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ii

FAMILY **P**RESERVATION **J**OURNAL

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SPECIAL FEATURES

ARTICLES

iii

Editorial

Broadening Our Vision, Refining the View

This issue of the Family Preservation Journal combines two emerging interests in the fields of family preservation and family support. First, contemporary forces are making the world a smaller and smaller orb, and we see the plight of families and children around the globe on a daily basis. Our vision of families' needs is broadening, bringing with it questions about how services and systems support families in different cultures and under different governmental structures. Accompanying this global awareness is a greater emphasis on making service delivery and the evaluation of services more transparent to families. True to the original vision of family-based services, more and more agencies are incorporating consumers' perspectives into the design of services and are seeking their perspectives on what works and why.

In these pages are descriptions and evaluations of family preservation and family support services around the world, including Australia, England, Italy and the United States. We have much to learn from these about the essential elements of helpful services. The essence of a caring, helpful relationship with families is consistent across these cultures, despite differing service systems, government mandates, and social safety nets.

These studies are particularly illuminating as to the nature of help because they dig deeper into understanding both consumers' perspectives and the particulars of the services provided. The first two articles in this collection focus on describing the specific and individualized services delivered in family preservation programs. These detailed examinations of services and treatment integrity exemplify the necessary evolution of family services research to unpack the "black box" of services, rather than assuming that the interventions delivered are faithful to a model and drawing conclusions from a doubtful assumption.

The three remaining studies in this collection use mixed methods to explore and describe the services that families need and appreciate in family preservation and/or family support services. Both service providers and service consumers are queried as to the essential elements of a successful partnership. In the studies from Australia and England, quantitative outcome measures are combined with qualitative interviews with both caseworkers and families to identify the effectiveness of services, the types of families most helped, and the beliefs of families and caseworkers as to the specific elements of services that most contribute to case outcomes.

Finally, we are fortunate to include in this issue two contributions from Professor Emeritus Anthony N. Maluccio of Boston College. He has penned an essay very relevant to this collection concerning the inclusion of consumers in the evaluation of services. This is followed by his review of an Italian study of family preservation services. As a scholar who has observed the evolution of child welfare services and research, and as a forefather of the move to more global awareness of family services, his perspectives in the collection are valuable and timely.

v

Editorial

By broadening our vision of family preservation and family support services to the global village of families raising children, we can learn so much about the nature of caring across cultures and settings. By listening to families about the specific behaviors and services they find helpful, we can refine our vision of preserving and supporting families everywhere.

Marianne Berry
University of Kansas

Looking Inside The Black Box

Daria V. Hanssen and Irwin Epstein

Intensive family preservation services (IFPS), designed to stabilize at-risk families and avert out-of-home care, have been the focus of many randomized, experimental studies. The emphasis on "gold-standard" evaluation of IFPS has resulted in fewer "black box" studies that describe actual IFPS service patterns and the fidelity with which they adhere to IFPS program theory. Intervention research is important to the advancement of programs designed to protect the safety of children, improve family functioning, as well as prevent out-of-home placement. Employing a retrospective "clinical data-mining" (CDM) methodology, this exploratory study of Families First, an IFPS program, makes use of available information extracted from client records to describe interventions and service patterns provided over a two year period. This study uncovers actual IFPS service patterns, demonstrates IFPS program fidelity, as well as reveals the usefulness of CDM as a social work research methodology. These findings are particularly valuable for program planning and treatment, policy development and evidence-based practice research.

Over the last three decades, the child welfare system has placed a high priority on keeping families intact, while simultaneously protecting the safety and well-being of at-risk children. One popular programmatic approach to achieving these objectives is Intensive Family Preservation Services (IFPS). This paper describes IFPS intervention patterns in a single highly regarded agency over the course of two years. Clinical data mining (CDM) (Epstein & Blumenfield, 2001) compares retrospective findings from agency records with patterns of service described in previous studies, thereby demonstrating comparability of the IFPS agency studied and the reliability of CDM as a methodology. Knowledge generated in this study is intended to inform and enhance practice and program development for intensive family-focused placement prevention programs. In addition, this study is intended as a test of the feasibility of CDM as a methodology for conducting descriptive and quasi-experimental evaluation research.

Literature Review

Service Provision

The intensive family preservation services model posits a family empowerment approach, encouraging family participation in intervention, goal setting, and in developing solutions to avoid family dissolution. The operational elements of this model include: 1) a home-based approach, 2) service intensity up to 20 hours per week for no longer than 90 days, 3) around the clock worker availability for emergency visits,

8·Daria V. Hanssen and Irwin Epstein

and 4) worker caseloads of no more than two families at any given time in order to insure intensive treatment (Wells & Biegal, 1992).

Services typically provided by IFPS programs have been described as soft, hard/concrete, and enabling services (Berry, 1995). Soft services include such activities as psychoeducation, family counseling, and individual counseling. Concrete services consist of a range of services such as financial assistance, home repairs, transportation, and recreational activities that families generally cannot afford. Enabling services provided on behalf of families include advocacy with social services, legal and educational systems, as well as assistance in negotiating access to community support services (Berry, 1995; Rossi, 1992; Wells & Biegal, 1992; Wells & Tracy, 1996).

Characteristics that distinguish IFPS from other holistic family-centered services and from the more traditional "person-centered" perspective (Farrow, 1991; Karger & Stoesz, 1997; Nelson, 1997; Whittaker, 1991) include: 1) establishing a service continuum with the capacity for individualized case planning, 2) promoting competence in children and families by teaching practical life skills and providing environmental supports, 3) providing services that are supportive and strengthening to families, 4) collaborating with families and other agencies to best serve at-risk children and families, 5) intensive and rapid service provision, of short duration, to all members of the household to restore family stability and, 6) ongoing assessment of the safety and well-being of the children with consideration of placement when necessary (Brieland, 1995; Pecora, et al., 1995; Rossi, 1991; Whittaker, 1991; Whittaker, Kinney, Tracy & Booth, 1990).

Intensive Family Preservation Services: Intervention Research

Since its inception, IFPS evaluation research has focused overwhelmingly on outcomes (Craig Van-Grack, 1997), with most reporting the placement prevention rate as their primary criterion of success (AuClaire & Schwartz, 1986; Berry, 1997; Feldman, 1991; Fraser, Pecora, & Haapala, 1991; McCroskey & Meezan, 1997; Schuerman, Rzepnicki & Littell, 1994; Yuan, McDonald, Wheeler, Struckman-Johnson & Rivest, 1990). The design of exemplary IFPS services for children and families is dependent on systemically describing intervention patterns *before* attempting to consider their impacts. Intervention research, conducted to examine the specific services and combination of family preservation services provided to at risk families, has paled in comparison to research focused on placement prevention outcomes.

Key studies that explore IFPS service provision include prospective descriptive intervention evaluations (Berry, 1992, 1995; Berry, Cash & Brook, 2000; Fraser, Pecora & Lewis, 1991; Kinney, Haapala & Booth, 1991; Lewis, 1991; Tjeerd ten Brink, Veerman, de Kemp & Berger, 2004), experimental studies (Feldman, 1991; Schuerman, Rzepnicki & Littell, 1994), and quantitative studies correlating services to placement and treatment outcomes (Berry, 1992; 1995; Cash & Berry, 2003; Kirk & Griffith, 2004). Additionally, two meta-analytic studies explore family preservation outcome research with attention to the provision of services and interventions to specific populations (Blythe, Salley, & Jayaratne, 1994; Fraser, Nelson & Rivard, 1997). The systematic description of actual patterns of service delivery has been referred to as the "black box" of evaluation research (Bickman, 1987; 1990). Directing attention to what is in that box allows for the assessment of "program fidelity", the extent to which interventions adhere to the program model employed (Mowbray, Holter, Stark, Pfeffer, & Bybee, 2005).

Without critical attention to the specificity of service delivery, causal inferences about intervention efficacy will remain not only problematic, but elusive.

Method

Pilot Project

Prior to gathering data for this study, a pilot project was conducted to determine if Families First adhered to the IFPS program model. Placement prevention rates from 1990 to 2000 revealed that 1995 had the lowest placement rate since the program's inception and was selected for analysis. Records were systematically reviewed and a detailed inventory of potential variables including interventions, demographics, risk factors, resiliency factors, placement outcomes, and family functioning were gathered.

All information accumulated on families was extracted from the narrative case notes, as well as written inter- and intra-agency documentation, including daily progress notes, case summaries, intake and discharge summaries, psychological and medical reports, and court reports. Families First did not systematically record information such as, family income, race, household composition, diagnosis, levels of abuse or neglect at intake and discharge, or placement and reunification information, thus necessitating other methods to quantify such data. From this initial subset of data, a preliminary data extraction form was developed. Outcomes of the pilot project demonstrated that Families First strongly subscribes to the philosophy and goals of the IFPS service model, as it provided: 1) home-based services, 2) short term with services for 4-8 weeks, 3) intensive treatment from 15-20 hours per week, 4) 24-hour emergency services, and 5) workers carrying no more than two families at a time.

Study Site

Families First is located in a small urban center, serving a suburban and rural community. This is a voluntary program that selects families for treatment based on their willingness to participate in intensive services. A continuum of hard, soft and enabling services are offered, tailored to accommodate individual family needs while building on family strengths (Berry, 1997). Referrals originate from units within the Department of Social Services including Child Protective Services, Mandated Prevention, Foster Care, Intake/investigation, Family Court, and Mental Health, as well as families themselves. Each worker serves no more than two families at any given time, with the requirement of being on call twenty-four hours per day and seven days per week. Family and individual meetings are scheduled at least four times per week, for up to fifteen hours per week in the home. Families First proved to be a prime site for this data mining research, particularly because client records contain detailed service information, which allowed for comparative intervention research with prior studies and made it possible to examine treatment fidelity.

Sample

The sample was comprised of case records for all families served by Families First during the two-year period from January 1, 2000 through December 31, 2001 resulting in 116 case records (N=116). Many of the currently employed Families First workers were also employed during the two-year period noted above. This allowed for

10· Daria V. Hanssen and Irwin Epstein

input from practitioners and corroboration of information for potential interpretation of interventions and services.

Design

  This study was essentially a case study of a single IFPS agency. Yin (1989) describes the case study as an "empirical inquiry that investigates a contemporary phenomenon within its real life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used" (p. 23). CDM was selected for determining the specific nature of IFPS practice and intervention patterns because it is an unobtrusive approach to gathering clinical information from existing client records (Epstein, 2001).

Instrument

  Guided by the pilot project review of client records, the "Inventory of Demographics and Services" was designed to retrieve and record available data from client records. This inventory reflected salient program theory and concepts derived from the family preservation literature. Three tools designed for prospective analysis of IFPS interventions informed the development of the present data-mining instrument: 1) Concrete Service Checklist and the Clinical Services Checklist (Fraser, Pecora & Haapala, 1991), 2) Major Techniques Checklist (Schuerman, Rzepnicki & Littell, 1994), and 3) Therapeutic Interventions and Concrete Services Inventory (Pecora, Fraser, Nelson, McCroskey & Meezan, 1995).

  The selection of variables was guided by the following questions: What were the specific services and interventions provided to families? How long did services last? Who referred the family for services? Why was the family referred for services? Were children placed in substitute care during service provision? Was the identified child reunited with the family following services? What were the individual and family stresses that could be associated with the risk of out-of-home placement for the children? The final, Inventory of Demographics and Services, resulted in 134 variable measures, 112 of these were interventions and the remainder were demographic characteristics. In order to insure that each intervention was mutually exclusive and simple to understand, an exhaustive list of operational definitions was developed for all variables, utilizing the review of the literature, as well as practice knowledge.

Measures

  Process notes, three- and six-week case summaries and termination summaries of the 116 case records were analyzed for distinctive services, interventions, and demographic information from supplemental material in the case record such as hospitalization or police reports, psychological testing reports, individualized education planning reports, school incident reports, and summaries from mental health counseling and other social service agencies. Data were entered onto the Inventory of Services and Demographics and later into SPSS for data analysis.

  Each intervention was counted and recorded only once, despite the number of times a worker might have utilized an intervention in a single case. This decision to record service provision only once was made because services were embedded in the case narrative, making it extremely difficult to count each dose. The priority was to discover the range of distinctive interventions and skills required to do this work versus the

frequency of each service. Types and combinations of interventions were treated as independent variables, while the dependent variable was placement outcome. The dependent variable was coded in a manner consistent with prior prospective research such as maintenance of the child in their home, reunification of the child with the family, and the reduction in family violence. For future examination, covariates considered to play a role in family functioning and placement outcomes included family constellation, number of children, age of identified child, and incidence of parental mental illness and childhood emotional disturbance. The child at imminent risk of being placed in substitute care is referred to as the "identified child", and was in physical and/or emotional danger in terms of personal safety at home, at school, or in the community. Only one child per family was considered as the "identified child", the child most in danger of placement.

Since Families First would not permit any outside readers of the case files, a compensatory means to establish reliability of the instrument was used. Ten case records were randomly selected and coded again three months after the initial data mining. The data-extracting instrument was validated through the literature review and through personal conversations with Family First practitioners who provided their interpretations of services. Reliability of the data-gathering instrument was assessed empirically within the study itself and by comparing study findings to those in prior empirical studies (Berry, 1992; Berry, et al., 2000; Fraser, et al., 1991; Lewis, 1991).

To assess program fidelity, the 112 interventions identified in the case records were then combined into existing categories defined by Berry (1995; 1997; et al, 2000) and Lewis (1991) as hard, soft, enabling, and strengths assessment services. Additional categories of service identified by Fraser et al (1997) and used in this study included: empowerment, skill building, collateral, marital and family, crisis, and concrete services. A Cronbach's Alpha was performed to determine reliability of the summated service scales, resulting in positive reliability scores ranging from .81 to .86 of the summated scales.

Results

Family Characteristics

Families First served 296 children from 116 families in the two year period under investigation, with one child from each family referred to as the identified child (N=116). The mean number of children per family unit was 2.55. In 32% of families, there were three children, 30.2% had two children, 23.3% had only one child, and in 12.6% of families, there were 4 to 8 children. The age of the identified child ranged from infancy to seventeen years with 14 and 15 year olds identified as equally at-risk, at 19.9% respectively, followed by 14.7% at 13 years of age. The child identified as being at risk of placement and most in need of services was more likely to be male (61.2%) than female. In more than half of the families (54.5%), the child most at risk of placement was between the ages of 13 to 17, and experiencing problems such as truancy and running away from home. Referrals made due to unmanageability at home and/or at school accounted for close to half of all cases (45.7%), followed by reunification (18.1%), child neglect (13.8%), child abuse (10.3%), domestic violence (5.2%), mental heath risk (4.3%), and self-referrals and cases that did not fit any of the aforementioned categories (2.6%).

12·Daria V. Hanssen and Irwin Epstein

"Data mining" the records revealed a core of risk factors for the families that received services. Approximately half (53.4%) of the 116 identified children were diagnosed with an emotional disturbance. The most common diagnoses were bi-polar disorder (15.5%) and post-traumatic stress disorder (12.1%). Slightly more than one fourth (28%) of the children served suffered from suicidal or homicidal ideations. Additionally, there were children served who were victims of sexual abuse (14.7 %), had experienced at least one previous placement in substitute care (14.7%), and were adopted (4.3%). Almost half of the children (48%) had committed a status offense (an offense which would not be considered a crime if committed by an adult). Close to one-fifth of the parents (19.8%) were diagnosed with a mental illness, and almost half (45.6%) of all parents/caretakers were identified as experiencing substance abuse problems. The case notes indicated that many families in the sample struggled financially, surviving on time-limited public assistance, Social Security benefits, or minimum wage salaries. Moreover, 7.8% of families either were homeless at the time of referral or became homeless during treatment. Finally, single mothers headed 50% of all families in the sample.

Service Typologies

The final Inventory of Demographics and Services identified 112 types of interventions provided to families in varying proportions. Of the 112 types of interventions, 82% were types identified as clinical or soft services, 11% were types of interventions identified as enabling activities and 7% were types identified as concrete activities. An average of 57 different types of interventions was provided per family unit.

Concrete services. The centrality of the provision of hard services is addressed extensively in the literature (Berry, 1995, 1997; Berry et al., 2000; Fraser et al, 1991; Kinney et al., 1991; Lewis, 1991). The application of a direct solution to a concrete problem early in the intervention pattern (Kinney et al., 1991) is thought to help the caseworker to engage the family in the treatment process and to sustain its involvement in the treatment process. Additionally, families may not find it possible to address emotional and/or communication problems if their more pressing day-to-day living condition is ignored. On the average, families received three types of concrete services during the treatment period. Transportation was the concrete service most often provided. Table 1 illustrates the proportion of families in receipt of concrete services.

