical expertise in child welfare. Therefore, they are responsible for ensuring that social workers and caregivers fully understand the child's disability as well as explaining the child's limitations and providing care advice. Each Public Health Nurse in the San

Bernardino County, Children and Family Services from each region location is responsible for one unit, which can amount to over 200 children. MAR children require teamwork by both the social worker and the PHN, with such high caseloads for both the social worker and the PHN, do MAR children really receive services they are entitled to?

Caretakers play the most significant role in the lives of these children. They hold the responsibility to care, provide for, and teach the children. Raising a child is not an easy task. Raising a child with special needs is even more difficult. Many of these children have complex medical problems that require them to be completely dependent on another for daily living. Caretakers must have the knowledge to operate special equipment, give children medications, and know several procedures to care for these children. However, studies have indicated that kinship (relative) care families receive fewer services than non-kinship care. They "are less likely to receive respite care, support groups, and training than foster parents. As many as 91% of kinship caregivers report not receiving any type of training" (as cited in Gordon, McKinley, Satterfield, & Curtis, 2003,

p. 3). Foster parents are employed by foster family agencies as well as county child welfare services to provide care for children. Foster families are trained and prepared to care for special needs children. These families are given many supportive services such as 24-hour support from a social worker (if involved in a foster family agency), and continuous training. Kinship caregivers are family members that have chosen to care for relative's children who were removed from the home. Kinship caregivers receive less financial, supportive, and training services. A great difference between MAR and SHCN is that MAR children are in relative care instead of foster care, which again questions whether the child and family is provided with adequate services.

The key to receiving services from special needs programs is entirely at the discretion of the social worker as well as a caregivers report. The social worker is required to make 1 face-to-face contact monthly. During this contact, the social worker will speak to caregiver and child to receive updates on the child as well as progress (education, developmental, medical, etc.) The social worker must assess for special needs based on this encounter. If the child does not show obvious symptoms, a referral for assessment will not be made. This can be difficult to rely on because many workers only have contact with children one time per month. Social workers and caregivers are not medical doctors; they do not have the medical expertise nor training to recognize signs to diagnose a child. Children who do not show obvious symptoms for conditions will not receive a referral for an assessment. Therefore, the actual number of children with special needs involved in children and family services is unknown because many may not be diagnosed.

Policy Context

In 1999, the United States Supreme Court hearing regarding the Olmstead decision called for the deinstitutionalization of people with disabilities (Legal Information Institute, 2009). The court ruled that the unnecessary segregation of individuals with disabilities in institutions might constitute discrimination based on disability. The court referred to the Americans with Disabilities Act, which required states to provide community-based services rather than institutional placements for individuals with disabilities (Legal Information Institute, 2009). As a result, Children and

Family Services are required to provide special needs children placements in family settings rather than medical care facilities. With little support from medical facilities, the social worker has the responsibility to advocate for clients, determine the best interventions, and coordinate services for them.

San Bernardino County, Children and Family Services

As of January 26, 2010 there were 3,608 children ages 0-19 involved in CFS in the county of San Bernardino (San Bernardino County: Children and Family Services [SBCCFS], 2010). Of these children, 126 were receiving SHCN or MAR services. Additionally, 48 of the 3,608 children had serious medical conditions that required the children to be placed in a nursing home, hospital, regional center, or psychiatric facility but were not receiving SHCN or MAR services. Special needs children represented 20.7 percent of children involved in CFS. Twenty-nine children receiving SHCN or MAR services were placed with a relative or non-related extended family member (NREFM). The number of special needs children with a family maintenance case plan was not specified (SBCCFS, 2010).

Children and Family Services Policy

Welfare and Institutions Code (WIC) of the California law 17710 defines children with special needs living in out-of-home placement and specifies state regulation procedures that must be followed when placing a child in a home with the exception of skilled nursing facilities (California Legislative Information, n.d.).

San Bernardino County, Children and Family Services (2009) define Special Health Care Needs children as:

> Child[ren] with special health care needs who ha[ve] a condition that can rapidly deteriorate resulting in permanent injury or death, and/or ha[ve] a medical condition that requires specialized in-home health care, and [are] a dependent of the juvenile court or [are] in the custody of the county welfare department, or [are]pending placement in non-relative out of home care. (Children and Family Services, 2009, p. 366)

San Bernardino County, CFS (2009) social workers are required to report any cases in which they suspect a child may potentially have high-risk medical needs to the regional Public Health Nurse (PHN) in order for the PHN to conduct an assessment of the child. If determined that child has a special health care need, the child may qualify for one of two programs for assistance: Special Health Care Needs (SHCN) program and Medically At-Risk children (MAR) program.

The SHCN program was established to provide services to special needs children involved in CFS. These children are primarily living in foster care, group homes, or medical facilities. The special health care needs unit consists of 3 full-time and 1 part-time special health care needs social worker. The social workers in this unit have a reduced caseload of 20 children for full-time staff and 10 children for part-time staff. (Regional social workers have caseloads of 30 to 50 children). Yet this unit is responsible for caring for all special health care needs children in San Bernardino County. The SHCN unit can properly care for a maximum of 70 special health care needs children. The SHCN program receives no additional funding, other than the special care increments given to caregivers, rather, referrals are made to community partners for assistance. Children in the SHCN program receive frequent contact by social workers' that are knowledgeable of special needs and a Public Health Nurse that is assigned to the unit. Many more children meet the qualifications for SHCN program. Unfortunately, there are not enough social workers to place children in this unit, and therefore, many SHCN children end up in regional social workers' caseloads. SHCN children are also placed in homes that specialize in caring for special needs. Caretakers of these children receive special care increments that provide extra monetary benefits to help care for a child's complex needs. Foster parents also receive further training in the field of special needs as well as have support from SHCN social workers and PHN's who have the time to coordinate appropriate services and support due to reduced caseload.

In response to the discrepancies of SHCN program, the MAR program was developed in April 2009. The MAR program was established for children who do not qualify for Special Health Care Needs (SHCN) but have a special need. Regional social workers' (SSP [Master's educational Level] or SWII [Bachelor's educational level]) role is to make a referral for a MAR assessment as well as carry the case and coordinate appropriate services.

A child who is Medically at-Risk must have the following conditions to qualify for the MAR program: the child [needs to have] a condition that can rapidly deteriorate resulting in permanent injury or death, and/or has a medical condition that requires specialized in-home health care, and is a dependent of the juvenile court or is in the custody of the County Welfare Department [and is living with a relative caregiver or non-related extended family member (NREFM)] (Children and Family Services, 2009).

The MAR program also serves children who qualify for SHCN program, but due to the limited availability, could not be accommodated in SHCN unit. The MAR program serves children with special health care needs through a team that consists of a regional social worker and a regional public health nurse. The team is required to have frequent communication with regards to the diagnosis, assessment, and service plan development for the MAR child. Medically at-Risk children are provided with a regional social worker (regional social workers, have no training in special needs) to coordinate services. The MAR program requires that the regional PHN visit the MAR child at least once per month to monitor medical and developmental needs.

Purpose of the Study

The study explored a social workers' perception of the MAR program. The program was recently implemented in April 2009 in the Children and Family Services Agency of San Bernardino County. The MAR program is an exceptional approach to help children that have been identified to have special needs, yet the referral and assessment process is broad and unfocused. The study will develop an understanding of the program through a social workers' perception of the program, since the program is highly dependent on a social worker for referrals, assessments, and compliance in order to ensure that children who need the services are receiving them. It was important to document social workers' perception county wide to evaluate the success and obstacles the program faced. The questionnaire will assess if social workers were prepared to handle the needs and challenges of this population. As well as assess if programs for special needs population are being utilized.

The primary mission of the social work profession is for social workers to be competent and have extended knowledge and skills that are necessary in working with various individuals who are "vulnerable, oppressed, and living in poverty" (National Association of Social Workers [NASW], 2009). It is important to study this issue because children who have special needs are among the most vulnerable within our society. Special needs children are also more susceptible to abuse and neglect. It is necessary to study this issue because social workers often work with special needs children or have a great chance of encountering a case.