Table 1. *Proportion of Families Receiving Types of Concrete Services (N=116)*

Type of Concrete Service	n	%
Transportation	105	90.5
Financial Assistance	65	56.0
Family Celebrations	44	37.9
Home Management Activities	33	28.4
Arranging for Daycare or Respite	35	30.2
Helping with Chores	10	8.6
Helping with Homework	8	6.9

*Note: Percentages add to more than 100% because families could
receive more than one service*

Enabling services.   Enabling services facilitate access to both the external soft and concrete services by helping the family establish community linkages. Fraser et al. (1997) refers to these services as collateral services. Approximately 9.5% of all types of service activities fell under this rubric. On the average, families received seven types of enabling services over the course of treatment. The most commonly provided enabling services were advocating on behalf of the family (94%), accompanying clients to agencies (91.4%), providing information and referral linkages (85.3%), providing information on various resources (84.5%) and providing case management service (73.3%). Enabling services to decrease social isolation included: testifying and attending court with clients (62.1%), teaching clients how to access services and modeling how to negotiate services (44%), assisting in building informal community supports (41.4%), and teaching clients how to use leisure time (38.8%).

Soft services.   Ninety-two interventions were categorized as soft service activities and of these; twenty-eight were categorized as marital and family interventions. Overall, soft services were provided more often than either concrete or enabling services. Each family in the sample received an average of 47 (46.73) types of soft services and an average of 27 (27.10) marital and family interventions. Table 2 illustrates the types of soft services and the proportion of families in receipt of each type of service.

14·Daria V. Hanssen and Irwin Epstein

Table 2. *Proportion of Families Receiving Types of Marital and Family Services (N=116)*

Type of Marital and Family Intervention	n	%
Makes purposeful phone call	114	98.3
Defines treatment plan	113	97.4
Examines past behavior/consequences	113	97.4
Examine current behaviors	112	96.6
Provides praise	110	94.8
Makes supportive phone call	110	94.8
Explores family coping skills	110	94.8
Reflect and validate feelings	109	94.8
Listen to client's story	109	94.8
Gives advice and direction	105	90.5
Encourage individual ventilation	104	89.7
Offers support and understanding	104	89.7
Use of family process	102	87.9
Worker observes	102	87.9
Discusses termination	101	87.1
Seeks verbal reports between sessions	101	87.1
Clarifies family rules	100	86.2
Conducts structured family interview	100	86.2
Discusses progress at termination	100	86.2
Builds in hope	96	82.8
Confrontation	88	75.9
Examines behavior patterns	88	75.9
Clarify family roles	84	72.4
Develop a time-line	84	72.4
Identify behavior sequences	81	69.8
Values clarification	79	68.1
Tracking child behaviors	70	60.3
Reframing	50	43.1
Tracks parent behavior or affect	43	37.1
Couples counseling	41	35.3
Encourages family and child	31	26.7
Hypothesizing function of symptom	28	24.1
Encourages client to get family facts	24	20.7
Predicts relapse	21	18.1
Uses metaphor to convey a point	21	18.1
Restrains change	15	12.9
Identifies feelings	15	12.9
Worker self-discloses	4	3.4
Team/Co-therapist is utilized	3	2.6
Family sculpting	2	1.7
Miracle exercise	2	1.7
Circular questioning	2	1.7
Uses paradox	1	.9

Note: Percentages add to more than 100% because families could receive more than one service

Skill-building activities (Fraser et al., 1997) or "psychoeducational" services, another type of soft service, combine psychotherapeutic and social learning approaches in an effort to teach families new methods of handling day-to-day activities, parenting issues, and family problems (Kinney et al., 1991). These activities constituted approximately 6.2% of the 112 soft services routinely provided and on the average families received 8.2 types of skill building activities. Table 3 illustrates the types of skill-building interventions and the proportion of families in receipt of such interventions.

Table 3. *Proportion of Families Receiving Types of Skill Building Services (N=116)*

Type of Skill Building Service	n	%
Teaches parenting skills	101	87.1
Teaches social skills	93	80.2
Teaches token system	87	75.0
Teaches time out	86	74.1
Teaches communication skills	77	66.4
Provides information on child development	76	65.5
Teaches relaxation skills	75	64.7
Teaches anger management	74	63.8
Teaches child management skills	72	62.1
Teaches problem-solving skills	72	62.1
Provides literature	69	59.5
Teaches through role-playing	64	55.2
Behavioral rehearsal	47	40.5
Teaches use of leisure time	45	38.8
Teaches home management skills	33	28.4
Teaches assertiveness and advocacy	28	24.1
Teaches sex education	25	21.6

*Note: Percentages add to more than 100% because families could receive more than
one service*

16· Daria V. Hanssen and Irwin Epstein

Building on family strengths, individualizing treatment, collaborative problem solving and goal setting are cornerstones of intensive family preservation practice (Berry, 1997). Such services are referred to as empowerment services (Fraser, et al., 1997) in the intensive family preservation literature and are considered a subcategory of soft services (Berry, 1997). Families received an average of 11 types of empowerment activities. Table 4 illustrates the proportion of families in receipt of empowerment services.

Table 4. *Proportion of Families Receiving Types of Empowerment Services (N=116)*

Type of Empowerment Service	n	%
Explores problems	116	100
Focus and define problems	113	97.4
Define obstacles to task achievement	112	96.6
Identify family strengths	110	94.8
Discuss problem impact on health	110	94.8
Generate action plan	108	93.1
Contracting and negotiating	106	92.2
Discusses future hopes and goals	92	79.3
Explores family coping skills	92	79.3
Solution-focused services	82	70.7
Explore family respect and support	77	66.4
Develops behavioral contracts	71	61.2
Explore religion and spirituality	65	56.0
Draws genograms	10	8.6
Draws eco-maps	5	4.3

Note: Percentages add to more than 100% because families could receive more than one service

All families referred to Families First were at risk of imminent placement, as identified by both the referral agent and the program director. The occurrence of crisis is

common for families struggling with mental illness, poverty, homelessness, domestic violence and child endangerment. Percentages of families provided with specific crisis interventions are as follows: encourages client to call during a crisis (87%), provides structure during crisis (75.9%), suicide assessment and recognition (25.9%), and use of crisis card (2.6%). Of the 116 families in this sample, only 6% did not receive any type of crisis intervention.

Clinical data mining also revealed a variety of non-traditional interventions provided to families. These activities were designed to fit the specific needs, strengths, and desires of each individual family member and the family as a whole. The most common activities provided to the sample are as follows: painting, drawing, sculpting (36.2%), indoor and outdoor games (35.3%), dinner preparation and hiking respectively (12.9%), caring for pets, gardening, and affirmations (3.4%) respectively, photography (2.6%) and talking stick activity (1.7%). A few interventions were provided to just one family: teaching a child yoga, meditation, or tai chi; taking a family on a window-shopping excursion to the mall; going to a museum, church, or on a foot race. These "creative" interventions exemplify the family preservation philosophy of "doing whatever it takes" to meet family needs.

Discussion

Intensive family preservation services are theoretically intended to holistically respond to the needs of a family relative to a child's placement risk. The model proposes that the core service components - hard, soft, and enabling services - should be "tailored" to meet individual needs, while strengthening the family to reduce the risk of placement and protect the safety of children (Berry, 1997). The findings of this study confirm the eclectic, diverse, and wide-ranging nature of services provided by Families First.

Consistent with the intensive family preservation philosophy, it was found that Families First provided services in a holistic manner, serving the whole family and considering the health, mental health and well-being of all individuals. Each family was provided with an array of services that "fit" developmental needs, aspirations, capacities and limitations of all family members. Services were pragmatic and hands-on in order to teach practical life skills. Additionally, services included communication skills training, encouraging and teaching about parenting, and linking families with resources and supports aimed at supporting the client's competence level and providing ongoing assessment for child well-being and support.

The provision of concrete services was consistent with findings of other authors including that of Fraser, Pecora, and Haapala (1991) and Lewis (1991), suggesting that workers tailored services to meet individual family needs (Lewis, 1991). The provision of transportation services exceeded that of other studies (Fraser et al, 1991; Lewis, 1991; Berry et al., 2000); however, this contrast might be explained by the constraints of a rural community that does not support comprehensive affordable or alternative transportation systems. All clients received some type of concrete service; however, less emphasis was placed on concrete service provision, possibly because of program budget constraints and the nature of family problems requiring more family and child counseling.

The soft services provided a heavy concentration of psychotherapeutic techniques, as well as a substantial number of "skill building" or psycho-educational interventions, empowerment interventions, and crisis intervention services. This study also found that

18·Daria V. Hanssen and Irwin Epstein

soft services were provided the most often and with the most variation. These findings were comparable to research outcomes in studies conducted by Berry (1992, 1995); Berry, et al. (2000); Fraser, Pecora and Haapala (1991), and Lewis (1991).

Enabling services bridge the gap between the soft and hard services (Berry, 1997). It was encouraging that all families received some type of support to facilitate linkages with both formal and informal support systems. The enabling services most often provided to families included advocacy with social service systems, schools, courts, and landlords, followed by accompaniment of clients to service organizations.

Examination of process notes indicated that family contact was provided almost daily, in many cases, even on weekends. Adherent to the IFPS model, services were provided for a brief, but intensive period, with a mean service time of 6 ½ weeks. Information contained in the case records indicated that approximately 88 % of families served were intact at case closure. This finding was consistent with other studies of IFPS (Berry, 1995; Berry, Cash & Brook, 2000; Pecora, Fraser, Bennett & Haapala, 1991). Almost half of all families served by Families First were referred for the child's unmanageable behaviors including running away from home, community vandalism, and truancy. These findings vary from those presented by Berry, Cash and Brook (2000), where 44% and 34% of families referred presented with physical abuse and neglect. In another study conducted by Berry (1995) it was found that 58% of families referred presented with physical abuse and 25% for physical neglect. Similarly, Fraser, Pecora and Haapala (1991) reported that in Utah, 59% of referrals came from Child Protective Services. According to the Director of Families First, this variation could likely be explained by the fact that Families First had become a prime referral source in this community for the treatment of incorrigible adolescents and their families. The findings validated that services were consistent with IFPS program theory.

Feasibility of "Clinical Data Mining" as a Research Strategy

A second goal of this study was to test the feasibility of using "clinical data mining" as a strategy for testing the effectiveness of intensive family preservation services. Berry (1997) urged evaluators and researchers to "begin to broaden the lists of design and measures available from which to choose, to include not only scientific and standardized methods but also qualitative methods in order to answer the evaluation questions, the research questions or some combination of both" (p. 171). This intervention research study was undertaken to explicate the nature, depth and breadth of IFPS service delivery, to compare these findings with previous studies of comparable intensive family preservation programs, and to assess the feasibility of utilizing CDM as a method for studying family preservation programs retrospectively with available case information. The review of process notes, three- and six-week summaries, as well as diagnostic assessments, yielded service variables and family characteristics not considered in experimental studies of IFPS interventions. "Mining the data" helped to add to the list of distinctive interventions that are often glossed over in the literature as simply "marital and family" or "enabling" services. Moreover, the complexity of family preservation interventions and of the families served became apparent in the detailed notes of family meetings, interactions and outcomes. A final supporting claim for "clinical data mining" is the unobtrusiveness of this method. This retrospective study of Families First made possible the in-depth study of service provision and families'

characteristics with no interference for family, worker or intervention process. Finally, it revealed that Families First clearly adhered to the IFPS program model.

Limitations of Clinical Data Mining

There were limitations to utilizing this methodology: 1) each practitioner possessed her/his own frame of reference, worldview, and style of treatment, which influenced how and what was documented in the case record; 2) this research method did not employ a control group; and 3) the sample size was small. In addition, CDM is time consuming; however, once the definitions are operationalized and the extracting tool is created, work proceeds smoothly. Despite these limitations, use of available clinical records is a very feasible method of research in evaluation of services and outcomes in social work practice, child welfare, and family preservation practice.

Future Directions and Conclusions

Home visitation, which can be traced back to the Charity Organization Society (COS) developed at the turn of the century (Popple & Leighninger, 1999), could be said to be a forerunner of IFPS programs. As in family preservation practice, the early COS workers called for a balance of social justice and individual intervention, the caseworker being alert to the implications of individual reform, as well as the provision of concrete services. Advocating to improve the human condition, case-by-case, is the backdrop of the social work profession (Reynolds, 1942), and that of intensive family preservation services.

Parents/caretakers (Pecora, et al, 1991) have rated highly the value of working with clients in their environment. It has been reported by IFPS practitioners that working with families in their environment emphasizes ongoing and more accurate family assessment, worker persistence, loyalty, and commitment, while new behaviors are being modeled for families and family boundaries are enforced. Furthermore, the home environment permits the practitioner to more readily assume a supportive position with the family, while reinforcing parental control and ability to make choices. Professional preparation for family preservation practice must give greater attention to the skills necessary for working in the home versus those for working in the office. In addition, professional preparation should emphasize the skills associated with effective case management and skills for working collaboratively with family-service providers.

Finally, social work professionals should be educated to participate actively in the development of practical and usable outcome measures, conversant in the research methods, and capable of translating service data into more structured formats that will capture the service delivery process. Research utilizing clinical data mining methodology can strengthen practitioners as researchers and expand the opportunities for practitioners to carry out research.

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20·Daria V. Hanssen and Irwin Epstein

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22·Daria V. Hanssen and Irwin Epstein

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Assessing Treatment Integrity: A Case Example

Anat Zeira, Betty Blythe, and Anita Reithoffer

This paper presents an example of assessing treatment integrity as part of an experimental study of home-based, intensive family preservation services (IFPS). Participants were 103 IFPS workers and 24 state public child welfare agency workers (FC). The structured, self-report questionnaire included questions about specific components of the services, as well as the characteristics of the family and the workers themselves. Findings suggest that IFPS workers delivered services according to the treatment model guidelines. The procedure yielded a good estimate of whether the structural components of treatment were delivered according to the model as delineated in the treatment manual. The paper discusses the advantages and disadvantages of this approach to assessing treatment integrity.

Key Words: Treatment integrity, practice research; family preservation services

Family preservation services, including intensive family preservation services (IFPS) are offered as an alternative intervention for children at imminent risk of removal from their families, before children are placed in substitute care (cf. Fraser, Pecora, & Haapala, 1991; McCroskey, 2001; Whittaker, Kinney, Tracy, & Booth, 1990). Early studies of IFPS reported very positive findings (Kinney, Madson, Fleming, & Haapala, 1977). In response to calls for increased rigor, a series of outcome studies utilizing experimental or quasi-experimental designs was implemented and the effectiveness of IFPS was called into question (Feldman, 1990; Shuerman, Rzepnicki, Littell, & Chak, 1993; Yuan, McDonald, Wheeler, Struckman-Johnson, & Rivest, 1990). While some of the studies found evidence suggesting that family preservation programs are effective in avoiding unnecessary out-of-home placements, others did not show a significant difference between children receiving family preservation services and those receiving other services (Blythe, Salley, & Jayaratne, 1994).

Various reasons have been proffered for these mixed findings including concerns about the research methodology of some of the studies. In fact, part of the debate around the effectiveness of IFPS concerns the difficulty in determining what was the intervention (i.e., what the workers do) and if it was delivered according to the treatment protocol. The study reported in this paper is part of a larger experiment aimed at assessing the effectiveness of a specific family preservation intervention program. A major component of the study was to record certain components of the intervention process to facilitate better inferences regarding the effectiveness of the program.

Many intensive family preservation programs follow a general model of providing services to families in their home with the ultimate goal of keeping families safely together and avoiding unnecessary out-of-home placements. Programs vary, however, in terms of the interventions employed and the means of attaining specific goals (Berry, 1995). The complexity and variation of family preservation programs may be another cause for inconclusive findings regarding their effectiveness as compared to the usual

24· Anat Zeira, Betty Blythe, and Anita Reithoffer

services for children at imminent risk of removal (Rzepnicki, Shuerman, & Littell, 1991). In each of the several variations of the family preservation model, workers use different content-related components (e.g., intervention techniques and strategies) as well as different structural components (e.g., length of treatment, amount of face-to-face contact, and availability of the worker). With respect to the content-related components, programs vary not only from one worker to another, but also from one client unit to another according to the clients' specific needs and circumstances. As a result, it often is difficult to show that the family preservation model and services were provided as intended in the model. Therefore, criticism often is directed at the treatment model and the poor validity of implementing the intervention (Blythe & Tripodi, 1989).

What is Treatment Integrity?

Recent developments regarding practice guidelines and treatment manuals are important contributions to the social work profession's efforts to become more scientifically based (Proctor, Rosen & Rhee, 2002). While practice guidelines aim at providing practitioners with the best-known interventions to attain specific outcomes, treatment manuals delineate the intervention process and allow for a more systematic and consistent delivery of services (Waltz, Addis, Koerner, & Jacobson, 1993). Still, even employing both treatment manuals and practice guidelines are not sufficient for systematic practice, because delivering the intervention in the prescribed manner requires constant training and supervision (Henggeler, Melton, Brondino, Scherer, & Hanley, 1997). Moreover, the delivery of the intervention should be accompanied by empirical checks to show that the interventions are properly implemented.

Treatment integrity, treatment fidelity, and adherence to treatment are terms that often are used interchangeably to describe the degree to which an intervention procedure is delivered as intended and in accordance with the planned intervention protocols (Ivanoff, Blythe, & Tripodi, 1994). Gambrill (1997) stress that treatment integrity should focus on the extent to which workers are using components that are part of the protocol and not using components that are not part of the protocol. Waltz et al. (1993) further suggest that sometimes treatment integrity is being confused with the worker's competence in executing the treatment. Hence, in order to deliver the intervention as intended, it is assumed that workers are trained and capable. In this study, the workers in the experimental condition were trained within the IFPS model.

Along with these definitions, the literature reveals a growing interest in treatment adherence research. Such research encompasses methodological strategies aimed at documenting the process by which an intervention is delivered to affirm that a given intervention is implemented as intended and according to the procedural and theoretical aspects of the model (Hogue, Liddle, & Rowe, 1996).

Why is it Important to Assess Treatment Integrity?

Every intervention program is aimed at making a change in a specific emotional, behavioral, or cognitive situation. Gresham and his colleagues (2000) assert: "A fundamental goal of all intervention research is the unequivocal demonstration that changes in a dependent variable are related to systematic, manipulated changes in an independent variable and are not due to other extraneous variables" (p.198). Outcome evaluation is thus based on the notion that interventions are responsible for the observed change. Therefore, researchers are obliged to provide evidence that the intervention was employed according to its theoretical and practical guidelines. That is, when an

intervention shows evidence of high treatment integrity, the resulting outcomes have greater internal validity (Moncher & Prinz, 1991). And, the converse should be considered when appropriate. If programs are found to be ineffective, is it due to a weak intervention or something else? In addition, measuring the level of treatment integrity enables researchers to compare outcomes across two or more specific programs. It also facilitates comparison between innovative interventions and "standard" services and may explain the effect of treatment assignment on outcome (Hargreaves, Shumway, Hu, & Cuffel, 2000). Because of the controversy around the effectiveness of IFPS, outcome studies that are able to show that the intervention was employed systematically and in accordance with the practice plan provide stronger evidence about the effectiveness of these interventions.

Measuring Treatment Integrity

Measuring the course of treatment and providing evidence that it was implemented as intended is a challenging task (Craig-Van Grack, 1997). In fact, many of the studies that allude to treatment integrity provide no empirical evidence regarding the degree to which interventions were implemented as intended (Gresham, 1997; Gresham, MacMillan, Beebe-Frankenberger, & Bocian, 2000). We identify two sources for this challenge. First, any interference with the prescribed course of an intervention poses a threat to its measurement validity (Moncher & Prinz, 1991). Second, social interventions, unlike such interventions as some medical procedures, involve interpersonal relationships that are more variable and thus more difficult to tap (Salend, 1984). Therefore, assessment of treatment integrity has to take into consideration the nature of the intervention and its various components such as workers' style and experience (McMahon, 1987).

Assessment of treatment integrity is based on information about the participants and their activities during the intervention course of treatment. Gresham et al. (2000) summarize the practical considerations in measuring treatment integrity and suggest three possible methods: direct assessment (e.g., observers conducting "live" observations or examining videotapes) indirect assessment (e.g., self-reports or interviews), and manualized treatment (e.g., detailed step-by-step manual). They stress that while the first two methods provide actual measurement of the way the intervention is implemented, the third method of using a treatment manual -- as often reported by researchers -- does not provide any information as to the actual implementation of the detailed instructions (Gresham et al., 2000). Thus, they recommend assessing treatment integrity by combining treatment manuals that delineate the treatment model with one or more forms of actual measurement of its implementation. In this study, the workers followed a treatment manual and reported on the implementation of the structural components of the intervention.

Treatment Integrity in Intensive Home-Based Family Service

While there are a growing number of studies on the integrity of treatment in other domains (e.g., education), published literature in IFPS is scarce. Because several structural components of IFPS intervention (such as length of treatment, minimum face-to-face contact, and spending flexible funds for specific needs) are not necessarily the same in all IFPS models, it is important that the integrity of the treatment be verified and reported. Notwithstanding this variability, very few studies of intensive home-based services have included integrity checks. The following review focuses on the IFPS

26· Anat Zeira, Betty Blythe, and Anita Reithoffer

components that were investigated and on the contribution of tracking treatment integrity in outcome studies.

Berry (1995) studied 40 families engaged in a family preservation agency in order to assess the provision of services. She argues that family preservation programs include three types of services: soft services, hard services, and enabling services. Soft services concern emotional needs (such as counseling, and providing support and understanding), hard services pertain to concrete needs (for example, providing funds for housing, medical care and food), and enabling services focus on "helping families negotiate access to the supportive services offered by agencies and institutions" (p.28). The study results show that soft services were the most frequently provided services, followed by enabling services. Hard services rarely were provided, however, largely due to budget cuts. The findings indicate also that there was no significant association between the total amount of time spent with the families and their severity of risk. Yet, in a 3 month follow-up, 90% of the families were still intact (Berry, 1995).

While Berry's study has several methodological limitations (Berry, 1995), its merit is mostly in stressing the importance of tracking provision of the different types of services. Unlike the expectation that a short-term treatment would emphasize provision of hard services and that workers will spend more time with the neediest families, the contradictory findings suggest that workers were not practicing the model as intended. Berry thus recommends further training for workers that include clarifying the principles of the IFPS model (Berry, 1995).

Another evaluation study of family preservation services in four different locations in the Netherlands (Brink, Veerman, Berger, & Kemp, 2000) depict the components of the intervention model from both theoretical and practical perspectives and examines if the program was carried out in practice as prescribed by the program model. The researchers provide detailed and specific information on the various components of the treatment model, including the length and duration of treatment, the availability of services, and the specific techniques and guidelines that were used. They found that most workers were following the treatment model (Brink et al., 2000). Tracking the workers' adherence to the treatment protocol also enhanced their ability to interpret data on the outcomes of the services. Moreover, when deviations from the model were detected, the workers' training was revised accordingly.

Henggeler and his colleagues (1992; 1997) studied the effects of family preservation using multi-systemic therapy (MST) with violent and chronic juvenile offenders and their families. Workers', parents', and adolescents' reports assessed adherence to the treatment model. Despite differences in the characteristics of the population served, the general goal of MST is similar to other intensive home-based programs, which is to maintain the adolescents safely with their families and to reduce and prevent future incarceration and arrest.

Henggeler et al. (1997) show that adherence to the MST treatment principles has a major role in attaining desired outcomes regarding adolescents' criminal activity. In an earlier randomized trial of MST with juvenile offenders in a controlled setting, MST cases had fewer arrests and a reduction in incarceration (Henggeler, Melton, & Smith, 1992). A subsequent study of MST, conducted in natural field conditions, did not find a significant change in arrests and incarceration (Henggeler et al., 1997). But, the researchers found that cases with greater adherence to the MST model attained substantially better outcomes. They argue that workers received intensive support to maintain integrity in the controlled study, while workers in the field study did not receive

any additional support to increase adherence to the model. Based on their analyses, they conclude that drift from the treatment model was related to undesired outcomes concerning the adolescents' criminal activity and incarceration (Henggeler et al., 1997).

In summary, despite the scarce empirical reports in the literature on IFPS, the positive effects of adhering to treatment practice guidelines and the theoretical model are well documented. Outcome studies, and especially those that concern controversial models of interventions, should provide information not only on the outcomes (i.e., measures and procedures) and the problems (i.e., population characteristics and diagnosis), but also on the interventions both as they were intended and as they were eventually implemented. This type of information is crucial to a fair and more accurate interpretation of the results of outcome studies.

The Research Problem

In this paper, we present an example of assessing treatment integrity in a study of home-based, intensive family preservation services. The services are funded by the state and implemented by private agencies. The contracts with the agencies stipulate the intervention model to be implemented, which is very similar to the Homebuilders model (Kinney, Haapala, & Booth, 1991). The study was conducted in a midwestern metropolitan area. To ensure adequate acquaintance with the treatment model, only "mature" IFPS programs that had been in existence for at least 6 months were included in the study.

Like most IFPS programs, these too follow a complex intervention model which includes a combination of required structural components and flexibly selected treatment strategies (McCroskey, 2001). The assessment of treatment integrity focused on the structural components of the treatment – that is the components that are defined by the structure and tenets of the intervention model and thus are shared by all the workers and considered to be the foundation of the model. For example, caseload size should be limited to 2 cases per worker at any given time, and the length of service limited to 4 to 6 weeks. Such components also were identified in previous studies (e.g., Berry, 1995; Brink et al., 2000; Della Toffalo, 2000). Within the confines of these structural components, workers are encouraged to select from a long list of hard and soft services or intervention strategies to tailor an intervention to meet the specific needs of each family. Thus, the structural components are viewed as the essence of IFPS and provide a critical indicator of treatment integrity.

The family preservation programs studied here follow a detailed manual that describes the process of treatment and documents its structural components (Families First Michigan, 2002). Documentation of services delivered is part of their routine case report. In contrast, the regular services that are provided by the state's public child welfare agency are described in broad, general terms and workers deliver them in many forms. Hence, we assumed that services delivered by IFPS workers differed from those delivered by the foster care (FC) workers at least with regard to the structural components of the treatment.

The purpose of this article is to suggest a procedure to assess the treatment integrity of complex intervention models. More specifically, we examine whether: 1) IFPS workers deliver services as intended; and 2) IFPS are markedly different from FC services.

28· Anat Zeira, Betty Blythe, and Anita Reithoffer

Method

Case Assignment

The appropriate target for IFPS are families who are at imminent risk of having one or more children removed into protective services. Because previous studies of IFPS were criticized for including lower-risk families in their sample, we wanted to be sure that the imminent risk criterion was met. Thus, cases for the study were drawn from the families in which a family court judge or referee had authorized an initial petition for removal of the children and randomly assigned the child to IFPS or FC. To ensure that the child could be safely maintained at home, should the case be assigned to the IFPS condition, we followed a meticulous process that involved several professionals working together over a short period of time. When asked, most of the workers in our study (92.2%) thought that their cases were an appropriate referral for the program. Families in both conditions could refuse to participate in the study but still receive services. In addition, families in the IFPS condition could refuse to receive family preservation services, in which case the child would go into foster care.

Sample

As mentioned earlier, this investigation is part of a larger outcome study that compared IFPS and FC. Of the 202 families participating in the outcome study (120 families in IFPS and 82 families in FC), due to administrative reasons we could track data pertaining to treatment integrity on 75% of the families. Our sample thus is comprised of 103 families receiving IFPS and 48 families receiving FC services.

In general, the workers in the two conditions had similar socio-demographic characteristics. The majority of the workers in both groups were female (66.3% in IFPS and 83% in FC). Most were caseworkers (89.8% in IFPS and 88.9% in FC), an additional 8.7% of workers in IFPS were supervisors and 6.3% in FC were intake workers. The vast majority held a bachelor's degree (88% in IFPS compared with 79.5% in FC) and some workers had a master's degree (11% in IFPS vs. 15.9% in FC). Most of the workers in both conditions were African American (70.9% in IFPS vs. 58.1% in FC), although more FC workers were Caucasian (11.7% in IFPS vs. 35.9% in FC). On average, IFPS workers had worked for the agency for 30 months (SD=33.4) with a range of 1 to 240 months and a median of 19 months. FC workers had worked for their programs between 3 and 96 months, with the mean of 34.3 months (SD=28.1) and a median of 24 months.

Workers in the two conditions had very different numbers of children in their caseloads. IFPS workers carried caseloads of 1 to 17 children with a mean of 5.1 (SD= 3.16) and a median of 5 children. At the same time, FC workers had caseloads ranging from 10 to 57 children with a mean of 29 (SD= 10.3) and a median of 27 children. In accordance with the IFPS model, the vast majority of IFPS workers (94%) did not carry more than two families at the same time.

Procedure

To reduce the interruption to routine practice, treatment integrity data were collected in a different manner from workers in each condition. IFPS workers completed

the treatment integrity questionnaires at the conclusion of each case, which was 4 to 6 weeks after the services were initiated. Slight adjustments were made to the questionnaire for the foster care workers and it was administered orally, over the phone, approximately 6 weeks after FC services were initiated.

Measurement

The integrity of treatment was measured by a structured, self-report, mostly closed-ended questionnaire that was based on a questionnaire already used by IFPS programs. The questionnaire was pre-tested on a sample of cases and slightly revised as a result of feedback from workers. Workers in each condition were presented with a series of items that describe the services provided and the participants in three areas. The first area includes items on the characteristics of the family and the nature of the specific case. For example, data were collected about whether the parents or children faced such issues as domestic violence, substance abuse, unsafe housing, loss of a family member, or loss of income. The second area refers to specific components of the services provided, such as length of treatment, amount of face-to-face time spent with the family, and flexible funds spent for the family. Items in the third area pertain to the workers' demographics, such as gender, race, education, and current position. Most of the information collected by the treatment integrity questionnaire should be part of any case record. Moreover, IFPS workers routinely provided similar information on all of their cases. The structural components are straightforward and their operational definition is self explanatory. Therefore, we do not expect that the differential data collection procedures affected the quality of the data.

Results

Before presenting the findings on the services provided by FC and IFPS, we compare the characteristics of the families in the two conditions. As described earlier, the criterion of imminent risk was met while assigning cases to the study. Because families had to meet the regular IFPS screening criteria (e.g., children could be safely maintained at home with an intensive intervention), the level of risk is assumed to be similar in both conditions. First, we describe the sample characteristics of the families in the two conditions. We then compare the services provided to families in each condition.

Family Characteristics

Families in the two conditions are fairly similar with regard to their socio-demographic characteristics. Table 1 presents the family characteristics for the participants in each condition. The only statistically significant differences were in the mother's race. As can be seen in Table 1, there were significantly more white mothers in FC and significantly more African-American mothers in IFPS ($\chi^2 = 9.9$, df=3, p=.04).

We also asked the workers to specify if they encountered any of the following issues regarding the parents' or the children's mental and physical condition during the intervention period: substance abuse, serious communication disorder, mental illness, physical disability or serious illness, sexual abuse and mental retardation. The participants in the two conditions shared similar characteristics with regard to those issues. Substance abuse was the only issue with a significant difference, with 43.8% of

30· Anat Zeira, Betty Blythe, and Anita Reithoffer

the parents in the FC condition experiencing substance abuse as opposed to 17.5% of the parents in IFPS ($\chi^2 = 12.3$, df=1, p= .006). See Table 1, pg. 36.

Workers also were asked to indicate if families experienced domestic violence, homelessness, threat of loss of home, unsafe neighborhood, unsafe housing, or loss of family income. Significant differences between families in IFPS and FC were only found in one area. Domestic violence was experienced by 33.3% of FC as compared to 13.6% of IFPS families ($\chi^2 = 9.1$, df=1, p= .028).

First Contact

IFPS workers contacted the vast majority (79.6%) of the families within 24 hours of the referral, as prescribed by the treatment model. Another sixteen families (15.5%) were contacted later because they were not available to meet the worker immediately due to work or other obligations. Data on first contact were not available on five (4.8%) additional families. While the majority of the first contacts with IFPS families were made within 24 hours of the case referral, FC families were contacted for the first time an average of 22 days (SD= 25.9) after referral. Only 1 FC family was contacted within 24 hours and 20.9% of the families were contacted 1 month or later.

Intensity and Length of Treatment

The duration of treatment for all IFPS families was within the model's guidelines and lasted between 6 to 44 days, with an average of 27 (SD= 7.5) days. The range of the total time IFPS workers spent with families was 9.5 to 217 hours and the median was 60.5 hours. Several of the families whose problems were described as more severe by the workers stayed in treatment longer (r = .22, p< .05). While IFPS families received services mostly during traditional hours (i.e., 8:00-5:00 on weekdays), workers also spent a substantial amount of time with families during non-traditional hours on weekdays and on weekends. Altogether, workers spent an average of 12.3 (SD= 10) hours in face-to-face meetings and 36 (SD= 61.2) minutes on the phone with families during non-traditional hours.