Significance of the Project for Social Work

It is expected that this study will enrich the field of social work in the area of special needs. The results will indicate how effective the program is in providing services as well as shed light on how well informed social workers are in coordinating needed services for medically fragile children. Thus, it will improve services for children who have special needs. The project will be significant to social work practice because it will encompass the ethical principles of the National Association of Social Workers (NASW). These ethical principals enhance human wellbeing and include service, social justice dignity, and worth of the person, importance of human relationships, integrity, and competence (National Association of Social Workers, 2009)

This information will also be useful in finding areas that need to be improved in the child welfare system. It will, most of all, promote advocacy for this population and may influence change or the development of new policies and laws that will help challenge many barriers that still exist for this population. The findings of this study will hold knowledge in the area of children with special needs involved in child welfare. The findings will contribute to social work research because it will address the inconsistent care children with special needs receive.

This study is relevant to child welfare because MAR is a new program implemented less than a year ago that focused on a population that has long been ignored; children with special needs involved in child welfare. The study will evaluate a program that has filled the gap for the special needs population. Currently, there are only programs that are in place for children with severe medical needs and complications; however, this study may open doors to the development of new programs that may help a larger population of special needs that can potentially include mental, emotional, behavioral disabilities, which have been found to have fewer services providing them with special need. The results from this study can impact child's outcomes for receiving needed assistance.

CHAPTER TWO

LITERATURE REVIEW

Introduction

Chapter two consists of a review of the literature that supports the present study. The Social Systems Theory was used to guide the conceptualization of this study. An examination of studies that involved children with disabilities and the services provided to these children and their families by Children and Family Services are provided. This chapter also provides a discussion of the literature that involves child welfare workers' knowledge and their skills needed to work with this population. The importance of caregivers and their needs was also discussed.

Theories Guiding Conceptualization of Study

The Social Systems Theory describes child development in terms of complex interactive systems. A social system is either a person or group of individuals that are comprised of inter-reliant parts that function together as a whole and work towards achieving a common goal, which is achieved in an orderly fashion over time (Lesser & Pope, 2007). "A[ny] change [that takes place] in [any] part of [the] system [affects] the system as a whole" (Lesser & Pope, 2007, p. 12). According to this theory, a child is a system that is part of a larger system, which consist of other entities that are also known as systems. These systems include a child's family, school, peers, and community. The Social Systems Theory proposes that children's possibilities to grow developmentally are either restricted or enhanced by their environment (Paul, 2001). The extent to which medically fragile children can develop to their full capacity largely depends on the appropriate accommodations their environment offers. Failure to provide these accommodations such as medical care, financial support, and counseling services, inhibits them to grow to their full potential.

The Social Systems Theory is relevant to this study because this theory helps one understand how a variety of systems such as the actions of the social workers, caretakers, and PHNs affect children with disabilities in the child welfare system. This theory also depicts how programs such as the SHCN and the MAR influence each other and how their services affect the children. The SHCN program failed to address all children who had a disability in how the SHCN's manual defines medically fragile children, leaving some of them without services. This caused the County of San Bernardino, Children and Family Services to develop the MAR program in order to provide services to those that did not fulfill the requirements of the SHCN program.

Definition of Medically Fragile Children

There is no clear definition of what constitutes a child to be labeled as having special needs, a term used by San Bernardino County, Children and Family Services to determine eligibility for services. There has been a broad range of studies on special needs children, but many do not provide a clear definition of what accounts a child to be labeled as such. Ratliffe, Harrigan, Haley, Tse, and Olson (2002) used the Office of Technology Assessment (OTA) definition of "medically fragile" to define special needs children. The term medically fragile was used for children who are technologically dependent and was defined as "a child who requires both a medical device to compensate for the loss of a vital body function and significant and sustained care in order to avert death or further disability" (OTA, as cited in

Ratliffe et al., 2002, p. 167-168). The study acknowledged that not all medically fragile children were dependent on technology but used the definition to define children with special needs as medically fragile. Another study also used the OTA definition of medically fragile children (Harrigan, Ratliffe, Patrinos, & Tse, 2002) but further included medically complex, medically fragile, technologically dependent, and children with special health care needs to define medically fragile. The definition is still vague and does not explain the criteria that defines a child as medically complex or with special needs.

Children and Family Services uses the term special health care needs to classify a child who is medically fragile or has a special need. Children and Family Services defines children with special health care needs as " a child who has a condition that can rapidly deteriorate resulting in a permanent injury or death and/or has a medical condition that requires specialized in-home health care" (CFS, 2009, p. 366). Special health care needs children include children under the age of 2 that have asthma as well as children born prematurely.

The U.S. Department of Health and Human Services (2009) examined the special health care needs of children who were in the child welfare system for three years from 2001 and 2003. This study concluded that during this period, 28% out of the 5,500 children in the study had a chronic health care condition. It was also reported that 42% of these children had 3 or more conditions that qualified them for special needs. Another 73% had two or more conditions that were considered special needs. The results from this study could not be generalized to the overall population due to the variation of the definition of special health care needs (U.S. Department of Health, 2009).

Child Welfare Workers and Training on Disabilities

Shannon and Agorastou's (2006) study examined whether children were identified as developmentally disabled in child protective services (CPS) agencies by looking at the measurements used to assess disability among children receiving services. Participants in the study included 50 state level child welfare administrators.

A questionnaire developed by Camblin (as cited in Shannon & Agorastou, 2006) was modified to five items and administered to participants. The first question inquired about the requirements to report information that addressed the following areas: a) pre-existing disability in maltreatment cases b) specific disability of child c) maltreatment being the cause of the disability d) delays in developmental delays e) document disability in narrative format f) standardized definition of disability. The second question focused on the accuracy (perceived) of the data on children with disabilities submitted from local agency to states central office. The third item questioned the central office about providing local CPS agencies with information or training tools about this population. The fourth item addressed whether the state required local agencies to be trained to identify disabilities in maltreated children. The last item pertained to the collaboration (if any) between CPS and developmental disability service agencies.

Results indicated that 38% of 50 states required documentation of a disability, 62% of 50 states provided social workers with a narrative section to document a disability but did not require social workers to fill in the section. Only 12% of the 50 states required social workers to document if a disability was the result of maltreatment. Furthermore, only 26% of the 50 states required to document a disability on a risk assessment by social workers.

When asked about screening for developmental delays, the following were the responses, 14% of the 50 states screened for cognitive delays, 10% for fine motor delays, 16% for social adaptive delays, 14% for speech, 12% for gross motor skills, and 20% for behavioral problems. Surprisingly, only 26% of the 50 CPS workers that participated in the study were provided with a standard definition for disabilities.

Results for the types of assessment trainings provided by the states for local agencies were: 68% of states provided house workshops; 40% provided consultants; 28% provided handouts; 12% provided some type of written material, 6% provided films, and 26% provided technical assistance. Only 40% of states provided formal training on disabilities.

Lightfoot and LaLiberte's (2006) study examined the delivery of services in child protective services in the midwestern states for cases that involved families of children with disabilities through telephone surveys. Social workers were asked about policies and procedures for cases that involved children with disabilities. Results indicated that child protective agencies had eighteen different methods in managing cases that involved children with disabilities. Social workers were asked about the barriers and strengths that their agencies had in regards to the service delivery for this population. Barriers with certain disabilities included communication and behavior that were linked with a disability, and the chronicity of a disability. Respondents also reported that social workers and other professionals lacked knowledge of disabilities and were considered a major barrier among these cases. Only 6.7 % of 84 counties had social workers who specialized in child protection and disabilities.

Fifteen percent of respondents believed that their agencies had well developed services available for this population in their agency strengths. Results also indicated that administrators lacked knowledge about their agency policies and procedures involving the special needs population. Lightfoot and LaLiberte (2006) stated that social workers were not the only ones who needed training with this population, the court system and law officials also lacked knowledge of policies and procedures that directly help them with working with children with special needs and their families. Lightfoot and LaLiberte (2006) suggested that social workers require training and standardized models for administrators and case workers in the Child Protective Services agency to deal with this population.

Manders and Stoneman's (2009) study examined the child protective services investigation and case management services regarding children with disabilities. One hundred thirty-eight counties were selected to participate in the study. A total of 75 social workers completed a survey and responded to questions related to vignettes provided along with the survey. Questions relating to knowledge and training on disabilities resulted in 69% respondents never had on the job training on disability, 74% never attended a workshop related to disabilities, and 90% never had a college class focusing on disabilities.

Participants were provided with one of 8 vignettes that presented children involved in cases of alleged physical abuse and also had one of the following emotional disability, a learning disability, behavioral disability, cerebral palsy, or no disability. The children in the vignettes presented either moderate or severe injuries. Vignettes with moderate injuries consisted of welts, bruises, and abrasions to the arms, legs, or back of the child, or the child having his/her hair pulled out. Vignettes with severe injuries consisted of either a child with a broken arm and bruising on the child's body, or bruised or swollen ear with a concussion.

Social workers were asked questions regarding the extent to which an investigation is warranted, attribution of causality for the abuse, empathy with the alleged abusive parent, and recommended services. Social workers were then asked to select one of the following case plan closing the case without further action, short-term or long-term in-home support/monitoring, foster care, temporary placement in a group home or institution, and termination of parental rights.

Results indicated higher rates of social workers who believed that an investigation needed to be warranted in the cases that involved children with emotional, intellectual, or behavioral disabilities. Less social workers believed a referral should be warranted in cases that involved children with cerebral palsy. Results concluded that children with cerebral palsy were not thought of as suffering from abuse, social workers reasoned that questionable bruises were the result of child's disability (jerking movements). Participants also reasoned that abuse in children with emotional/behavioral disabilities was the result of having characteristics contributing to their abuse. Social workers showed higher rates of empathy toward parents that abused their children who had emotional and behavioral disabilities. Parents who had children with no disabilities were empathized less by social workers. Child evaluations and counseling was suggested most for children with emotional/behavioral disabilities, followed by children without disabilities; counseling was suggested least for children with intellectual disabilities and cerebral palsy. For injuries of moderate severity, a significantly larger proportion of respondents recommended out-of-home placement for children with cerebral palsy, than those with no disabilities.

Parents of children with emotional and behavioral disabilities were recommended services that were child-focused. Cases involving children with severe injuries and cases with emotional and behavioral disabilities were recommended anger management. Manders and Stoneman (2009) recommend more training on disabilities and the increase of disability specialists for child protective services agencies.

Waldman, Perlman, and Lederman (2007) reviewed secondary analysis of existing data from individual, state and local reviews. Findings showed that children in foster care have poor health care, thus resulting in poor health. According to Waldman et al. (2007) these children were less healthy than homeless children or children living in the poorest sections of inner cities. The report concluded that of the children in foster care, 40% were born premature, or with low birth weight. Eighty percent of infants were born with a positive toxicology report, 20% were fully handicapped, 30-40% required special education services. Fifty to eighty percent had an intellectual or behavior health problem, and 30-50% suffered from dental decay. The article emphasized the need for emergency response social workers to be provided with proper training, tools, and support to ensure identification and assessment of children who have a disability.

Education on Disabilities and Social Work

Russo-Gleicher (2008) conducted a study using "semi structured in depth interviews." Participants included MSW social workers that worked with medically fragile individuals and were members of the Association on Mental Retardation (AAMR). The study was a part of a larger study conducted by Russo-Gleicher who examined factors influencing MSW workers to work with children who are medically fragile. Participant responses from Russo-Gleicher's (2008) study were used to study what influences MSW students to work with individuals who are medically fragile, since studies have shown that interest in working with this population is very low.

Russo-Gleicher's (2008) study found that participants expressed that working with this population was 'rewarding' and 'gratifying' (p. 136). They also expressed that many of their coursework and field placements in their MSW program did not address this population. Many of these participants became interested in working with this population because they knew another person who was either working or was interested in working with this population. Russo-Gleicher (2008) found that the curriculum of MSW programs that include knowledge about developmental disabilities often influence MSW students to work with this population. However, MSW programs tend to address this population to a minimum extent or not at all. These programs often lack a focus on disabilities and early intervention in regards to identifying disabilities, which is crucial in the assessment process (Malone, McKinsey, Thyer, & Straka, 2000; Russo-Gleicher, 2008).

Early Intervention for Children with Disabilities

Child Abuse Prevention and Treatment Act (CAPTA) was an important legislation that required all children under the age of three served by child protective services be referred for early intervention assessment. If the child were determined to have a disability or delay of some sort, the child would receive services. Herman's (2007) article describes the CAPTA policy in great detail. Child Abuse Prevention and Treatment Act (CAPTA) mandates' all minors under the age of 3 that are receiving services from child welfare to have a developmental assessment.

The program was offered through the Part C of Individuals with Disabilities Education Act (IDEA). Children between the ages of 0 and 3 are over represented in the child welfare system. Children among these ages are at higher risk for various health, behavioral, and/or emotional problems. These problems may be caused by a variety of factors which may include but are not limited to, perinatal complications, prematurity, substance abuse, reactive attachment disorders, and teenage parents. Approximately 75 percent of maltreated children between the ages of 1 and 3 were categorized as having medium to high-risk neurodevelopment. Another reason why children should receive early intervention services is because the inattention to service referral can burden the child welfare system. Children who have developmental and health problems have a higher number of out-of-home placements, longer stays in foster care, and decreased likelihood of returning to family. The program is cost effective in the long run. CAPTA recently adapted the policy that disability status for children and their parents be included in the list of required data for state and local programs.

Lack of Services for Children with Disabilities in Children and Family Services

Many studies have found that basic needs of children with disabilities served by child welfare agencies are not being addressed by various helping professions (Geenen & Powers, 2006; Middleton, 1998). Geenen and Powers' (2006) study examined academic achievement for children with a disability in the child welfare system. They compared children in the child welfare system and who were receiving special education services to children who were only receiving special education services, and those children who were only receiving general education. The results of the study indicated that children with a disability who were also in the child welfare system, had lower grades, less credit, and lower state scores in relation to the comparison groups. A major barrier that was present in the study was that children in child welfare changed schools. The researchers suggested that there was a lack of advocacy for the educational needs for children with special needs in the child welfare system. Geenen and Powers (2006) suggested that child welfare social workers and other helping professions need more training and education regarding the special health care needs population.

Zetlin (2006) surveyed county child welfare agencies and county offices of education. Four focus groups were coordinated; participants consisted of stakeholders and former foster youth. The focus group discussed barriers in education with foster children. Data was analyzed and categorized into common themes. Results concluded that there was a need for informed advocates of education. The results called for a cooperation and collaboration between social workers and schools to be proactive and ensure timely and appropriate assessments for special education practices. Zetlin (2006) concluded that it was important for child protective workers to have information about a child's disabilities and educational needs, in order to actively monitor and advocate for clients. Additionally, child welfare workers need proper training and support to minimize or eliminate problems with special education.

Social Workers Working with Medically Fragile Children

Innstrand, Espnes, and Mykletun (2004) studied workers' stress, burnout and job satisfaction when working with clients who have intellectual disabilities. The team conducted a longitudial, quasiexperimental study to determine if an intervention would be helpful. The Maslach burnout inventory in which, burnout was defined as "a psychological syndrome of emotional exhaustion, depersonification, and reduced accomplishment" (Innstrand, Espnes, & Mykletun, 2004, p. 273).