All FC cases still were open at the time of data collection (approximately 6 weeks after case was assigned to the study). Yet, IFPS workers spent significantly more time with families than FC workers. On average, they had 66 (SD= 31.4) hours of face-to-face contact with families as compared to 4.7 (SD= 7.7) hours for FC workers (t= 17.4, p< .000). No significant differences were found with regard to the average time workers in both conditions spent with families on the phone (106.9 minutes in IFPS and 95.6 phone minutes in FC).

Service Characteristics

Our findings show that most of the IFPS families had meetings with workers during weekends (68%) and after hours on weekdays (89.3%), whereas only one FC family (2.1%) was visited during the weekend and 15 FC families (31.2%) met their workers on weekdays after hours.

In accordance with the IFPS treatment model, the vast majority of the workers (94%) had a caseload of two families at a time. Moreover, very few meetings with the families were held in the agency's office (11.8%). While all IFPS families had a plan in place so they could reach the worker 24 hours a day, only 40.4% of FC families had such plan in place ($\chi^2 = 53.9$, df= 1, p= .000). About one third of the IFPS families made crisis calls to workers during the course of treatment.

The vast majority (93.2%) of IFPS families participated in developing the treatment goals. The equivalent process in FP is to develop a parent/agency agreement. Less than one-third (29.2%) of the FC families had such an agreement. Moreover, only one-half of these agreements were accepted by the court. This may indicate that the agreements do not reflect a true harmony between the worker and the family vis-à-vis the treatment goals.

Provision of Funds

Use of flexible funds enables workers to provide immediate help to the families in different areas (Berry, 1995). Workers were asked to indicate the extent and nature of use of the flexible funds that are available for families and that are part of the specific services of IFPS. The findings indicate that nearly three-fourths of the IFPS families (73.8%) received some form of these flexible funds, ranging from $2 to $2,190 with an average amount of $304 (SD=422) per family. At the same time, only three (6.4%) FC families received some form of funds directly from their FC workers.

Table 2 presents the amount of dollars provided to IFPS families by the type of fund. Funds were most often provided for recreation, housing (rent/deposit), furniture and/or appliances, and groceries. Less frequent expenditures include funds for household repairs, cleaning or maintenance, transportation, substance abuse (treatment or screening), utilities, personal care items, and clothing. Other types of flexible funds (e.g., baby products, day care, state documents and medications) were given to 29.1% of the families.

Most of the families in both conditions were referred to and received a wide range of other services (86.4% in IFPS and 81.2% in FC). Table 3 compares the percentages of families receiving services in each condition by type of service. One in every two FC families and one in every three IFPS families received parent training. Public income support was provided to one in five families in both conditions. Other frequent services were health care and outpatient mental health counseling for FC families, and childcare or babysitting and housing to IFPS families. As can be seen in Table 3, significant differences between conditions were found in several types of services. More IFPS families received childcare or babysitting, financial assistance for housing, family planning, household management, housing services, SER, and recreational services. In contrast, more FC families used parent training, drug treatment, health care, and inpatient mental health services.

There was no significant difference in the mean number of different services provided to families. On average, families in IFPS received 3.8 different services and FC families received 3 services (t= .72, N.S.). The median number of services per family, however, was three for IFPS and two for FC. Furthermore, 21.4% of the IFPS families received five or more different services compared with 16.8% of the FC families ($\chi^2 =$ 20.9, df =12, p= .052). See Tables 2 and 3, pgs. 37 and 38.

Discussion

Adhering to treatment protocols has been recognized as essential to concluding that effective outcomes can be attributed to a specific intervention (Dunbar-Jacob & Schlenk, 1996). Assessment of treatment integrity thus is fundamental to a valid study of the efficacy of intervention protocols. As part of a larger outcome evaluation of family preservation services, this study examined whether IFPS workers delivered services

32·Anat Zeira, Betty Blythe, and Anita Reithoffer

according to the treatment guidelines, and if these services were markedly different from those delivered by the foster care services offered by the state.

Our findings indicate that IFPS workers implemented the critical structural components of the model as intended. The overall length of the treatment was brief and intensive. During the intervention period, IFPS workers were available 24 hours per day. Most of the intervention took place in the family's home during and after office hours. Families were involved in setting the treatment goals and IFPS workers supported families with both "hard" services (i.e., flexible funds) and "soft" services (i.e., parent training) to increase their ability to keep the children safely at home. These findings are consistent with the literature that describes intensive family preservation interventions (c.f., Berry, 1995; Blythe, 1990; Craig-Van Grack, 1997; Kinney, Haapala, Booth, & Leavitt, 1991; Lewis, 1991).

Because some observers expressed concern that FC workers who knew they were part of an outcome study might change their practice, the study compared the key elements of IFPS with those of FC services. Our findings show that, despite the resemblance in family and worker characteristics in both conditions, IFPS were markedly different from FC services. For example, families receiving services from FC workers were engaged in significantly longer treatment. In fact, after 6 weeks – the longest treatment allowed by the IFPS model – all FC cases were still open. In addition, many IFPS workers met families during weekends and evenings while the majority of FC workers met with families during traditional weekday hours. We also found that most IFPS families received funds to improve their housing and enjoy recreational activities. At the same time, FC families seldom received funds for such things. Finally, in most cases IFPS workers made greater use of other available services than did FC workers.

While this study of treatment integrity does not attempt to ascertain which services yielded more favorable outcomes, it does provide empirical evidence that IFPS was implemented in accordance with underlying treatment model and different from the alternative foster care services. Thus, it strengthens the internal validity of outcome research on IFPS and increases the likelihood that successful treatment can be ascribed to the IFPS intervention (Craig-Van Grack, 1997; Henggeler et al., 1997).

Data on adherence to a treatment model can be collected directly from workers or by means of observation (Gresham et al., 2000). Observation may involve unreliable interpretations by the observer while self-report may be subject to social desirability biases. Data collection in this study was accomplished by asking the workers to report on their activities. For the IFPS workers, this reporting was integrated into their routine activities and occurred regardless of the study. FC workers were interviewed retrospectively, by phone. We believe that these data collection procedures -- despite their differences -- eliminated biased reports for both conditions and yielded a reliable picture of the services provided. For instance, our findings indicate that services matched the population characteristics (e.g., substance abuse was significantly more prevalent among FC families and, subsequently, we found that more FC families were referred to drug treatment).

The focus of this study was on the structural components of the treatment. By definition, these components are easier to operationalize and measure. At the same time, the structural components represent key elements of IFPS. We examined only the components that were possible under the circumstances (cost, time, etc.). Our study did not include specific intervention strategies or techniques employed by the workers in both conditions. Even by measuring only the structural components rather than specific

intervention strategies, the findings provide a good estimate of whether the treatment as a whole was delivered according to the model as delineated in the manual.

IFPS models use a wide range of hard and 'soft' services or intervention techniques depending on the goals that workers set with the families (e.g., anger management, negotiation skills, specific parenting skills, hanging bedroom doors, cleaning kitchens, and training in budgeting, just to name a few). Because of the large number of different techniques and the variability between different IFPS models, any attempt to examine treatment integrity with regard to the specific intervention techniques would require a large sample and be very costly. Workers' difficulties with reporting detailed information on specific interventions employed also may inhibit such examination (Hayes & Gregg, 2001). Many social work interventions are as complex as IFPS and the approach described here offers a beginning point for assessing their integrity as part of larger experimental studies. Nevertheless, we agree with Craig-Van Grack's (1997) suggestion that future research should attempt to address other elements of the model such as specific intervention techniques.

In order to promote procedures for maintaining adherence to the treatment model, we suggest that agencies provide intensive initial training in the intervention procedures followed by on-going "booster" training sessions (Gresham, 1997). Treatment manuals must be sufficiently specific to allow such training and systematic recording of workers' activities. Including treatment integrity protocols as part of daily practice also will enhance adherence to the model.

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34· Anat Zeira, Betty Blythe, and Anita Reithoffer

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36· Anat Zeira, Betty Blythe, and Anita Reithoffer

Table 1: Family Characteristics of the Participants in the Two Conditions

	IFPS (N=103)	FC (N=48)
Child's Gender	59.8% boys	45.8% boys
Child 's Mean Age	7.4 (SD=4.5)	6.7 (SD=5.4)
Mother's Mean Age	31 (SD=7.6)	30.7 (SD=7.2)
Father's Mean Age	41 (SD=7.3)	37.6 (SD=7.2)
Caretaker's Mean Age	41.8 (SD=11.3)	41.5 (SD=11.4)
Total Household Income		
$0	1.9%	2.1%
$1-4,999	28.2%	29.3%
$5,000-9,999	26.2%	29.2%
$10,000-19,999	16.5%	14.6%
$20,000+	21.4%	16.6%
N/A	5.9%	8.3%
Mother's Race		
African American	68.9%	42.6%
White	12.6%	27.7%
Hispanic	1.0%	2.1%
Other	2.9%	6.4%
N/A	14.6%	21.3%
Father's Race		
African American	6.3%	2.9%
White	N/A	5.8%
Hispanic	N/A	N/A
Other	2.1%	N/A
N/A	91.7%	91.3%
Mother living with child prior to hearing	6.2%	70.8%
Mother is the primary caretaker	81.6%	72.9%

Table 2: Dollar Amount Spent on IFPS Families by Type of Fund

Type of fund	Percentages of families receiving funds (N= 103)	Range ($)	Mean ($)	SD ($)
Recreation	21.4	1-125	5	15
Housing- rent / deposit	19.4	16-1,400	130	302
Furniture / appliances	18.4	40-891	58	155
Groceries	18.4	4-235	12	36
Household repairs	12.6	25-611	27	93
Transportation	9.7	2-330	5	33
Substance abuse – treatment / screening	9.7	10-80	3	12
Utilities	8.7	11-1,095	33	142
Personal care items	7.8	6-138	4	17
Clothing	6.8	11-312	8	41
Legal documents	3.9	2-41	1	4
Other (e.g., day care, medications)	29.1	1-430	20	66

38· Anat Zeira, Betty Blythe, and Anita Reithoffer

<u>Table 3</u>: Percentages of Families in IFPS and FC by type of service

Type of Service	Percentage of IFPS Families (N=103)	Percentage of FC Families (N=48)	χ^2 (df=1)
Parent training	33.0	48.9	3.4*
Childcare or babysitting	24.3	10.6	4.1**
Public income support	22.3	21.3	N.S.
Housing services	21.4	10.6	2.7*
Outpatient mental health counseling	20.4	14.9	N.S.
Financial assistance for housing	19.4	6.4	4.8**
Family planning	19.4	6.4	4.8**
Food assistance	17.5	10.6	N.S.
Help with education	17.5	12.8	N.S.
Household management	16.5	6.4	3.2*
Self-help groups	14.6	10.6	N.S.
SER	12.6	2.1	5.3**
Recreational services	12.6	0.0	12.6**
Drug treatment	9.7	31.9	10.7***
Alcoholism treatment	8.7	8.5	N.S.
WIC	7.8	6.4	N.S.
Food stamps	6.8	10.6	N.S.
SSI	6.8	2.1	N.S.
Health care	6.8	17.0	3.5*
Job training	3.9	8.5	N.S.
Emergency financial assistance	3.9	2.1	N.S.
Health assessment	3.9	2.1	N.S.
Legal aid	2.9	4.3	N.S.
Emergency shelter	1.9	6.4	N.S.
Respite care	1.9	4.3	N.S.
Inpatient mental health	0.0	6.4	7.1***

* $p < .09$
** $p < .05$
*** $p < .01$
N.S.   not significant

Post-Permanency: An Assessment for Families'
Needs for Services and Supports

Madelyn Freundlich, Rosemary J. Avery, Sarah Gerstenzang, and Sara Munson

This article reports the results of a qualitative study that sought the perspectives of birth parents and adoptive parents following reunification or adoption of children from foster care. Using a participatory action design that actively involved young adults formerly in foster care and parents in the design and implementation of the study, the study focused on the consumers' perspectives on several issues related to permanency. The article reports findings from interviews with a subset of 27 birth and adoptive families in New York City who were asked about their post-permanency experiences and from interviews with 38 child welfare professionals who were asked to respond to the parents' perspectives. The article offers directions for child welfare practice and program development.

Key words: Post-permanency, adoption, reunification

Introduction

Although permanency planning and achieving permanency have been areas of focus in child welfare since the 1980s, post-permanency outcomes have received limited attention. Less emphasis has been placed on the experiences of families after reunification, the permanent placement of children with relatives, or adoption (Freundlich & Wright, 2001). Since the enactment of the Adoption and Safe Families Act (ASFA) in 1997, there has been a heightened focus on permanency for all children in the child welfare system, and increasing numbers of children are achieving permanency within shorter time frames. ASFA, however, addresses the achievement of permanency and not the quality of children's and families' experiences following reunification with their birth families or adoption. Increasingly, permanency has come to be understood not simply as an event but, instead, as a process that involves a range of issues related to the well-being of children and families over time, even into the post-permanency period (Freundlich & Wright, 2001). The issues include safety considerations that can result in a child's return to foster care, the child's psychological and social well-being, and the family's overall health and functioning. When permanency is viewed as a process, an understanding of families' post-permanency experiences and needs for services and supports becomes more important to consider as part of permanency planning (Freundlich & Wright, 2001).

Recognition of the need for post permanency services and supports is not a new concept. There has been emphasis on post adoption services and supports, coupled with a recognition that children with special physical, mental health and developmental needs and their adoptive families are likely to need ongoing help in the post-permanency period (Barth & Berry, 1988; Kramer & Houston, 1999). The same attention, however, has not been given to service and support needs of parents who are reunified with their children or to the needs of relatives who assume permanent responsibility for children formerly in

40·Madelyn Freundlich, Rosemary J. Avery, Sarah Gerstenzang, and Sara Munson

foster care (Freundlich & Wright, 2001). The needs of these families, as well as the needs of adoptive families, continue to be areas requiring greater understanding.

The qualitative study described in this article focused on the post-permanency experiences of families served by the New York City foster care system. The study utilized interviews with parents of children formerly or currently in foster care, young adults formerly in foster care, adoptive parents of children formerly in the City's foster care system, and child welfare professionals. This article reports on the results of interviews with a subset of birth parents who had been reunified with their children and parents who adopted children from the City's foster care system, as well as interviews with child welfare professionals who responded to these parents' views of the quality of post permanency services and supports. It provides a brief review of the research literature related to post permanency services and supports and then describes the results of the interviews. It concludes with a discussion of the findings and directions for future practice in this area.

Literature Review

Each year, approximately 280,000 children leave foster care nationally (U.S. Department of Health and Human Services, [US DHHS], 2005). Most children leave care to be reunited with their birth families: in 2003, more than one-half (55%) of the children leaving care returned to their parents and another 11% left care to live with relatives (US DHHS, 2005). Slightly less than one-fifth (18%) of the children who left care in 2003 were adopted and another 4% left care to guardianship arrangements (US DHHS, 2005).

Since 2000, the research literature has given greater attention to post-permanency outcomes for children and families and the need for post-permanency services and supports (Pecora et al, 2000; Casey Family Services, 2001; Christian, 2002; Casey Family Services, 2003a). Although the success of permanency arrangements can be considered along a range of dimensions (Freundlich & Wright, 2001), post-permanency success has been assessed primarily in terms of rates of reentry to foster care. Research suggests that reunification is generally successful, but a significant percentage of children, ranging from 10% to 33%, return to foster care after being reunified with their parents (Fein & Staff, 1993; Thomlison, 1997; Terling, 1999; Frame, Berrick, & Brodowski, 2000). The success of adoption, similarly, has been assessed in terms of rates of disruption (before legal finalization) and dissolution (after legal finalization). Studies suggest that disruption rates range from 10% to 25% for children with physical, mental health, and developmental difficulties (Festinger, 1990; Berry, 1997; Goerge, Howard, Yu, & Radomsky, 1997). Adoption dissolution occurs far less often. One study indicated an adoption dissolution rate of 6.6% from a sample in Illinois (Goerge et al, 1997) and another found a 3.3% dissolution rate from a sample in New York City (Festinger, 2001). There have been few studies focused on the success of permanent kinship care arrangements, particularly, subsidized guardianship, but these studies indicate that these permanency arrangements are as stable as adoptions, with disruption of guardianships ranging from 10% to 16% (Barth, Gibbs, & Siebenaler, 2001; Cornerstone Consulting Group, 2001).