The study consisted of 112 staff members working with clients who had an intellectual disability. Participants were divided into experimental and control groups. The study was completed over a 10 month period using pre-test and post-test measurements for the three components (stress, burnout, and job satisfaction). The experimental group received an intervention throughout the 10month period, while the control group received no intervention. The experimental group participated in five seminars with educational topics such as autism, ethics and values, conditions for people with disabilities after reform, motivational conditions, taking care of self and getting inspiration back in work.

At the end of the 10-month period, both groups were administered a posttest. Results showed a significant difference in stress, exhaustion, and job satisfaction with a positive difference in the experimental group. There appeared to be no significant difference in cynicism or professional self efficacy between the experimental and control group.

There has been no previous research done on child welfare workers experience with medically fragile children. Studies focus on the foster parents experience with raising medically fragile children. Each study has yielded results that call for training and experience for social workers working with these families.

Most studies about this population focus on the parents' perspective or other individuals who are concerned about the needs and services of this population. There are also not many studies that integrate the opinions of social workers and parents of these children. A study conducted by Middleton (1998) found that parents were often confused or were not aware of the services available to their children and about their children's legal rights. Parents and social workers agreed that parents had to go out and look for services themselves, due to social workers not having a proactive role with their cases with medically fragile children. Social workers suggested that this lack of taking a proactive role in cases that involved medically fragile children was because they had large caseloads and in many instance they did not have enough backup in on-going support that was needed. Parents and social workers agreed that parents were not receiving services such as counseling that were strongly needed. Additionally, this study found that social workers were not clear about their role as a service provider and lacked confidence about their competence level.

Lack of Services to Caregivers

Gordon, McKinley, Satterfield, and Curtis (2003) studied the needs of kinship caretakers. Between June and July 1998, four focus groups were held. The study sample consisted of 37 participants 85% had a formal kinship caregiver relationship with child protective services while 15% had informal arrangements. The study focused on examining what were the types of support services needed by kinship caregivers.

There was an overwhelming resentment for the child welfare system. Many caregivers felt that they had no say in case planning. Caregivers felt that child welfare workers withheld valuable information. Results concluded that the child welfare system failed to provide relative caregivers with support and services needed. They failed to recognize the special circumstances these families were in. These issues included role confusion, relationship issues with birth parents, extended family, child's safety, marital issues, and/or issues with their significant others, and service needs for birthparents (Gordon, McKinley, Satterfield, & Curtis, 2003).

The family-centered model has been used in Children and Family Services. The reasoning behind this is that a child can be best helped in the context of understanding the family of origin. Shannon's (2004) study focused on identifying barriers to family-centered services. Twenty-two families were interviewed for the study. The study also interviewed 20 early intervention professionals. Five were social workers; two were pediatricians, two physical therapists, two nurses, four educators, two services coordinators, and one family practice physician.

Results indicated that professionals reported experiencing pressure to provide only services that private insurance or other funds would reimburse as opposed to services that were best for the family.

Professionals also did not tell families about all available services because they did not want families to request all services. Many families did not want to apply for services in fear that they would be reported to child protective services. According to many participants, families who had children with disabilities had a higher risk of being reported to CPS. Participants felt that professionals applied middle class values to families in depressed environments. Participants also expressed concern about physician's "wait and see" approach to determining if delays persist. This approach can be harmful to children because it delays access to early intervention services. Other barriers included professionals labeling participants as noncompliant or unmotivated when families refused services. Family's personalities also could be a barrier to receiving services, those who were demanding and did not give up until services were given received services while passive clients often did not receive as many services.

Summary

As demonstrated by the literature, there is a lack of a clear definition that determines for a child to be labeled as medically fragile or to have special needs. Social workers working for children and family services are not provided with a standardized definition of disability, which may constitute for a higher percentage of children with disabilities that are not accounted for, resulting in their needs to be unmet. There is a need for social workers to be provided with proper training, tools, and support to ensure identification and assessment of children who have a disability. However, educational programs such as, the Master's of Social Work (MSW) programs offered to those seeking to be social workers often lack a focus on disabilities and early intervention in regards to identifying disabilities. During the assessment process social workers are often responsible to determine if a child is in need of special services; however, without formal training and education, cases with children who need services may go undetected. The social system theory helps conceptualize this issue as it suggests that a child is ultimately effect by the actions or inactions of the systems in their environment. Lacks of training, funding, support, and knowledge about disabilities among social workers ultimately affect children who are involved in the child welfare system.

CHAPTER THREE

METHODS

Introduction

This section presents a description of the research methods used in this study. Specifically, this chapter describes the design of the study, sampling, data collection, procedures, and protection of human subjects in this study. This chapter will also include data analysis procedures that were employed in the present study.

Study Design

The Special Health Care Needs (SHCN) program and the Medically at-Risk (MAR) program are two programs that assist children with disabilities and their families in the Children and Family Services agency in the county of San Bernardino. The SHCN program assists children with disabilities and their families who are in non-relative care. The MAR program was recently created in April 2009 by the Children and Family Services agency in San Bernardino County to assist children with disabilities and their families that did not qualify for the SHCN program and who are in family-maintenance case plans, or in relative care placements, who previously did not qualify for assistance under the SHCN program. The purpose of this study is to evaluate the social workers' perception and knowledge about the MAR program as well as to assess for the further needs that the program may have.

The present study will employ a quantitative and qualitative research design, utilizing a self-administered questionnaire about the Medically at-Risk program. The questionnaire asked two open-ended qualitative questions. The rationale for using a self-administered questionnaire approach is due to the time limitations of the study. The data needs to be collected within a 6 week time period between February 2, 2010 through February 18, 2010. Self-administered questionnaires are also inexpensive and enable the researcher to obtain data from a large sample size quickly.

There are several limitations that apply to this study, primarily are the time constraints of this study. Another limitation is that, the utilization of using a self-administered questionnaire does not provide the researcher with the opportunity to ask for further explanation from the participant. Another disadvantage to using self-administered questionnaires is that, the researcher cannot observe nonverbal behavior. However, this method is useful in eliminating interviewer bias.

Sampling

The study used both qualitative and quantitative measurements to survey 295 social workers in San Bernardino County. A questionnaire along with an informed consent and a debriefing statement was given to all social workers that had the job title of Social Service Practitioner (social workers with a masters degree) and Social Worker II (social workers with a bachelors degree). The questionnaire packets were mailed to 6 region offices: central, eastern, western, desert, Yucca, and special services. Questions 1 through 6 enquired about participants' demographics, questions 7 through 12 were likert-scale questions (strongly agree, agree, undecided, disagree, and strongly disagree), questions 13 through 14 were open-ended questions. A total of 14 questions were asked. The questionnaire took participants between 8-10 minutes to complete. Participants' responses on the questionnaires were coded and analyzed.

Administrators, managers, clerical and supporting staff, and interns were excluded from participating in the study given that they did not directly work with the children.

Data Collection and Instruments

This study utilized a self-administered questionnaire that was created by the researchers. Since the MAR program was recently implemented in April 2009 and had only existed for 10 months when the research questionnaire was administered, there existed no instruments to measure the research study. The researchers created a survey questionnaire using information from the San Bernardino County CFS handbook (Children and Family Services, 2009). The questionnaire was pretested by 2 social service practitioner supervisors, a public health nurse, the department of public health supervisor, and a social service practitioner. The questionnaire was tested for clarity and accuracy.

The demographics that were collected for this study include gender, age, job title, job description; job region and years of experience participants have with working with Children and Family Services. Participants in this study were asked to answer 6 questions that dealt with participants demographics. Six questions enquiring about a social workers perception of the MAR program were likert-scale questions. Two open ended fill in the blank questions were included to identify any further questions, comments, or suggestions.

Questions about a participants demographics served as the independent variable of this study. The independent variable was measured by the data obtained from social workers who completed the survey.

Likert scale questions regarding the MAR program served as the dependent variable.

The potential strengths of using this survey is that, the researchers may analyze the questionnaire according to demographics to see if years of experience, position, or office location play a role in the knowledge and success of the MAR program. A limitation in this study is that the instrument used is newly created and was not tested for its validity or reliability.

Procedures

To conduct the study, permission from Children and Family Services of San Bernardino County was obtained. The researchers mailed survey packets to six regional offices, which included central, eastern, western, desert, Yucca, and special services unit. The questionnaires were mailed through interoffice mail, the package included a note signed by the researcher's unit supervisor that asked the clerk to distribute questionnaires to all social services practitioners, and social worker II's that had cases. Each individual packet contained an envelope and included an informed consent, a two-page questionnaire, and a debriefing statement. The questionnaires were mailed out on February 2, 2010 with a requested response date on or before February 18, 2010. A three-week period was provided for participants to receive, respond, and return the questionnaire. A total of 69 surveys were returned. The response rate was 23%.

Protection of Human Subjects

In order to protect the anonymity of participants, no names or forms of identification were taken. The researchers obtained a count of every social services practitioner and social worker II in each office. The researchers informed the participant that all information was confidential and there was no way of identifying the participant. All returned questionnaires were stored in a locked cabinet. Once inputted into Statistical Package for the Social Sciences (SPSS) program, the questionnaires were destroyed.

Participants were given an informed consent form in their packet. Participants were informed of the purpose of the study, voluntary right withdraw from participation at any time. A description of the study was provided in the informed consent. Participants were informed that the questionnaire was confidential and that no identifying information was used. There were no foreseeable risks to participation in the study. If participants had any questions or concerns about the survey, a phone number was provided to contact Dr. Vang, the research project advisor. If a participant wanted to read the study once it was completed, information about obtaining results of the study were provided.

Data Analysis

A total of 12 quantitative questions were asked. The measurements used were nominal and ratio. Results were coded and inputted into a computer using the SPSS program. The data was analyzed according to frequency and percentage distribution. Measures of central tendency and dispersion were also used to describe ratio data collected. Inferential statistics using pearsons bivariate correlations were used to identify positive or negative associations. Significance was established at the 0.01 and 0.05 level. Two questions on the survey were open-ended qualitative questions. The answers to the questions were transcribed onto index cards. They were then two-level coded and separated into themes. The themes were interpreted for meaning and relationship.

Summary

The methods used in the study were presented and discussed in chapter three. Chapter three discussed six themes the study design, sampling, data collection, and instruments, procedures, protection of human subjects, and data analysis. The study design will employ qualitative and quantitative methods of measurement. The sample frame for the study will include 295 Children and Family Services employees. A survey questionnaire was used to collect data. Data collected included the demographics of employees, perceptions, and knowledge they have about the qualifications and terminology on the Medically-at-Risk program. As well as information about the training and preparation they receive about the program. The data was delivered and responses were returned via mail. Data was collected from February 2, 2010 through February 18, 2010. Informed consent and a debriefing statement were included in the survey packet. No identifying information was used in the data collection. The research employed both qualitative and quantitative analysis to answer the research question.

CHAPTER FOUR

RESULTS

Introduction

The focus of this study was to assess social worker's perception the MAR program. The information that is presented in this chapter was obtained from questionnaires that were provided to social workers employed at Children and Family Services of San Bernardino County. This chapter specifically discusses the demographics of social workers who participated in this study, along with a presentation of the findings both qualitative and quantitative.

Presentation of the Findings

Quantitative Analysis

Demographics of Participants. A total of 69 participants completed the questionnaire for this study, a response rate of 23%. Out of the 69 social workers who participated in the study, a total of 19 (28.8%) participants were from the Eastern region, 7(10.6%)Central division, 16 (24.2%)Western division, 21(31.8%)High Desert division, and 3(4.5%)were from the Special Services division.

The population of respondents included 59 (85.5%) females and 10(14.5%) males. When asked "what is your job title?" Fifty-eight (84.1%) of participants answered Social Service Practitioners (SSP) and 11(15.9%) identified themselves as social worker IIs (SS IIs). When asked about job description, 22 (32.4%) participants responded intake worker, 36 (52.9%) were carriers, and 7 (10.3%) were adoption and concurrent planning social workers. Three (4.4%) stated that their job description was other.

Measures of central tendency indicated that the mean age of participants was 44.97 years of age and 102.49 months of experience.

The study identified age, gender, job title, job description, office location, and months of experience as independent variables.

The questionnaire provided participants with a description of the MAR program. What it was, who it served, as well as qualifications needed. To avoid confusion, the questionnaire provided examples of children who would qualify for MAR. The questionnaire then stated "prior to reading this information" and continued to ask questions addressing the study's dependent variables.

The questionnaire asked six questions concerning the social workers perception of the MAR program (dependent variables). The first question addressed whether the participant was aware that the MAR program existed. Of the 67 participants that answered the question 61.2% were aware that the MAR program was available for children with special needs (20.3% strongly agreed and 40.3% agreed). Six percent of respondents were undecided while 32.8% were unaware that the MAR program existed (19.4% disagreed 13.4% strongly disagreed).

The second question, answered by 68 participants, addressed whether participants were aware of the qualifications for the MAR program in which the majority of respondents 52.9% answered that they were unaware of the qualifications needed (17.6% strongly disagreed 35.3% disagreed). Respondents who reported undecided were 4.4%. Respondents who reported being aware of the qualifications was 42.6% (11.8% strongly agreed 42.6% agreed).

The third question related to a participants ability to identify symptoms, behaviors, or delays that would merit a referral for MAR assessment. Sixty-eight participants answered the question. The majority of respondents, 61.8%, felt that they were able to identify symptoms, behaviors, or delays (22.1% strongly agreed 39.7% agreed). Undecided participants accounted for 14.7%. A small percentage 23.5% felt that they were unable to identify (19.1% disagreed 4.4% strongly disagreed).

The fourth question examined whether participants believed they received sufficient training and education about the MAR program. Sixty-eight people responded to the question. Only 16.2% believed that they received adequate training (5.9% strongly agreed 10.3 agreed) 7.4% were undecided. The majority of participants, 76.5% did not believe that they received sufficient training and education (55.9% disagreed 20.6% strongly disagreed. Undecided accounted for 7.4% of responses while 16.2% believed that they received training and education. (5.9% strongly agreed 10.3% agreed).

Question 5 analyzed participant’s feelings as to whether they believed that the MAR program adequately provided children with needed services. Sixty-nine people responded to this question. The majority 55.1% responded undecided. Those who believed that MAR provided adequate services accounted for 39.1% (of those 8.7% strongly agreed and 30.4% agreed). Those who believed that MAR did not provide adequate services accounted for 5.8% of responses (2.9% disagreed 2.9% strongly disagreed).

The sixth question inquired about a participant's caseload and if they felt they had the time needed to provide and coordinate services for a MAR child. Sixty-six people responded to the question. The majority of respondents 46.9% disagreed (22.7% disagreed and 24.2% strongly disagreed). Respondents who believed that with the caseload they had they were able to provide and coordinate services accounted for 33.3% of responses (6.1% strongly agreed 27.3% agreed). Respondents who were undecided accounted for 19.7% of responses.

Correlational Analysis

A bivariate analysis was used to identify correlations between two variables. The following pearson's correlations were found:

Perceptions toward MAR program providing adequate services to children was positively correlated to participants being aware of the MAR program (r = .267), participants being aware of qualifications needed (r = .316) participants receiving sufficient training (r = .529) and participants being able to identify symptoms, behaviors, and delays to refer for assessment(r = .456),

Respondents having the time needed to provide and coordinate services for a MAR child was positively correlated to: workers being able to identify symptoms, behaviors, and delays to refer for assessment (r = .300) and participants believing that the MAR program adequately provided children with needed services (r = .342).