With regard to the factors associated with post-permanency success, the research literature generally has focused more on placement stability than on the quality of children and families' experiences. With regard to adoption, several studies have found that children with special needs, particularly behavioral challenges, emotional problems, and developmental or physical disabilities, account for a disproportionate number of

adoptions that disrupt (Barth & Berry, 1988; McDonald, Propp, & Murphy, 2001; McGlone, Santos, Kazama, Fong & Mueller, 2002). Similarly, children's emotional and behavioral problems have been associated with the likelihood of reentry to foster care following reunification with their parents and with the disruption of placements with relatives (Thomlison, 1997; Terling-Watt, 2001). Studies also have found a relationship between post-permanency stability and the stability of children's placements while they are in foster care (Goerge & Wulcyzn, 1990; Webster, Barth, & Needell, 2000), as well as the length of time that children remain in care (Pinderhughes, 1998; Wells & Guo, 1999). Other research has found higher rates of reentry from reunification for older children and African-American children (Jones, 1998; Thomilson, 1997; US DHHS, 2001a, 2004a).

The research literature further suggests that post-permanency instability is associated with certain family circumstances. Reunification has been found to be undermined by inadequate housing, economic problems, poor parenting skills, maternal criminal activity, domestic violence history, and substance abuse (Fein & Staff, 1993; Jones, 1998). Specifically, research indicates that reunified families experience considerable stress when rebuilding relationships after separation and that the continued presence of some of the conditions that led to the initial removal of children from their families may exacerbate the stress they experience during this transition (Festinger, 1996; Taussig, Clyman, & Landsverk, 2001). Permanent kinship placements appear to be at risk when caregivers experience declining health and stressors associated with birth parents' involvement (Terling-Watt, 2001). Studies suggest that adoption disruption is associated with adoptive parents' higher educational attainment and higher parental expectations (Pecora, Whittaker, Maluccio, Barth, & Plotnick, 2000; US DHHS, 2001b), while adoption stability appears to be related to marriage longevity and prior experience fostering children (Westhues & Cohen, 1990; Barth & Berry, 1991). Adoptive parents' commitment to the child and parent-child compatibility in terms of personal attributes also have been found to influence adoption success (Flynn, Welch, & Padgett, 2004).

The literature particularly has highlighted the importance of post-adoption supports and services in contributing to permanency, including information, clinical services, basic needs assistance, and support networks (Barth & Berry, 1991; Barth et al, 2001; McGlone et al, 2002). Specifically, adoptive parent support groups, adoptive parent training, and the provision of children's health and other background information have been found to play key roles in successful, stable adoptions (Marcenko & Smith, 1991; Avery, 2004). Other services, including medical and dental care, recreational opportunities, counseling, special education, and employment, financial, and housing supports also have been identified as relevant adoptive family supports (Fein & Maluccio, 1992; Adams, Howard, & Kelly, 1995; Festinger, 2002).

Far less has been written about post-reunification services and services to relatives who assume permanent responsibility for children formerly in foster care. The limited research literature suggests that although families' needs for services post-permanency may vary, families often need therapeutic services, substance abuse counseling, crisis intervention, income support, job training, access to insurance, housing assistance, day care, support groups, and other services (Dougherty, 2004; Wulczyn, 2004). The federal Child and Family Services Reviews, however, indicate that these reunification support and services are not consistently provided. Insufficient and/or inadequate post-reunification services were noted to be one of the "common challenges" confronting the 35 states reviewed during 2002 to 2004 (US DHHS, 2004a). More than

42·Madelyn Freundlich, Rosemary J. Avery, Sarah Gerstenzang, and Sara Munson

one-third of the states (37%) were found to offer insufficient support and services for families after reunification (US DHHS, 2004a).

Study Objective

This study was designed to achieve a clearer understanding of the post-permanency experiences of birth families and families who had adopted children from the New York City foster care system. The views of birth and adoptive parents were sought regarding their post-permanency experiences, including the extent to which needed services and supports were available. The study further sought child welfare professionals' responses to families' perspectives on their post-permanency experiences and needs in order to further enrich the understanding of post-permanency needs for services and supports in New York City.

Method

The study utilized a participatory action design (PAD) involving young adults formerly in foster care, parents who had been reunified with their children, and adoptive parents in crafting the design and implementation of the study, the analysis of data, and the development of recommendations (see Allen-Meares, Hudgins, Engberg & Lessnau, 2005; Coughlan & Collins, 2001). The research was conducted in four phases: collaborative development of the four domains guiding the data collection and analysis; selection of an interview sample and conducting of interviews; identification of patterns and issues within and across respondent groups through content analyses; and verification, corroboration, and sharing of the study's findings.

To develop the study domains, exploratory discussion groups were held with young adults, birth family members and adoptive parents to learn directly from these individuals the issues on which the study should focus. To ensure an appropriate study design, identical eligibility criteria were used for exploratory discussion group participants and for interview respondents. Participants in all exploratory discussion groups provided written informed consent prior to participation. All received a cash stipend. Each group was conducted using an established protocol, and all interview protocols were translated into Spanish. All groups were audiotaped with the participants' written agreement; the content was transcribed; and the key issues raised by parents and adoptive parents were identified. This analysis provided the foundation for the development of interview protocols that were approved by the study's Institutional Review Board.

The interview protocols used a semi-structured format organized around the study's four domains: the meaning of permanency, permanency goals and options, the permanency process, and post-permanency experiences. The protocols incorporated a series of open-ended questions designed to explore the respondent's experiences. With regard to the fourth domain, "Achieving Permanency and Post Permanency," the focus of this article, questions probed the experiences of parents once their children had been returned to them or they had adopted. Birth and adoptive parents were asked about the quality of their lives with their children since reunification or adoption, the extent to which they needed and received services, and the key supports in the families' lives.

Adoptive parents also were asked about the extent of contact with children's birth families and their experiences with openness, if relevant.

In addition to one-on-one interviews with young adults who had exited the New York City foster care system in the past five years (n=30), interviews were conducted with family members who either had a child in care at the time of the interview or had been reunified with their child within the past five years (n=20), and adoptive parents who had adopted or were in the process of adopting a child from the New York City foster care system in the past five years (n=21). This article reports on findings regarding families' post-permanency experiences based on interviews with a subset of 11 parents who had been reunified with their child within the past five years and a subset of 16 adoptive parents who had finalized an adoption of a child from the New York City foster care system in the past five years. Written informed consent was obtained from all respondents.   All interviews were audiotaped after receiving respondents' written permission to do so. All interviewees were paid a $25 stipend for their participation.

Respondents were located through a snowball sampling technique with multiple starting points. A random sample was not sought given the qualitative nature of the research and the study's focus on exploring experiences in-depth. Although the use of a snowball sampling technique limited the generalizability of the findings, the use of a variety of starting points for drawing the sample helped to ensure that a range of experiences and viewpoints were included in the study. Parents and adoptive parents who met the research criteria were located by enlisting the help of organizations engaged in serving families. Once parents and adoptive parents were identified, they were contacted by phone, briefly told about the study, and invited to participate. All respondents came from the five New York City boroughs and had had contact with many different private child welfare agencies in the City.

The audiotapes of the all interviews, including the interviews with parents and child welfare professionals that are the focus of this article, were transcribed by two experienced transcriptionists who were specifically hired for the study. The tapes were transcribed using a two-reviewer sequential method, so that each transcriptionist reviewed and/or transcribed every interview. The first reviewer completed the first stage of the review by preparing a transcript of all interview content from the audiotape. The second reviewer completed the second stage by conducting a thorough review of the tape and the transcript for verification and refining purposes. There was an extremely high level of agreement between the two reviewers. In a small percentage of the reviews, the second reviewer added to the transcript content. In no case did reviewers disagree on interview content. This two-stage process enhanced transcript accuracy and reliability (c.f., Freundlich, 2003).

Data reduction and analysis were completed using N6 qualitative data analysis software. Research staff members each reviewed three to five transcripts from both respondent groups (birth parents and adoptive parents), compiling lists of analytic codes specific to each group's responses. These code lists were combined and expanded to create an initial coding scheme for each group. Each transcript was then coded using N6 software. As the transcripts were coded, the material was analyzed, and as new themes came to light, more codes were added. After all transcripts were coded, the data linked to each code were cleaned, organized, and highlighted so that patterns in responses could be seen clearly. The Principal Investigator reviewed and synthesized the highlighted data for each domain across the respondent groups, producing a rough narrative of the major patterns in the data, illustrated by verbatim quotes. The research staff who had conducted

44·Madelyn Freundlich, Rosemary J. Avery, Sarah Gerstenzang, and Sara Munson

the interviews and reduced and coded the data then reviewed this narrative for thoroughness and accuracy. Based on this iterative process, a summary of the findings for each respondent group was developed, detailing key themes for each study domain. Using summaries of findings as a guide, the research team developed a list of 11 preliminary cross-cutting themes, one of which is the focus of this article: the essential role of post-permanency services and supports.

The final phase of the research involved both validation of and elaboration on the preliminary themes illuminated by the study. This process involved several steps: a review of the preliminary findings by the study's Advisory Board; feedback groups with young adults, birth parents, and adoptive parents who had participated in the interviews in which they offered an assessment of the preliminary themes and assistance in developing the themes into the final research findings; and interviews with a diverse group of child welfare professionals who were asked to review, critique, and offer suggestions about the preliminary themes based on their own observations and experiences with families post-permanency in the New York City foster care system. The feedback groups with youth adults, birth parents, and adoptive parents, a critical component of the participatory action design, ensured the active involvement of consumers in the data analysis at the preliminary phase of analysis.

The child welfare professionals who were interviewed (which included directors of child welfare agencies and programs, community activists, judges, social workers, law guardians and private attorneys) were identified by research staff and the study's Advisory Board. Thirty-eight professionals contributed to the study, either through taking part in a discussion group (n=20) or through a personal interview (n=18). They were invited to comment on all cross-cutting themes that they found to be relevant, including the theme related to post-permanency services and support. All interviews were tape recorded after obtaining participants' written consent, and the interviews were transcribed using the two-stage review process discussed earlier. Content analysis was conducted using N-6 qualitative data analysis software. The final data analysis included the results of the interviews with young adults, birth parents and adoptive parents and the results of the interviews with the child welfare professionals.

Study Results

The study elicited the views of parents, adoptive parents, and child welfare professionals regarding post-permanency issues.

Interviews with Parents

Eleven birth parents who had reunified with their children were interviewed. Most had more than one child formerly in foster care, with two parents each reporting having four children previously in foster care. Parents indicated that their children entered foster care for a variety of reasons, including parental drug- or alcohol-related problems, parental arrest or incarceration, physical abuse of the children, and child neglect. In some cases, parents reported more than one of these factors. Parents reported that their children had been in foster care from a minimum of three months to a maximum of almost six years. None of the children had been in foster care more than once. While in care, the majority of the children lived with foster families or with relatives, with only three parents reporting that their children were placed in a group home or residential treatment center. Ten of the parents reported that their children who had been in foster

care were living with them at the time of the interview. Three parents reported having additional children who had not entered foster care.

In connection with their experiences since their children returned to them, parents were asked, "How have things been for you since your child/ren left care?" No parent appeared ambivalent or regretful regarding his or her child's return. Most parents reported that all was going well. One parent, for example, stated:

> *"So good. I'm so happy. . . . I just look at her everyday and I still can't believe it." "Well, I feel much better, you know what I'm saying? And I'm happy that my daughter came out of care but now I'm focusing on getting my son out of care."*

Some parents, though happy with their lives since their children had returned to them, nonetheless reported a level of stress in their lives, commenting on the challenges and hard work related to reintegrating their children into their lives. For example, one parent commented:

> *"Well, you want them back home but once you get used to that serenity,…so you get used to cleaning the kitchen and its stays clean. You get used to mopping and there's no juice spilled on the floor…So once they come [home], it's like . . . 'awww', so you have to [do a lot], it's hard. It's not that it's not joyous, but it's hard. You're dealing with different children when they come home. . . . It takes a while to establish . . . ground rules."*

Parents also spoke about the lingering impact of their children's removal from their care and the associated trauma for the family, including, in some cases, fears that the children might be taken from them again and placed into foster care. In this regard, parents, for example, said:

> *"[Things are] way better, way, way better. But it's still scary because they [the public child welfare agency] got away with it one time. I always worry."*

> *"But when they first came home, it was really scary for me. I wouldn't even raise my voice. My voice was at such a low tone that they would like, Huh, what did you say? Because I was so nervous, like, if I yell, you know, that they're going to come take my children away again. I was really nervous for a long time."*

Some parents spoke about their children's trauma due to the removal and time spent in foster care as well as children's fears that parents might again have serious problems. One parent, for example, stated that her daughter was thriving, but that her son was having difficulties:

> *"Like I said, everybody's individual, some can get over it. My son's like, when he walks his feet is like dragging. He shuffles. He's dragging when he's talking."*

Other parents referred to their children's confusion when they returned home, particularly when they were very young when they were placed in foster care. One parent, for example, said:

46·Madelyn Freundlich, Rosemary J. Avery, Sarah Gerstenzang, and Sara Munson

> *"In the beginning it was really, really kind of hard. Because I had to deal with my son's attitude, my baby son, he's only 5 now, so he really, he probably knows, but he really can't express it, like my older son could."*

Parents also were asked about the services they were receiving and what services they felt they needed. Some parents reported that they and/or their children were receiving counseling and other preventive services, which they viewed positively. Other parents reported that they had received support from their partner and/or their family. Six of the eleven parents, however, stated that they had experienced problems obtaining services, including educational services, counseling, health and health care insurance for their children. One parent, for example, stated:

> *"The Medicaid coverage was done very poorly and I didn't have medical coverage for [my daughter] and she was taking medication so when the medication ran out I had to go to the agency for them to do whatever they had to do and for me to get another set of pills."*

Another parent reported difficulties accessing respite care:

> *"It's funny, I kind of feel again like I'm stuck at ground zero. . . . I mean like one of my biggest things with [the public child welfare agency] and [the private agency] was requesting for respite care, homemaking services, something to help like two days out of the week . . . And they just made it very, very clear that they don't offer that. . . . This is very frustrating."*

Some parents made it clear that they did not want aftercare services if they were provided by the public child welfare agency or the private agency to which their cases had been assigned. Parents, for example, said:

> *"I just wanted it to be over. I didn't want anything to do with them. I didn't want them in my house."*

> *"I don't want no more services. I just want to be left alone and get a job and live my life normally."*

One parent, however, expressed frustration that the agency did not help her with post-reunification services:

> *"That's another beef that I have with the foster care system. I feel like kind of used. 'Cause it's like after the children came home...I haven't heard from my caseworker in, I don't know how long...does it hurt to pick up the phone just to see how the family that [the caseworker] helped reunited, how are they doing?... [The caseworker could say] 'give me a call and maybe I could connect you with someone.'"*

Interviews with Adoptive Parents

Individual interviews were conducted with sixteen adoptive parents who had finalized adoptions within the five-year period prior to the interview. In total, they had finalized 31 adoptions. Seven of the parents had adopted one child from foster care, eight adopted two or three children, and one parent adopted four children from foster care. Three of the parents adopted their children as recently as 2004, seven adopted in 2003, and six adopted during the 2000 to 2002 time period. The ages of the children at the time of adoption ranged from 3 years to 16 years old. The length of time the parents had their children before the adoption was finalized ranged from 1 year to 10 years. Most of the children who were adopted had siblings. Some of the children's siblings had remained with their birth parents or relatives or had been adopted by the adoptive parents or another family; a few of the children's siblings had remained in foster care or had aged out of foster care.

Adoptive parents were asked, "How have things been for you since you adopted your child?" Five adoptive parents were unequivocally positive about their lives with their children since adopting, reporting that life was *"good, good,"* and *"great."* Other parents reported that although things were going well at the time of the interviews, it had been a difficult transition. For example, one parent said, *"It was really overwhelming with the teenager part . . . but we got over it."* Two parents expressed some ambivalence about the adoption. One stated, for example, the hope that all would go well but also stated, *"I don't think it will get to the point where I don't want to be bothered with him at all."*

The adoptive parents generally were quite positive about their child/ren's progress since the adoption. Parents, for example, said, *"I feel good because I've brought them so far,"* and *" . . . I know he had this problem [destructive behaviors] before I adopted him, and I can say it is getting better."*

In connection with children's contacts with birth families since the adoption, ten parents reported some contact between one of their adopted children and their child's birth family and stated that they were supportive of those contacts. One parent, for example, highlighted the importance of family connections based on her own experiences:

> *"...Family is family. I came from a foreign land and I know how it is to always want to go back. You go back, you make that connection, but you know you don't want to stay. And I think it will be the same for them."*

When asked who had helped them since they adopted, adoptive parents identified a range of supportive people and services, with their families mentioned most frequently as key sources of support. Several adoptive parents described the helpfulness of community supports. Two adoptive parents focused on the support they received from their social workers. One, for example, said, *"I've had my social worker after the adoption, and [the agency] never stopped holding my hand."* Another adoptive parent said that she primarily relied on *"me, me, and God."*

With regard to the quality of the post adoption services that they received, several adoptive parents expressed satisfaction. Adoptive parents, for example, said, *"I get good services,"* and *"I would leave everything as it is. Everything works."* This group of adoptive parents commented on the benefits of medical services, therapy, medication

48· Madelyn Freundlich, Rosemary J. Avery, Sarah Gerstenzang, and Sara Munson

management for their children, home health aide services, and speech therapy for their children. Some stated that Medicaid was very important to them in covering the cost of services. Some adoptive parents spoke about the value of the Circle of Support program provided by the public child welfare agency in New York City which offers monthly neighborhood-based support and informational meetings for foster and adoptive parents.

Adoptive parents most often identified subsidy arrangements as the issue that presented problems for them. Although some adoptive parents reported satisfaction with the subsidy arrangements for their children, others reported that they did not receive subsidies as expected, saying, *"We're still waiting for [the public child welfare agency] to get it together [regarding our subsidy]"* and *"Even to this day, I still don't get any money for [my child]."* Some adoptive parents encountered problems with the subsidies they received. One stated that it took over a year for her child's special subsidy to be approved because the agency lost the paperwork and failed to notify the parent that additional paperwork was needed. Another stated that her child's adoption was delayed because the agency did not want to approve a subsidy for the child, claiming that the child was healthy when, in fact, she was diagnosed with HIV. Some adoptive parents reported dissatisfaction with the level of subsidy that they received, reporting:

> *"I think [my child] should have gotten an exceptional rate because . . . he's really mentally retarded. . . . It's a lot of . . . extra stuff that you have to do."*

> *"I feel that the stipend that he gets, it's not really enough money for him."*

Adoptive parents also reported dissatisfaction with the level of other services and support:

> *"I could use more resources, more help and stuff. They have pre-adoption [help] but that only is for a little bit."*

> *"Once you adopt them, that's it. It seems like they don't help you with any more services. You're on your own now. You have to go out there and search and find whatever you can . . ."*

> *"It's sad because after they put the child with you, then it's no longer their concern. It's like 'forget it.' . . . 'We have nothing else to do with them.' . . .That's not fair. . . . The City just turns their back on [the children] and that's not fair to the kids. It's like no one is really there to help you after you adopt these kids and you need help."*

Adoptive parents in this group stated that they needed more information about post-adoption services and supports. Adoptive parents also expressed concerns that services were not readily available when their children reached adolescence. One adoptive parent, whose 15-year-old son was living on the streets at the time of the interview, said, *"I just went back to the agency for help, and there was none there. . . . I needed all kinds of help for [my child] . . . they didn't help me."* The adoptive parent added, *"If I knew that, I could have left him to be a foster child, instead of adopting him because I had more services."* These adoptive parents also reported a need for help in

accessing appropriate educational services and a need for more counseling and mentoring programs. One adoptive parent was particularly unhappy with the quality of counseling that her children received, stating:

> *"And the post adoption [services], I got them for a little while. I might fire them soon. Because they get involved and they cause more chaos than they do anything because they lead the kids to believe that they can change [anything they don't like]. They can say, 'oh, well, your mother shouldn't do this because . . .' ' How can you tell my child what I can't do?'"*

Adoptive parents as a group highlighted several ways that post adoption services could be improved. Frequently mentioned areas were the need to make counseling available for children and families, the need to process subsidy arrangements in a timely way, and the need to process Medicaid coverage in a timely way to ensure that Medicaid coverage for children remains current.

Interviews with Child Welfare Professionals

Thirty-eight professionals were interviewed through individual interviews or in focus groups. They included judges, law guardians, social workers, adoption attorneys, representatives from private agencies and public-private initiatives, and representatives from community-based and other advocacy organizations in New York City. These individuals were asked to respond to the cross-cutting themes that were identified from the consumer interviews, including the theme related to the essential role of post-permanency services and supports.

Child welfare professionals agreed with consumers that post-permanency services were critical. Child welfare professionals stated that although post-permanency services and supports are essential, they often are not provided. One professional, for example, said:

> *"It is just a travesty that there is so little after-care or post-adoption services in the system. It just cries out as one of the stupidest things that we do... Everybody pretends that there's aftercare. The State pretends that we [the agencies] provide it. The City pretends that we provide it. So, in turn, agencies pretend that they provide it."*

Several stated that funding was a major barrier to post permanency services. Two professionals, for example, stated:

> *"The reason we don't do better [at providing post permanency services] is because it's literally an un-funded service."*

> *"[Although the City might agree in theory that aftercare is needed, they] can't back it up with money. It's going to slap them back in the face because these are the kids coming back into care and so it's costing them more money."*

50·Madelyn Freundlich, Rosemary J. Avery, Sarah Gerstenzang, and Sara Munson

Some professionals expressed concern that services are not specifically designed to meet the needs of families whose children have been in foster care. They commented that the same services are provided to parents with no history with the foster care system and to parents whose children have been in foster care. Professionals stated that parents involved with the foster care system need specialized services to assist them in addressing foster care-related issues, such as disruption and separation. In this regard, one professional stated:

> *"We do refer our kids to preventive services and they don't know what the hell to do with our kids because they're all about keeping kids from going to [foster care], not about what do you do with a kid after he comes back from [foster care]. It's not their area of expertise. So often we find they're completely useless."*

Child welfare professionals were asked what is being done or what should be done to strengthen post-permanency services. Some focused on the need to use and build on preventive services. One respondent, for example, stated:

> *"Some of the supports that you can offer post-discharge are roughly equivalent to preventive services, so it's like we have some services in place that could serve as a useful model... You can provide preventive services to prevent re-placement. I think the fear of people working in the field of preventive services is that our field is already dwarfed by foster care in terms of size and spending and we don't want it to be re-defined as the backdoor out of foster care. We don't want people to experience problems that are severe enough to result in placement before they can even qualify for our services. We want it to be truly preventive in nature."*

Other professionals described specific practices that may strengthen post-permanency outcomes. One, for example, suggested that when children are reunified with their parents, children should be returned over time rather than several children returning to the family at the same time. Another stated that parents and children should receive information on neighborhood-based organizations that provide aftercare services. Some professionals emphasized the need for post-adoption services. One, for example, said:

> *"We found in terms of the need for post adoption and post permanency services that by and large, clinicians who do family therapy are not particularly aware of or tuned in to adoptive families' specific and unique needs... One of the services that we provided actually for a time was clinician training to try to create a cadre of adoption-sensitive clinicians in the community that we could refer people to. That was great."*

Several professionals endorsed specific post-permanency services such as parent mentor programs for parents whose children are returning home and neighborhood-based support programs for adoptive parents.

Discussion and Recommendations

The interviews with parents, adoptive parents, and child welfare professionals yielded a number of common themes. Both parents and adoptive parents reported high levels of satisfaction post-permanency. Parents were delighted that their children were home with them, and most adoptive parents were very happy with their decision to adopt and were positive about their adopted children. Consistent with other findings in the research literature, both groups expressed the need for post-permanency services and supports. As has been found in other studies (Festinger, 1996; Taussig, Clyman, & Landsverk, 2001), parents described the significant transitions involved when their children returned to them from foster care and the lingering trauma that, in some cases, their children experienced. Consistent with the current research literature (Doughtery, 2004; Wulcyzn, 2004), many parents reported the stresses they experienced following reunification and problems obtaining needed services. Some parents, however, said that they did not want ongoing involvement with the child welfare agency, a view that seemed to be connected to their experiences with their agencies and, possibly, anxieties that their children could again be removed from them. Although adoptive parents expressed a high level of satisfaction with their agencies pre-adoption, they often reported dissatisfaction in connection with the availability of needed post-adoption services, with subsidy being the issue that elicited the most concern. This finding is consistent with other studies of families' experiences post-adoption (Adams, Howard, & Kelly, 1995; Festinger, 2002).

Child welfare professionals agreed that post-permanency services are essential and expressed concern about funding constraints and other barriers to the development and implementation of these services. This finding is consistent with the results of the federal Child and Family Service Reviews regarding the general inadequacy of post-reunification services in all states (US DHHS, 2004a).   The child welfare professionals made several recommendations to address this service deficiency: the use of a preventive service model as a basis for the provision of post-permanency services; shaping services to specifically meet the needs of families whose children have been in foster care and adoptive families; and offering services for longer periods of time.

The findings from this study strongly suggest that the services and supports available to families post-permanency must be strengthened. Consumers and child welfare professionals agreed that post-permanency services for children, youth, and families are critically needed, both concrete services, such as educational and mental health services and respite care, and services to address the long-term impact of foster care on the child and family. The findings also suggest that the current model for preventive services should be examined in light of the needs of parents whose children have been in foster care and adoptive families. This model provides a basis for post-permanency services for birth and adoptive families that could be strengthened by drawing on the guidance of these families in developing and providing such services.

Strengths and Limitations of the Study

This study had both strengths and limitations. The purpose of qualitative research generally is to describe and interpret a phenomenon in the words of individuals experiencing that phenomenon. Strengths of this method include the capacity to explore

52·Madelyn Freundlich, Rosemary J. Avery, Sarah Gerstenzang, and Sara Munson

topics of sensitivity and depth that are not amenable to the structured and distancing approach of quantitative methods (Padgett, 1998). Given the topic of inquiry, random sampling was not possible and the trust and rapport needed to elicit candor and depth of experience was essential. At the same time, smaller and purposively-selected samples and lack of breadth of qualitative studies, including this study, signal caution in generalizing findings. Although any study conducted in a large urban environment may be deemed exceptional given the size and scope of foster care services, many of the findings will resonate with service providers in other communities.

Another potential limitation of this study arises from social desirability or other biases which may result in respondents' exaggeration, either positively or negatively, of their experiences and opinions. Clearly, the trustworthiness of the data collection and the results are dependent on the skills of the interviewers and on the rigor of the analyses. In this study, strong emphasis was placed on the training and supervision of interviewers as well as on systematic verification and corroboration of findings during data analyses.

Conclusion

There is a critical need to focus more methodically on the quality of families' experiences post-permanency and the services and supports that can strengthen and stabilize post-permanency arrangements. This qualitative study provides a foundation for understanding some of the issues that families may face following the return of their children from foster care and following adoption. Through the perspectives of birth parents and adoptive parents and child welfare professionals, the study offers insight into some of the areas on which child welfare agencies should focus in order to promote successful permanency outcomes.

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Are Intensive Family Preservation Services Useful?: A Study in the United Kingdom

Marian Brandon and Jo Connolly

This evaluation of the first year of an Intensive Family Preservation Service in England is based on the analysis of eighty-six families: fifty-seven families who received the service and a comparison group of twenty-nine families who did not.   The study considered whether the program was fulfilling its objectives of reducing the number of children and young people in the public care system; offering a safe, supportive service for children who need protection; integrating the program into family support services as a whole, and improving family functioning. The findings were complex to interpret. Child protection was improved but there was not a reduction in the number of children needing out of home care (indeed there was an increase) meaning that short term savings in costs could not be made. Nor were there lasting improvements in the children's behavior. There were instead a number of more subtle, arguably more sensitive outcomes: parents' capacity to tolerate their child's behavior was greater and overall family functioning was better for most families who received the service. Also families were, on the whole, able to make better use of follow up services.

Introduction

'The aim of the .. intervention is to protect children by strengthening, empowering and preserving families rather than by removal from home.' (NCH 1998:1)

The concept of intensive family preservation services has aroused renewed interest in recent years in Europe, and specifically in the UK, as a means of translating the rhetoric of 'refocusing from child protection to family support' into action. The family preservation aims of keeping children safe at the same time as keeping families together and strengthening family bonds chimes well with English national policy and guidance. In addition these services aim to increase the families' skills and competencies and facilitate their use of a variety of helping resources (Berry, 2001). Intensive family preservation services differ from other models of family support in that they are home-based, of brief duration (usually one month) and intensive, with one worker being available, in person or on call, to a family 24 hours a day, 7 days a week (Kinney, et al, 1991). The over-riding principle is to invest as many resources in preserving birth families as might be invested in providing substitute care (Whittaker, 1993).

Intensive family preservation is also attractive to service developers as a potential means of reducing the escalating costs of out of home care. This factor, coupled with the poor outcomes for older children leaving care (DH 1998), have made family preservation services attractive propositions to some English local authorities and voluntary organizations.

57·Marian Brandon and Jo Connolly

Early studies of family preservation services tended to show effectiveness in the crude measure of preventing out of home placement in between 40 and 90 per cent of cases. US studies from the 1980's and early 1990's, however, showed that many children in comparison groups (i.e. not receiving FPS) also stayed at home (Schuerman, et al, 1994). Since some children in the comparison groups had received no services at all, this highlights the possibility that these were not the children most at risk of placement. Given the problems in predicting imminent risk of placement and the possibility that placement can be a positive experience, it could be argued that measures of success should also take into account the child's developmental trajectory and the functioning of the family, including its stability.

Feedback from families who have experienced a family preservation service tends to be very positive. Studies have indicated that this is largely because they find the service less stigmatizing and prefer work directed towards keeping the family together rather than assessing their competence as parents (Jackson & Thomas, 1999). These authors maintain that if problems can be resolved without separation from the family, the chances of the child experiencing continuity and stability are much higher than if they enter the care system.

The Study

The study considered the extent to which a 4-week intensive family preservation program, based on an adaptation in the Netherlands of the 'Homebuilders' model (de Kemp, et al 2003, Kinney, et al, 1991) and being piloted in England, was fulfilling its objectives. These included: reducing the number of children and young people in the public care system; offering a safe, supportive service for children who need protection; achieving the integration of the program into family support services as a whole, and improving family functioning. The evaluation was commissioned by the two English local authorities and the non-governmental organization who were jointly running the pilot scheme. The evaluation began in April 1998 and was completed in April 2001.

Methodology

The Sample

In the twelve months of the program, a total of eighty-six families were referred to the program and were considered to have met the threshold for the service. Variable amounts of data have been collected on these 86 families. The cases have been broken down into two research groups, the Project Group and the Comparison Group as summarized in Table 1.

Table 1: Sample Groups (n=86)

Comparison Group Cases (did not complete the program)	**Project Group Cases** (completed the program)
14 families unallocated 8 families failed to complete 7 families refused the program	57 families **Intensive sub-group** 24 families agreed to further interviews
TOTAL 29	**TOTAL 57**

In fifty-seven cases, a project worker was allocated to the family and the program was completed - these 57 cases are the 'Project Group'. An intensive sub-sample of 24 families was drawn from the Project Group Cases. This was made up from families who agreed to be interviewed, and about whom more data were collected. The 'Comparison Group' comprised the 29 families who did not complete the program about whom data was collected at referral only. It was not possible to allocate a project worker to fourteen of these families at the time of referral. In another 8 cases, families commenced but failed to complete the program. A further seven families were offered the service but refused to join the program.

A criticism of most studies of intensive family preservation services has been the lack of a comparison group. By studying a group of families assessed as eligible but who did not receive the service, alongside those who did, the possibility arises for better claims to be made about the success or otherwise of the program. The Comparison Group and the Project Group were compared on key indicators to see if the two groups of families were similar at referral. Marked similarities were found between the two groups in terms of family characteristics and referral profiles. However, there were important less 'tangible' differences, such as attitudes towards accepting help. Hence it is important to stress that this is a comparison, and not a control group.

59· Marian Brandon and Jo Connolly

The key research questions were: does the program reach the intended target group, are the intended treatments/programs provided and are the intended results achieved? The measures used in the evaluation are explained below.

Interviews

Semi-structured interviews were carried out with members from up to twenty-four of the families who attended the program. Interviews were carried out with all project staff and also with a small number of area team caseworkers who referred families to the service. When analyzed as a whole, the interviews helped to draw together diverse pieces of information into a more unified interpretation of events.

Quantitative measures

Structured file searches were carried out from the case notes of all families in the study sample (n= 86) [1]. Information about services to families was collected from files for all 86 families at Time 1 - one year leading up to referral to Families First service and one year later (Time 4). Information about the 57 families who completed the program was collected at Time 2 - at the start of the program and Time 3 – immediately after the program. Additional questionnaires and interviews were undertaken with 24 families at times 2 and 3, and at Time 4, one year later. From all these data details emerged about child protection investigations and child protection registrations and about levels and types of services provided by Social Services and other agencies. Data were coded, loaded and analyzed using the statistical package SPSS.

Questionnaires: The set of questionnaires compiled for the evaluation were used with the twenty four families as a measure of four aspects of family functioning: child conduct, parent wellbeing, family and environment and child and family interaction. The measures sought to distinguish differences and similarities between the families studied for the evaluation and the general population. Individually and together, they also identified the changes in children and families' functioning over time in order to indicate, potentially, whether there was evidence of families being strengthened to help them to meet the needs of their children.