Aware that MAR program existed was positively correlated to awareness of qualifications for the program (r = .626). Ability to identify symptoms was positively correlated to awareness of the program (r = .381) and awareness of qualifications for the program(r = .408). Receiving sufficient training for MAR was positively correlated to awareness of the program(r = .393), awareness of qualifications(r = .607), and ability to identify symptoms, behaviors, and delays for assessment referral(r = .408).

A negative correlation was found between age and receiving training (r = .275). The older a respondent was the less training they received about the MAR program. Another negative correlation was found between years of experience and ability to identify symptoms (r = .259). The more years of experience a respondent had the less able they were to identify symptoms, behaviors, or delays that would merit a referral for MAR assessment.

Qualitative Analysis

The survey used in this study asked participants two qualitative questions. The answers that were provided by participants were divided into themes in order to examine the findings.

The first question asked if participants had any additional questions about the medically-at-risk program. This question had three themes. The first theme pertained to social workers wanting to know more about the referral process. Participants in the study wanted more information about the criteria for referring clients as well as who to contact in order to obtain more information about the MAR program. Participants also wanted to know about other medical issues that may qualify for the MAR program that were not listed.

The second theme concerned participant's awareness of the MAR program and training. Some participants expressed that they were aware of the program, but did not have to refer clients to the program yet. Participants thought there was a need for more training and increase awareness about the MAR program.

The third theme concerned terminology. Participants questioned if medically-at-risk and medically fragile were considered the same term.

The second qualitative question asked participants if they had any recommendations or suggestions for the Medically-at-Risk program. The answers fit into five themes. The first theme addressed social workers needing more training on the MAR program. Participants recommended that social workers need training on identifying signs and symptoms for a potential referral.

The second theme was about social workers' awareness about the MAR program. Participants suggested that there should be flyers or emails provided to social workers to increase their awareness about the MAR program.

The third theme focused on social workers recommending that children be assessed by the PHN or SART program, rather than the social worker.

The fourth theme suggested that more funding should be allocated for programs in the special needs field such as the MAR program.

The fifth theme that social workers who carried MAR cases needed additional support, but did not specify how additional support should be provided.

Summary

Chapter four presented findings on the study: a social workers perception of the medically-at-risk program. The findings discussed demographics of participants, a quantitative analysis using frequencies to discuss respondents answers. A bivariate analysis used pearsons correlation to identify positive and negative associations. The study also used qualitative answers to analyze themes.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter will provide a discussion about the results of this study. A description of the limitations of this study was also be provided. Chapter five includes recommendations for future social work practice, policies, and research on children with special needs in the child welfare system.

Discussion

This study found that social workers do not receive adequate training concerning Medically-at-Risk children. An overwhelming 76.5% stated that they did not receive training for the MAR program. Furthermore, the issue was restated in the qualitative section of the questionnaire. Respondents believed that they should receive more information on programs such as the MAR. A study conducted by Shannon and Agorastou's (2006) found that 40% of respondents stated formal training on disabilities was needed. They also recommended that more training among social workers is needed in order to work with this population.

Participants of the present study, stated that the terminology about special needs children was confusing. This finding was also expressed in various articles (Harrigan, Ratliffe, Patrinos, & Tse 2002; Ratliffe, Harrigan, Haley, TSE, & Olson 2002; Holen 2009; Children and Family Services 2009). Different definitions were used to identify a child as special needs. Terms such as special health care needs, medically fragile, medically-at-risk, and technology dependent were used interchangeably by several research studies. There is a failure to provide a consistent definition in policies, research and other areas that address this population (Harrigan, Ratliffe, Patrinos, & Tse 2002; Ratliffe, Harrigan, Haley, TSE, & Olson 2002; Holen 2009; Children and Family Services 2009). Participants of this study may have been have been misguided and/or confused due to unclear definitions of special needs leading them to not fully be aware of the qualifications of Medically-at-Risk simply because they were unfamiliar with the terminology used.

Only 16.2% of participants stated that they believed they had sufficient training and education about the MAR program. Previous research that examined the delivery of services to children with special health care needs also suggest that there is a need for training social workers to work with this population (Lightfoot & LaLiberte, 2006; Manders & Stoneman, 2009; Waldman, Perlman, & Lederman, 2007). The lack of training and education among social workers can be detrimental to a child's mental, psychological, emotional, or physical state. The importance of social workers obtaining knowledge about special needs has been expressed by various studies (Lightfoot & LaLiberte, 2006; Manders & Stoneman, 2009; Waldman, Perlman, & Lederman, 2007). However, Russo-Gleicher's (2008) study found that there is a lack of emphasis on special needs in professional academic education. Russo-Gleicher's (2008) study also found that Masters of Social Work programs did not have an emphasis on teaching potential social workers on how to identify symptoms, behaviors, or delays in children.

The study discovered that a majority of social workers did not believe that with their current caseloads, they could dedicate the time needed to coordinate services for a MAR child. Herman (2007) stated that social workers having large caseloads limits the time they can dedicate to a family that is involved in child welfare services. Middleton's (1998) study found that large case loads contributed to informal routine assessments and referrals. Due to large case loads, social workers are unable to provide children with special needs and their families the emotional support for complicated interventions because they do not have the time to dedicate to the substantial needs presented in these clients.

Limitations

The study considered many limitations that were apparent when the research was conducted. At the time when the questionnaires were distributed, the MAR program had existed for 10 months. The lack of awareness and training can be directly attributed to the program's recent implementation.

Another limitation was that the MAR program is a program that is only available to a small population of children with special needs, which include only the most fragile of this population. For this reason, many social workers were unaware of the services because these children would most likely be referred to the Special Health Care Needs unit.

Another limitation of this study was that the survey instrument was a questionnaire and did not allow participants to express their attitudes and feelings toward the program. There answers had to fit into 1 of 5 likert style selections. The likert scale questionnaire did not allow the researchers to obtain further information about answers provided.

Most importantly another limitation of this study focused on a specific program for children with special needs in the specific county of San Bernardino and not on children with special needs in general. The program was very specific to the type of clients that qualified for services. This program was established to care for the most vulnerable children who were in regional care. The program failed to provide services to children who had special needs but did not present severe conditions that rendered MAR services. Having a social workers' perception of special needs children in general would have provided a better foundation in understanding the complexities of child welfare, and social workers' feelings toward working with and coordinating services for children with special needs.

Recommendations for Social Work Practice, Policy and Research

Based on the findings of this study and the literature on children with special needs, the researchers of this study have several suggestions for social work practice, policy, and future research regarding this population.

The results of the study suggests that many workers do not receive formal training on the MAR program nor the special needs population. The special needs population has been an area that has been neglected, which has lead to the development of several policies and legal action to protect, advocate, and to provide equal rights for this population. However, despite a long history of changing laws and policies around the country, there is a great need to continue to change these policies in order to provide a consistent definition of who qualifies for special needs services. A consistent definition for social workers would assist in having identifiable criteria for all programs for this population.

The special health care needs population has been an area that has been neglected from various helping professions (Lightfoot & LaLiberte, 2006). However, CFS was able to identify the need to address this population throughout their agency and develop programs that are meant to serve this population; yet, due to the significant amount of children with special needs many of these children end up in a regional caseload. It is important to establish and demand requirements for training and education for social workers so that they are better equipped to serve the special needs population because children in child welfare are at a higher risk for developing a disability or having a special need (Dicker & Gordon, 2004; Child Welfare League of America, 2009).

Interestingly, when analyzing bivariate correlations, it was discovered that there was a negative correlation between age and receiving training. Meaning, the older a respondent was the less training they received about the MAR program. A negative correlation was found between years of experience and ability to identify symptoms. That is to say social workers perceived that the more years of experience they had, the less able they were to identify symptoms, behaviors, or delays that would merit a referral for a MAR assessment. The researchers of this study recommend that future research should be done in order to study the reasons why there was a negative correlation between the years of experience a social worker has and their ability to identify symptoms of a disability or delay on children.