All questionnaires used in the evaluation are standardized and have psychometrically acceptable characteristics with evidence to show that they are sufficiently reliable and valid.

Child Conduct: Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997). The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioral screening questionnaire that provides balanced coverage of children and young people's behaviors, emotions and relationships. The SDQ poses questions about 25 attributes, some positive and others negative. These 25 items are divided between 5 scales of 5 items each – covering conduct problems, hyperactivity, emotional symptoms, peer

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[1] Whilst every effort has been made to extract accurate information from client files, the inconsistent nature of file recording left some doubt about total reliability.

problems and pro-social behavior. All but the last are summed to generate a total problem score.

Parent Well Being: Rutter Malaise Inventory (PHQ) (Rutter, et al, 1970). This provided a broad indicator of the degree of depression and emotional distress being experienced by the parents/carers since a parent overwhelmed with unpleasant feelings of anxiety and depression is likely to be less able to cope with the ordinary stresses and strains of parenthood, let alone with serious problems. The 24-item questionnaire was adapted for use in a British community setting and its validity has been strongly maintained. The questions concern emotional and physical symptoms and must be answered 'yes' or 'no'. A point is awarded for each positive response. Scores of seven or more mark a cut-off between the normal range of reactions and those that might be regarded as evidence of clinical disturbance**.**

Family and Environment: Gibbons Family Problem Questionnaire (FPQ) (Gibbons, et al, 1990). This was a measure of the parents' problems, parents' needs for support and an indicator of how they used newly-created support provision. It was based on the most commonly mentioned reasons for referral to English Social Services Departments. This questionnaire is sensitive to changes in environmental circumstances, for example improvements in housing.

Parenting Stress Index (PSI) (Abidin 1995) This measure assessed a variety of dimensions of parenting. It is a screening and diagnostic instrument designed to identify stressful areas in parent-child interactions and to assess facets of the parent-child system i.e. child characteristics, parent characteristics, family context, and life stress events.

Most questionnaires were completed by the main carer and an index child (the child identified as most at risk of immediate admission to public care) in all families who had participated in the IFPS. The SDQ was completed by the child at three time points: at the start of the intervention, immediately after the service and one year later. All other scales were completed by parents at the start of the program and one year later.

Findings

Key findings are presented in response to the research questions:
Does the program reach the intended target group?
Previous studies have indicated that family preservation services are not always targeted at high threshold cases where families are at the point of breakdown. This issue was examined in terms of the following factors: risk of entry into public care, risk of serious impairment to child's health and development, nature of concern, and pathway to referral.

Almost two-thirds of the referrals met the established criteria for the service clearly. In the remainder, the high risk of out of home care and /or crisis was not made explicit. Three quarters of the children who received the service were in the formal child protection system. In almost half of all referrals the identified problem was child conduct and its deleterious impact on family life. Concerns about parenting capacity were expressed in a third of referrals and the breakdown in family relationships accounted for the remaining cases.

Findings from the children's Strengths and Difficulties Questionnaire showed that, when compared to the general population, the conduct of more than three-quarters of the project group children was significantly 'abnormal'. We know that children with serious conduct problems are often further handicapped by school difficulties and are at a

higher risk for criminal conviction (Farrington, 1995). That these problems are serious risks to optimum development were borne out by the various data collected. The children's profile further showed troubled and troublesome behavior at school, at home and in the community. Almost a quarter of the children were excluded from school, and the same number experienced mental ill health.

The high incidence of the children's conduct disorders and overall problems with emotions and relationships provides evidence to demonstrate that the service was appropriately reaching children with a very high need of services to contain further serious impairment of development. Taking all these factors into consideration, the service was, for the most part, provided to the intended target group of high threshold cases.

Are the intended treatments provided?

The program generally ran for 28 days (as planned) and there was evidence that the project workers (all of whom were well qualified social workers) were accessible and engaged well with all family members. We found that workers and families set commonly agreed goals, and that specific behavioral techniques were employed. The most commonly agreed goals set by workers and families were: safety and protection of children, improving communication skills, setting boundaries, establishing daily routines, anger management, school attendance, dealing with stress, confidence building, negotiation skills, and achieving practical results. The skills and techniques most frequently employed included skills teaching, modeling, role play, behavior charts, advocacy, project exercises and project homework with the overriding principle of engaging all family members in the work.

The families interviewed were unanimous in their praise of the project workers saying they 'valued being listened to 'and 'trusted the project worker'. It appeared that the nature of the relationship was central to the work. The relationship was routinely referred to by families as 'special' and 'different to a social worker'. A high level of closeness and trust appeared to develop quickly between the worker and the family members.

> *"it was wonderful, just to have somebody that I knew I could ring up when things started going wrong and she would be there for me – it was absolutely brilliant – I can't tell you what a feeling that gave me."* (Parent)

Although the families spoke highly of the service, there was a variation in which service aspects the families found helpful. Some parents welcomed the intensity of the program, while others found the commitment required of them too onerous. One year after the program ended some parents and children gave examples of behavioral techniques that had worked for them and some recalled feelings of sadness when the service had ended.

Social workers who had referred families to the service regarded it as very useful claiming for example that it had *"helped things from deteriorating a lot further"*. Project workers were highly regarded:

> *"……some excellent workers who have brought about…. some very effective changes in very difficult cases in terms of risk and man hours involved – cases which have since closed." (Social Worker)*

There were however concerns about the scarcity of follow up services and lack of flexibility in providing a longer service.

> *"The difficulty is that they will do a lot of good work which will be undone because we are not in a position to follow up." (Social Worker)*

Are the intended service results achieved?

> *'The importance of the Families First Program is a) its integration into family support programs as a whole, b) the reducing of the number of children and young people in the public care system and c) a reduction of the need for formal child protection procedures'* (NCH, 1998).

Integration into family support

The 'wish list' of wrap around services drawn up by project workers and families at the end of the service was frequently not met by hard pressed social service departments and voluntary agencies. However it was not always the case that additional services failed to be offered, since families sometimes refused further support – either because they felt confident in their abilities to cope unaided or because they were skeptical of professional help. One referring social worker was critical of the strict time limits applied by the service:

> *" Some families are borderline, where with just a little bit more input (they) would not require longer term input". (Social Worker)*

Numbers of children in public care:

In the year following referral, the numbers of children in out of home care in the Project Group actually *increased* from 22% to 35%. In the Comparison Group who had not received the service, there was a slightly larger increase from 20% to 40%. At first sight it appears that continuity and stability is disrupted for children in both groups. But what appears to be different in the two groups is the pattern of accommodation. More children in the comparison group were moving into potentially harmful unplanned, non time-limited accommodation in the period after referral to the service, whereas Project Group children's entry into public care was planned with re-entry home featuring as part of the plan.

It is possible that the rates of admission to care increased overall, in both groups in the community during this period because the level of difficulties in the children were already very high and the problems were entrenched. Resistance to change is always a risk with late intervention services as opposed to early intervention which aims to catch problems before they become severe. However, we will demonstrate later that some families in crisis with severe and entrenched problems did achieve the most lasting success.

63· Marian Brandon and Jo Connolly

The use of child protection procedures:

The incidence of formal child protection procedures decreased in both the Project Group and the Comparison Group at the end of the research period but the reduction was greater in the Project Group (child protection enquiries were halved in the Project Group and reduced by a third in the Comparison Group). In both groups it could be surmised that the most difficult children to look after, who were most at risk of maltreatment, were those who entered public care. This would explain the decrease in enquiries alongside the increase in admission to public care. However, although we know that the children's problems in the Project Group did not really subside over time, we did learn that the parents' relationship with their child and their capacity to tolerate their child's difficult behavior improved (see nest section). This heightened tolerance arguably translated into better child rearing and lower levels of maltreatment than in the comparison group.

Improved family functioning:

Analysis of the completed schedules for an intensive sub-group of up to 24 of the families who had participated in the program provides a fuller set of quantitative and qualitative data. It gives a broad picture of improved family well being the year after the service where overall, as Figure 1 shows, family problems declined.

Figure 1: Family Problems sub-scores at Time 2 (at referral) and Time 4 (one year later).

N=22
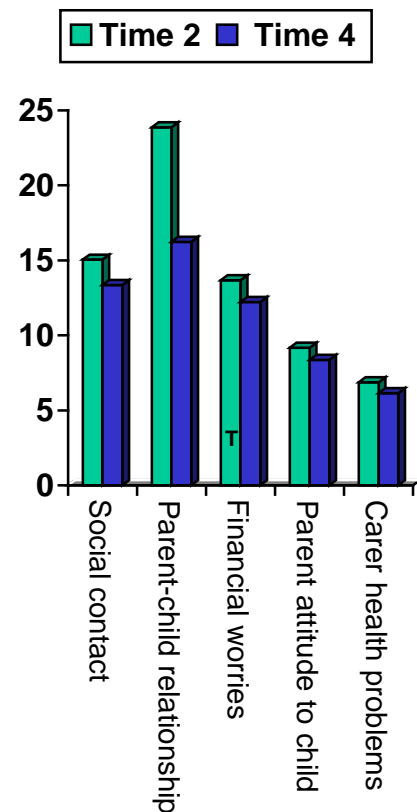
A lasting improvement in parent-child relationships was also confirmed by the Parenting Stress Index (see Figure 2). At the beginning of the intervention 30 (77%) of parents were scoring above the clinically significant stress threshold but one year later this had dropped to 23 (65%). Family health and well being also improved overall, as chart 6 shows, with more main carers reporting better health one year on.

Figure 2: Parent Health Total Scores at Time 2 (at referral) and Time 4 (one year

later)   **(N=18)**
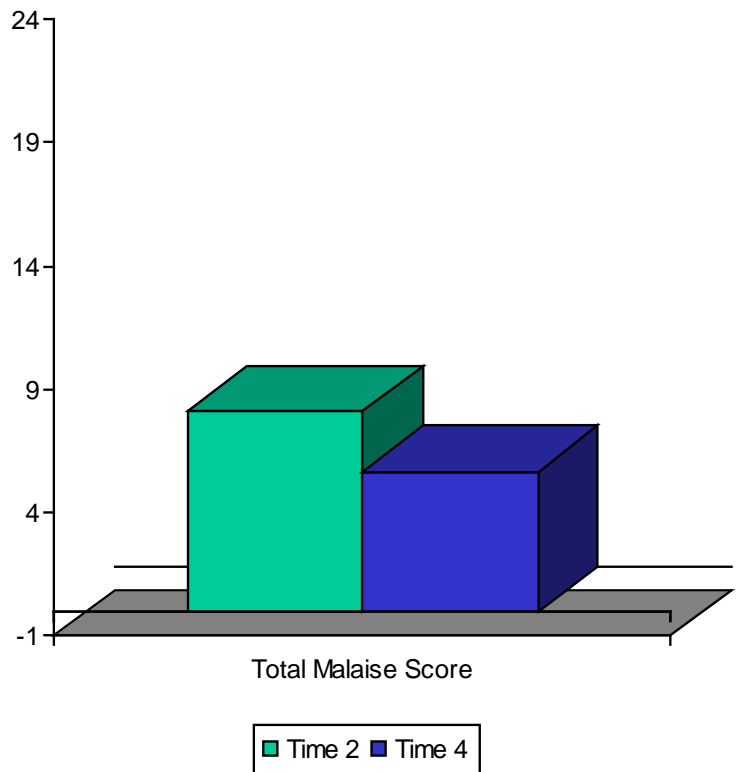
The pattern was less straightforward in relation to the children's conduct. At the end of the program there was a marked improvement in the children's conduct, but one year on, conduct had reverted to the same level as at the beginning of the program. A similar pattern was evident for pro-social relationships, which improved initially, then slipped back. There was however a lasting improvement in hyperactivity and peer relationships.

The modest overall improvement in the children is perhaps to be predicted because the children in the sample had severe and multiple problems at the time of referral to the program. Although we learnt that difficulties in the child's conduct were still apparent one year on, interestingly, the 'impact' scale in the SDQ revealed that the parent and /or child were mostly saying "this doesn't affect my life so much anymore". This was corroborated by the other measures like the Family Problem Questionnaire, and Parenting Stress Index, which showed that the parent/ child relationship had improved for many families who had used the program. Even though the child's behavior may not have changed dramatically, many parents were less distressed by the behavior, or were coping better, rendering the child less vulnerable to maltreatment and possibly expulsion from the family.

We cannot link the overall improvement to the intervention, although there was a perception by family members and area team social workers that some of the improvement was attributable to the program.

Tentative Outcome Findings

The overall findings from the intensive sub-group of 24 families revealed different levels and patterns of improvement in families who had used the service. To determine these patterns data were assessed in relation to family functioning, consumer satisfaction, level of stability of the index child, pattern of support for the family, risk of child maltreatment, risk of entry into public care and family profile at the time of referral.

Research ratings from the data elicited three main categories of family, which indicated the varying levels of successful outcome for the families one year on. These were:

1) **'Lasting success'** where 10 families (42%) made immediate improvement and consistent and continuing progress
2) **Initial improvement'** where 6 families (25%) improved after the program but the progress was not sustained over time, and
3) '**Apparent change'** where 8 families (33%) showed little or no improvement.

In the 'Lasting Success' group family functioning improved in all 4 areas immediately after the program and progress was maintained one year later (see Figure 3). There were smaller improvements in family functioning in the 'Initial Improvers' group with some gains in child conduct and parent health over time and a slight move in the direction of 'better' on the remaining two scales. While children from the 'no apparent change' group made small improvements in behavior, there was no change in parent health, although some evidence that families were interacting slightly better. There were however some signs of improvements in their environment.

Figure 3: Family Functioning: 'Lasting Success', 'Initial Improvers', 'No apparent Changers' – Overall Improvement Rates at One Year Follow-up.
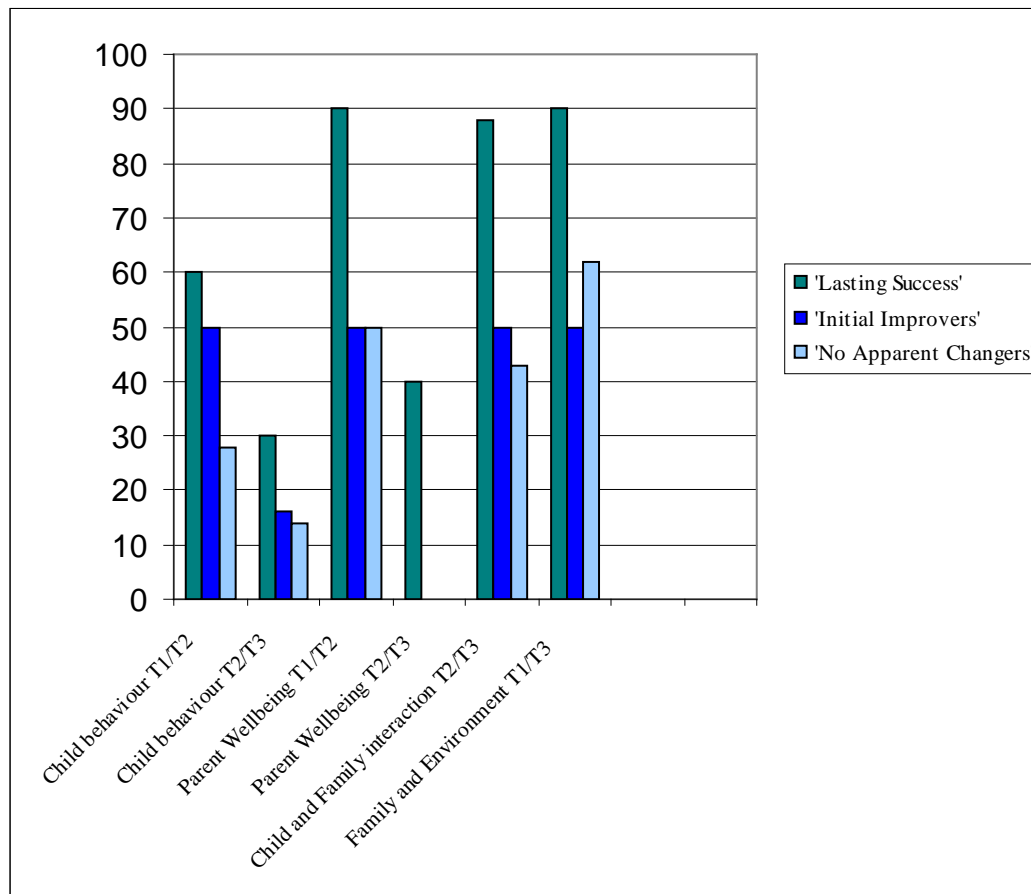
It was notable that families in the 'Lasting Success' group expressed most satisfaction with the program and were the most cooperative participants.