Conclusions

This study sought to evaluate Social Workers perception of the Medically-at-Risk (MAR) program. The researchers of this study concluded that there is a need for training and education on the special needs population among social workers in the child welfare system. It was also suggested that there should be consistency in criteria among policies, procedures, and programs in order to obtain common knowledge of what qualifies children as having special needs. There were several limitations to this study; however, the results of this study may assist future research in order to further assist this population.

APPENDIX A

QUESTIONNAIRE

QUESTIONNAIRE

The questionnaire will consist of a 3-page document, please mark an X in the line that you identify with:

The following information relates to the Medically at-Risk program. If you would like more information about the program or would like to know about making a referral please refer to the CFS handbook (vol. IV in Specialized placements, pg 366).

The Medically at-Risk (MAR) program was developed in April 2009. The MAR program was established for children who do not qualify for Special Health Care Needs (SHCN) but have a special need. Regional social workers' (SSP or SWII) role is to make a referral for MAR assessment as well as carry the case and coordinate appropriate services. A child who is Medically-at-Risk is a child who:

- Has a condition that can rapidly deteriorate resulting in permanent injury or death and/or
- Has a medical condition that requires specialized in-home health care and
- Has a family maintenance case plan, or has a family reunification case plan BUT is in the care of a relative or Non-related extended family member (NREFM)

Assessment Procedure: Regional Social Worker must make a referral to the regional Public Health Nurse (PHN) for all children under the age of 3 or for those that are believed to have special needs. The Medically at-Risk (MAR) child is then assessed by a PHN as at-risk of complications due to a medical condition that must be monitored. Clear communication between the assigned Social Worker (SW) and the regional PHN are essential with regard to the diagnosis, assessment and service plan development for the MAR child.

Contact Requirements: Ongoing contacts are made by the PHN and SW, at least once each month with children and families in cases involving a diagnosis of failure to thrive or other severe or life threatening diagnosis.

Secondary caseload assignment- The PHN has the authority to add him/her self as secondary assignment that will show on the CWS/CMS caseload.

****

Examples of children who may qualify for MAR services are/but not limited to:

- Child born pre-term less than 30 weeks gestation
- Diabetes type I or II
- Children with seizure disorders
- HIV positive
- Failure to thrive
- Diagnosed medical syndrome
- Infant experiencing severe drug withdrawal in addition to physicians' diagnosis.
- Asthma in a child under 2 years of age on long-term medications and nebulizer treatment.

Children who require special health care equipment or procedures such as:

-Enteral feeding tube
- ventilator
-oxygen support
-or any other medical or surgical procedures or special medication regimens, including injection and intravenous medication

1. What is your gender?
    ___ (1) Male
    ___ (2) Female

2. What is your age? __________

3. What is your job title?
    ___ (1) SWII
    ___ (2) SSP
    ___ (3) Other (please specify) ____________

4. What is your job description?
    ___ (1) Intake
    ___ (2) Carrier
    ___ (3) Other (please specify) ____________

5. What office do you work in?
    ___ (1) Central Region
    ___ (2) Eastern Region
    ___ (3) Western Region
    ___ (4) Other (please specify) ____________

6. How many years of experience do you have with Children and Family Services?
    ______________Years ______________Months

7. I was aware that the MAR program existed:

___(1)Strongly Agree ___(2)Agree ___(3)Undecided
___(4) Disagree ___(5) Strongly Disagree

8. Prior to reading this survey, I was aware of the qualifications needed for a child to be in the MAR program:

___(1)Strongly Agree ___(2)Agree ___(3)Undecided
___(4) Disagree ___(5) Strongly Disagree

9. I am confident that if I encounter a case where a child can potentially qualify for MAR program, I will be able to identify symptoms/behaviors/delays etc. to refer child for assessment:

___(1)Strongly Agree ___(2)Agree ___(3)Undecided
___(4) Disagree ___(5) Strongly Disagree

10. I believe that the MAR program provides the support and training I need:

___(1)Strongly Agree ___(2)Agree ___(3)Undecided
___(4) Disagree ___(5) Strongly Disagree

11. I believe that the MAR program adequately provides children with needed services:

___(1)Strongly Agree ___(2)Agree ___(3)Undecided
___(4) Disagree ___(5) Strongly Disagree

12. With the caseload I currently have, I can dedicate the time needed to provide and coordinate services to a MAR child:

___(1)Strongly Agree ___(2)Agree ___(3)Undecided
___(4) Disagree ___(5) Strongly Disagree

13. Additional questions about Medically at-Risk program:

____
____
____

14. Recommendations/suggestions for the Medically at-Risk program:

____
____
____

APPENDIX B

INFORMED CONSENT

INFORMED CONSENT

This study in which you are being asked to participate seeks to evaluate social workers perception of the Medically at-Risk (MAR) program that has recently been implemented in Children and Family Services of San Bernardino County. This study is being conducted by Corina Chavez and Lilia Razo, Master of Social Work graduate students under the supervision of Assistant Professor, Dr. Pa Der Vang from the School of Social Work of California State University, San Bernardino. This study has been approved by the School of Social Work of Human Subjects SubCommittee of the Institutional Review Board, California State University, San Bernardino.

PURPOSE: The purpose of the study is to evaluate Social Workers perception of the Medically at-Risk (MAR) program. To examine whether social workers receive adequate training in providing services for the special needs population.

DESCRIPTION: You are being asked to participate in a study by completing a questionnaire. You will be asked a few questions about your background and experience in Children and Family Services. You will also be asked about the Medically at-Risk (MAR) program and the knowledge and training you have received to serve this population.

PARTICIPATION: Participation in this study is voluntary; refusal to participate will not involve any penalty. Those who decide to participate are free to withdraw at any time during the study.

CONFIDENTIALITY: The information you give in the questionnaire will be coded and analyzed using qualitative and quantitative methods. There will be no identifying factors that would reveal the identity of participants.

DURATION: An estimated 8 to 10 minutes of your time will be needed for completion of this questionnaire.

RISKS: There are no foreseeable risks to your participation in the study.

BENEFITS: A benefit of taking part in the study will be to have a role in contributing to improvements in the training for the MAR program as well as improving services for special needs children involved in Children and Family Services.

CONTACT: If you have any questions or concerns about the study, please contact the research project supervisor, Dr. Pa Der Vang, Assistant Professor, School of Social Work, California State University, San Bernardino, 5500 University Parkway, San Bernardino, CA 92407, pvang@csusb.edu, (909) 5373775.

RESULTS: The results of this study will be available at the Pfau Library, California State University, San Bernardino after September 2010.

APPENDIX C

DEBRIEFING STATEMENT

"A Social Workers' Perception of the Medically at-Risk (MAR) Program"

DEBRIEFING STATEMENT

The questionnaire that you have just completed was part of a study that seeks to identify a social workers perception of the MAR program. The researchers were particularly interested in studying if and how the MAR program benefits the special needs population by studying social workers' knowledge of the program, whether they received adequate training about the MAR program and special needs children. This study will examine whether children with special needs are provided with the proper services. The results from this study will help to identify any additional needs that are considered necessary to improve the services provided by the MAR program to enhance the lives of children with disabilities in child welfare services.

Thank you for participating in this study and for not discussing the contents of the questionnaire with other people. If you feel uncomfortable or distressed as a result of participating in the study, you are advised to contact Dr. Pa Der Vang (research supervisor) at (909) 5373775 or by email at pvang@csusb.edu.

APPENDIX D

FREQUENCIES

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	10	14.5	14.5	14.5
	Female	59	85.5	85.5	100.0
	Total	69	100.0	100.0	

Job Title

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	SWII	11	15.9	15.9	15.9
	SSP	58	84.1	84.1	100.0
	Total	69	100.0	100.0	

Job Description

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Intake	22	31.9	32.4	32.4
	Carrier	36	52.2	52.9	85.3
	Adoption/ Concurrent Planning	7	10.1	10.3	95.6
	Other	3	4.3	4.4	100.0
	Total	68	98.6	100.0	
Missing	99	1	1.4		
Total		69	100.0		

Office Location

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Central Region	7	10.1	10.6	10.6
	Eastern Region	19	27.5	28.8	39.4
	Western Region	16	23.2	24.2	63.6
	North Desert Region	21	30.4	31.8	95.5
	Special Services	3	4.3	4.5	100.0
	Total	66	95.7	100.0	
Missing	99	3	4.3		
Total		69	100.0		

Aware of qualifications

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	8	11.6	11.8	11.8
	Agree	21	30.4	30.9	42.6
	Undecided	3	4.3	4.4	47.1
	Disagree	24	34.8	35.3	82.4
	Strongly Disagree	12	17.4	17.6	100.0
	Total	68	98.6	100.0	
Missing	99	1	1.4		
Total		69	100.0		

Recieved sufficient Training and Education about MAR

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	4	5.8	5.9	5.9
	Agree	7	10.1	10.3	16.2
	Undecided	5	7.2	7.4	23.5
	Disagree	38	55.1	55.9	79.4
	Strongly Disagree	14	20.3	20.6	100.0
	Total	68	98.6	100.0	
Missing	99	1	1.4		
Total		69	100.0		

I can dedicate the time needed to provide and coordinate services

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	4	5.8	6.1	6.1
	Agree	18	26.1	27.3	33.3
	Undecided	13	18.8	19.7	53.0
	Disagree	15	21.7	22.7	75.8
	Strongly Disagree	16	23.2	24.2	100.0
	Total	66	95.7	100.0	
Missing	99	3	4.3		
Total		69	100.0		

MAR program adequately provides children with needed services

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	6	8.7	8.7	8.7
	Agree	21	30.4	30.4	39.1
	Undecided	38	55.1	55.1	94.2
	Disagree	2	2.9	2.9	97.1
	Strongly Disagree	2	2.9	2.9	100.0
	Total	69	100.0	100.0	

Aware MAR Existed

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	14	20.3	20.9	20.9
	Agree	27	39.1	40.3	61.2
	Undecided	4	5.8	6.0	67.2
	Disagree	13	18.8	19.4	86.6
	Strongly Disagree	9	13.0	13.4	100.0
	Total	67	97.1	100.0	
Missing	99	2	2.9		
Total		69	100.0		

Able to identify symptoms/behaviors/delays to refer for assessment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	15	21.7	22.1	22.1
	Agree	27	39.1	39.7	61.8
	Undecided	10	14.5	14.7	76.5
	Disagree	13	18.8	19.1	95.6
	Strongly Disagree	3	4.3	4.4	100.0
	Total	68	98.6	100.0	
Missing	99	1	1.4		
Total		69	100.0		

APPENDIX E

BIVARIATE CORRELATION

Bivariate Correlation

Correlations

		Gender	Age	Job Title	Job Description	Office Location	Years of Experience	Aware MAR Existed	Aware of qualifications	Able to identify symptoms/ behaviors/ delays to refer for assessment	Recieved sufficient Training and Education about MAR	MAR program adequately provides children with needed services	I can dedicate the time needed to provide and coordinate services
Gender	Pearson Correlation	1	-.109	.158	.091	.209	.119	-.039	.050	.015	.096	.004	-.094
	Sig. (2-tailed)		.403	.194	.461	.093	.334	.751	.686	.905	.434	.971	.454
	N	69	61	69	68	66	68	67	68	68	68	69	66
Age	Pearson Correlation	-.109	1	.201	.156	-.084	.458**	-.255	-.187	-.165	-.275*	-.071	.183
	Sig. (2-tailed)	.403		.120	.235	.528	.000	.052	.153	.208	.034	.589	.169
	N	61	61	61	60	58	61	59	60	60	60	61	58
Job Title	Pearson Correlation	.158	.201	1	.185	.074	.275*	-.172	-.096	-.212	-.065	-.064	.144
	Sig. (2-tailed)	.194	.120		.131	.554	.023	.163	.438	.082	.599	.599	.248
	N	69	61	69	68	66	68	67	68	68	68	69	66
Job Description	Pearson Correlation	.091	.156	.185	1	.240	.179	-.160	-.113	.057	-.145	-.133	.020
	Sig. (2-tailed)	.461	.235	.131		.054	.148	.199	.363	.647	.242	.281	.872
	N	68	60	68	68	65	67	66	67	67	67	68	65
Office Location	Pearson Correlation	.209	-.084	.074	.240	1	.019	-.011	-.071	.129	-.121	.013	-.107
	Sig. (2-tailed)	.093	.528	.554	.054		.882	.932	.576	.305	.336	.920	.405
	N	66	58	66	65	66	65	64	65	65	65	66	63
Years of Experience	Pearson Correlation	.119	.458**	.275*	.179	.019	1	-.188	-.210	-.259*	-.220	-.051	.118
	Sig. (2-tailed)	.334	.000	.023	.148	.882		.131	.088	.034	.073	.680	.350
	N	68	61	68	67	65	68	66	67	67	67	68	65
Aware MAR Existed	Pearson Correlation	-.039	-.255	-.172	-.160	-.011	-.188	1	.626**	.381**	.393**	.267*	.096
	Sig. (2-tailed)	.751	.052	.163	.199	.932	.131		.000	.002	.001	.029	.449
	N	67	59	67	66	64	66	67	66	66	66	67	64
Aware of qualifications	Pearson Correlation	.050	-.187	-.096	-.113	-.071	-.210	.626**	1	.408**	.607**	.316**	-.002
	Sig. (2-tailed)	.686	.153	.438	.363	.576	.088	.000		.001	.000	.009	.987
	N	68	60	68	67	65	67	66	68	68	68	68	65
Able to identify symptoms/behaviors/delays to refer for assessment	Pearson Correlation	.015	-.165	-.212	.057	.129	-.259*	.381**	.408**	1	.408**	.456**	.300*
	Sig. (2-tailed)	.905	.208	.082	.647	.305	.034	.002	.001		.001	.000	.015
	N	68	60	68	67	65	67	66	68	68	68	68	65

Recieved sufficient Training and Education about MAR	Pearson Correlation	.096	-.275*	-.065	-.145	-.121	-.220	.393**	.607**	.408**	1	.529**	.231
	Sig. (2-tailed)	.434	.034	.599	.242	.336	.073	.001	.000	.001		.000	.064
	N	68	60	68	67	65	67	66	68	68	68	68	65
MAR program adequately provides children with needed services	Pearson Correlation	.004	-.071	-.064	-.133	.013	-.051	.267*	.316**	.456**	.529**	1	.342**
	Sig. (2-tailed)	.971	.589	.599	.281	.920	.680	.029	.009	.000	.000		.005
	N	69	61	69	68	66	68	67	68	68	68	69	66
I can dedicate the time needed to provide and coordinate services	Pearson Correlation	-.094	.183	.144	.020	-.107	.118	.096	-.002	.300*	.231	.342**	1
	Sig. (2-tailed)	.454	.169	.248	.872	.405	.350	.449	.987	.015	.064	.005	
	N	66	58	66	65	63	65	64	65	65	65	66	66

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

APPENDIX F

DESCRIPTIVE STATISTICS

Descriptive Statistics

	Mean	Std. Deviation	N
Age	44.97	8.676	61
Years of Experience	102.49	71.703	68

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ASSIGNED RESPONSIBILITIES PAGE

This was a two-person project where authors collaborated throughout. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection:

   Team Effort: Corina Chavez & Lilia Razo

2. Data Entry and Analysis:

   Team Effort: Corina Chavez & Lilia Razo

3. Writing Report and Presentation of Findings:

   a. Introduction and Literature

      Team Effort: Corina Chavez & Lilia Razo

   b. Methods

      Team Effort: Corina Chavez & Lilia Razo

   c. Results

      Team Effort: Corina Chavez & Lilia Razo

   d. Discussion

      Team Effort: Corina Chavez & Lilia Razo