Stability

The pattern, nature and number of moves experienced over two years within the research period formed the basis of three criteria of the child's level of 'felt security'. Findings indicated a marked peak, or crisis, at the time of referral to the service in the stability of children from the 'Lasting Success' and the 'Initial Improvers' groups. This was not the case in the third 'no apparent change' group. It is only the 'Lasting Success' group of children whose security and consistency of residence remained stable after one year.

Pattern of Support for Families

In the 'Lasting Success' group where the program appeared to have most impact, the level of support to families decreased three months after the service and remained at that level after one year. In both the 'Initial Improvers' group and the 'No Apparent

67· Marian Brandon and Jo Connolly

Change' groups, the percentage of families getting an 'intensive' level of support one year after the service is higher than that in the year leading up to referral.

Risk of Child Protection Registration and Risk of Accommodation

Changes in levels of risk in the 'Lasting Success' group suggest a crisis time in terms of Child Protection Registration and risk of accommodation coinciding with the referral to the program. The level of risk is minimal one year on. In the 'initial improvers' group, the trend is also downwards with a reduced risk of registration and accommodation. It is however less markedly reduced with 76% of children remaining at high risk of either registration or accommodation. For the 'No Apparent Change' group, the risk of registration improves in a similar way to the middle group. There is also slight reduction in the risk of accommodation.

The level of risk of Child Protection Registration and out of home care appears to decrease most markedly in the 'Lasting Success' group of families with crisis at the referral stage alleviated.

Family Profile at Time of Referral to Families First

At first glance the profiles of families do little to help distinguish the type of families who appear to benefit most from the Families First program. On closer examination, however, there is a difference in the referral category criteria – all families in the 'lasting success' group met the threshold for the service, unequivocally, that is they were at the point of breakdown. This is not so clearly the case for the other two groups where 50% and 37% respectively come into the broader 'general concern' criteria. This would seem to suggest that these families may not have been ready to accept and work with this kind of intensive crisis intervention program. The message appears to be that the service was most effective for families in crisis, with serious difficulties, who met the threshold for the service unequivocally. This is shown in Table 4.

Table 4: Risk of Child Protection and Risk of Public Care

(Accommodation)

	'Lasting Improvers'				'Initial Improvers'				'No Apparent Changers'			
	Time of program		One year later		Time of program		One year later		Time of program		One year later	
Level of risk	High	Low	High	Low	High	Low	High	Low	High	Low	High	Low
CPR	60%	40%	-	100%	33%	66%	16%	84%	62%	38%	50%	50%
Accommodation	80%	20%	-	100%	84%	16%	50%	50%	75%	25%	38%	62%

Discussion

It has been argued that the objective of delivering more effective services will be furthered, if there is more rigorous evaluation of pilot projects prior to their being fully implemented (Axford, et al, 2005). The two authorities who commissioned this study followed this route by making the decision to pilot and evaluate the first year of the program before making longer term decisions about its future.

The findings from the pilot, however, were complex to interpret. Child protection was improved but there was not a reduction in the number of children needing out of home care (indeed there was an increase) meaning that savings in costs could not be made. Nor were there lasting improvements in the children's behavior. There were instead a number of more subtle, arguably more sensitive outcomes. Although the children's behavior had not improved, the parents' capacity to tolerate the child's behavior was greater and overall family functioning was better for most families who received the service. Also families were, on the whole, able to make better use of follow up services (where they were available). As one area team worker put it, "*we used to dread working with this family but they're much easier to work with now*".

The study findings informed the authorities' decision not to continue the service which was disbanded after its first year. This was a difficult decision to make as the more sensitive outcomes were valued by the two local authorities who felt compelled to make the decision largely on financial grounds. The program might also have been a victim of poor timing in relation to access to funding. Shortly after the program was disbanded government funding became available to combat child poverty and social exclusion for children aged 5-12 (Children's Fund). This was aimed primarily at voluntary organizations working in partnership with local authorities and could have offered a life line to this particular project.

Another possible explanation for the lack of success in preventing out of home care is the high level of thresholds of entry into social services in England. This is a longstanding concern for English policy makers (DH, 2002; 2005) and thresholds for services appear to be higher than in neighboring European countries. In the Netherlands where a parallel program had been implemented family functioning improved, as in the UK study, but levels of out of home placement were much lower (Veerman, et al, 1997).

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'The best thing I've ever done is ring these people…':
Making a Difference through Family Support

Elizabeth Fernandez

Effective family support strategies offer early intervention and help for families and children at risk of experiencing social exclusion and maltreatment. This paper reports a study which evaluated client outcomes from participation in an Intensive Family Support Service by comparing views of workers and service users on perceived benefits. It profiles the characteristics and circumstances of families recruited to service, services and interventions delivered and the potential of IFSS to lead to safe and positive outcomes for children and families. Findings discussed highlight the individualized and collaborative approach and the high degree of engagement with service users that facilitated gains in the domains of child and family functioning targeted. Implications of the findings for policy and practice in responding to vulnerable families and children are discussed.

Introduction

Over the last two decades the nature of intervention in child and family services has changed to emphasize greater support for children living with their families. The development of family support services has been international, stemming from concern about the mounting incidence of abuse and neglect and recognition of the need to focus on programs of early intervention centered on vulnerable families with children to interrupt patterns of maltreatment and prevent removal to protective care (Ryan & Schuerman, 2004; Denby & Curtis, 2003; MacLeod & Nelson, 2003; Hayward & Cameron, 2002; Chaffin et. al., 2001; Armstrong & Hill, 2001; Walton, 2001; McCartt Hess et. al., 2000). A range of family support models have proliferated throughout the United States, Canada and European countries (Dagenais et. al., 2004) and parallel developments are evident in the Australian context where Intensive Family Preservation Services, more commonly known as Intensive Family Services, were introduced to assist families whose children are at risk of entering care (Campbell, 2004; Fernandez, 2004). The increasing focus on early intervention is reflected in the commissioning of projects to expand the service network supporting families including family support programs, center-based child care, supported play groups, parenting programs, home visiting, one stop shop family centers, specialist family support services with culturally and linguistically diverse (CALD) family workers, Aboriginal play groups and young parents' groups (AIHW, 2005, p.8).

The challenges and limitations of research evaluating the impact of family-based services are highlighted in the literature. There are mixed findings on the capacity of family-based services to prevent children's entry into care (Dore & Alexander, 1996). Hayward & Cameron (2002) acknowledge that despite unfavorable results reported by some evaluations of IFPS programs, there is growing evidence that highlights their ability to moderately transcend traditional child welfare services in maintaining children in families. However, reliance on placement rates as the prime outcome measure has attracted criticism (Berry, 1997). There is a need to expand the scope of outcome research to include indicators of

parent functioning, family interaction, child wellbeing and safety, to profile the characteristics of clientele and services offered (Dagenais et. al., 2004) and to incorporate strengths-based measures of outcome (Berry, 1997). Key developments in evaluation research have also transferred the emphasis from outputs to processes advocating a sensitive outlook on influential players and accommodation of stakeholders' perspectives (Pawson & Tilley, 1997). Focusing on final outcomes only thinly describes client gains and overlooks intervening processes that are steps on the way to change (Warren-Adamson & Lightburn, 2004). In this regard, methodologies that elicit thick descriptions of practice that enable identification of sensitive outcomes are advocated. Evaluative research has helped to shape current family support services, however there is still much to learn about family support delivery and its clientele and processes (Broadhurst, 2003). This paper reports research undertaken to identify outcomes of intervention through intensive family support services.

Methodology

The aim of the research was to investigate the impact of family support interventions by comparing the views of families and their family support workers with respect to the perceived need of the target group and outcomes of the services offered. Quantitative and qualitative methods were used as complementary strategies (Alston & Bowles, 1998). A qualitative approach in the tradition of Strauss & Corbin (1998) was used to capture the process of interaction between service users and providers, and intermediate and long term outcomes. A multistrategy or triangulation approach which enables combining different data sources and accounts of everyday events (Hammersley & Atkinson, 1983) was incorporated in the design. The research was carried out in two phases using a pre and post-test design. Personal interviews with workers and parents were main sources of data and were carried out on two occasions, six months apart. A major analytic objective was to capture as much of the complexity of processes and interactions between parents and service providers as possible over time, and to make group comparisons of these outcomes.

An innovative component of the research was the use of a validated standardized assessment tool namely the (NCFAS) North Carolina Family Assessment Scale (Kirk, 2001), a multidimensional instrument developed to aid workers and researchers in assessing need and change in families. It conceptualizes family functioning into five domains: Environment, Parental Capabilities, Family Interactions, Child Wellbeing, and Family. The NCFAS assessment for families was completed by RWIFSS workers as part of the initial research interview (Time 1) and the subsequent interview (Time 2) six months later or at case closure. The data from Time 1 provided a baseline on outcomes against which to compare ratings at Time 2 and assess changes in family and child functioning. The SCARF (Supporting Children and Responding to Families) case management system (Fernandez & Romeo, 2003) used in all the agency's family support programs, complemented and facilitated the use of the NCFAS tool and ensured comprehensive developmental and ecological assessments.

Overview of the Site and Service
The research was carried out at the Barnardos Redfern Waterloo Intensive Family Support Service (RWIFSS) which offers a range of family support interventions. Home visits and centre based services, practical and clinical interventions are included in the continuum

of complementary crisis oriented and preventative strategies provided by the service. Designed to provide support to vulnerable families of the Redfern/Waterloo area, RWIFSS do not have a defined time limit for providing a service to a family. Families access the service through the State Department of Community Services (DoCS), Barnardos assertive outreach, other agencies, and self referrals. A fuller account of the project is available in Fernandez & Healy (2005).

Redfern is a suburb of great importance and significance to Australian Aboriginal people and a gathering place for the indigenous community. Both Redfern and Waterloo are known to be over-represented in statistics relating to disadvantaged groups having one of the most densely populated public housing estates in New South Wales (NSW), Australia. In terms of indicators of social disadvantage, Waterloo is ranked as the third most disadvantaged community in NSW (Vinson, 1999).

Participating Families

A total of 25 families participated in the study. Of these, 64% were single mothers, 8% were single fathers, and 28% involved two parent/ caregiver families. The total number of children in the study was 53. 62% were girls and 38% were boys. 32% of children were under the age of five, 15% of children were between 5 - 10 years and 36% children were aged over 10 years. Most families came to the attention of the IFSS worker either via DoCS (32%) or they self-referred (32%), with almost one quarter (24%) being referred by other agencies.

Conceptualization of Need and Change in Families through the North Carolina Family Assessment Scale

The North Carolina Family Assessment Scale (NCFAS) Version 2 is a multidimensional instrument developed to aid workers and researchers in assessing need and change in families with significant psychosocial difficulties to evaluate the Intensive Family Preservation Services (Kirk, 2001). The NCFAS contains five domains (i) Environment, (ii) Parental capabilities, (iii) Family safety, (iv) Family interactions and (v) Child well-being. Each of these domains comprises a series of subscales. For example, the Family Interactions domain contains the following four subscales, (i) Bonding with the child(ren), (ii) Expectations of child(ren), (iii) Mutual support within the family, and (iv) Relationship between parents/caregivers. The five domains and the subscales within each domain appear at the end of the paper. See Figure 1, pg. 89.

To complete the NCFAS IFSS workers were required to score each family, on each item in the subscales, along a spectrum ranging from '+2=clear strength' '+1=mild strength' '0=base line' '–1=mild problem' '–2=moderate problem' '–3=serious problem'. In addition to the subscales within each domain there is a global item that asked the worker to provide an overall rating of functioning in relation to that domain. This overall rating was completed after each subscale was given a specific rating. To enable consistency in the rating process an orientation session was conducted by the research team at RWIFSS for all staff participating in the research. This orientation included the rating of a hypothetical case followed by comparison of ratings and rationale for ratings assigned across workers participating in the training session.

Findings

Multiple Problems A Common Theme

The environment of intensive family support encompasses many aspects of families' and workers' experience. In attempting to present an overview of the process of identifying and responding to needs this paper will draw on thickened descriptions from parents and workers of the experience of the helping encounter as well as quantitative data emerging from questionnaires. The families presented with multiple needs which included: inadequate housing, poverty, financial deficits and unemployment; domestic violence, physical, sexual and psychological abuse; personal and institutional racism; alcohol and drug use; physical and psychological illness; child neglect and abuse; lack of support networks; perceived interference from family and human services; death and loss; depression and stress; and in many cases a need for somebody to talk to in order to overcome their isolation. The following examples of families with multiple and overlapping concerns drawn from the qualitative data are illustrative.

Ann was referred by the hospital after the birth of her child. Some of her presenting needs stemmed from her depressed state however, the worker soon began to unravel the complexities around her partner's mental health and the couple's isolation in the community.

> *Alicia (worker)*
> *'They'd been referred by the Mental Health team...mum has, she still has mental illness. She had a post-partum depressive episode just after the birth. So when I actually started working with the family she just came back from hospital...helping mum to deal with the baby...also dad has mental illness...they don't have any family.'*

In another instance, an IFSS worker while helping a parent with financial assistance, and linking her with community resources, recognized the impact of the parent's drug and alcohol abuse and instances of domestic violence on the children's safety.

> *Nicole (worker)*
> *'We targeted this family through assertive outreach initially because of poverty, family safety and child safety at home and in the community. Since then we have found out that there are serious drug and alcohol issues, domestic violence issues and issues of safety for the children.'*

In order to profile the presenting needs of families IFSS workers were asked to identify areas of difficulty and rank order them. The first three prioritized areas of need are presented in Table 1. The primary presenting problem for most families related to environmental issues (32%) such as housing and threat of eviction, followed by a parent with a mental health problem (12%) and behavioral/control issues in relation to the child/young person (12%). The main secondary presenting problem related to school problems (16%) such as attendance, performance and exclusion; parenting (16%), and behavioral/control issues in relation to the child/young person and school problems (16%). Just over 10% of secondary presenting problems were due to financial difficulties and having a parent with a drug or alcohol problem. The most common tertiary presenting problem was parenting (16%) followed by parent's drug/alcohol problem (12%), domestic violence (12%) and

financial problems (12%). A small minority (8%) also reported teenage pregnancy and behavioral/control issues in relation to the child/young person. See Table 1, pg. 88.

      In a large proportion of cases (48%) the IFSS workers reported that there might be other needs or problems that had not yet been uncovered. An aggregation of primary, secondary and tertiary needs/ problems suggests that environmental issues (44%), child behavior difficulties (36%) and parenting concerns (32%) were predominant presenting issues. This overview of needs and concerns elicited from IFSS workers is elaborated in the data drawn from the North Carolina Family Assessment Scale completed by workers at initial engagement with the family and six months later.

Need and Change in Families

      In the analysis that follows the global ratings on each domain are discussed and represented diagrammatically. In relation to the subscale ratings the frequency of ratings of 'moderate' (-2) and 'serious' (-3) problems are presented in Tables 2 to 6.

      Environment In the sub scales of the environment domain the most frequently reported "serious" or "moderate" problems were safety in the community, financial management and learning environment affecting 44% of families (Table 2). The most frequently reported "serious" or "moderate" problems for families in Interview 2 were safety in the community (30%) followed by housing stability (19%) and habitability of housing (19%).

      The "overall" rating at Interview 1 for this domain indicated that most families (56%) were experiencing problems, mainly in the "moderate" range (30%) (Figure 1). A substantial proportion of families were functioning at an "adequate" or better level (45%). In the six-month period between Interview 1 and Interview 2 the overall domain ratings for the families demonstrated apparent improvement. For example, there were 4% of families rated as functioning at a "clear strength" at Interview 1 and 29% at Interview 2. In keeping with this finding were apparent decreases in the proportion of families reported as experiencing "moderate" or "serious problems" and those rated as functioning at an "adequate" level. There was an apparent increase in the category of "mild problems" which appears to have accumulated some of the downward shift from the serious and moderate problem categories. See Figure 1 and Table 2, pgs. 89 and 90.

      Parental Capabilities In this domain the most frequent problem areas were disciplinary procedures (30%) and supervision of children (26%) (Table 3). At interview 2 IFSS workers reported that although a small proportion of families were affected by "moderate" to "serious" problems, the proportions affected were similar for almost all parental capability subscales. The most frequent problems for these families were the parent(s)'/ caregiver(s)' use of drugs/alcohol (19%), followed by supervision of children (15%).

      For the "overall" parental capabilities domain almost half of the families (44%) at Interview 1 were rated as having problems, with more than one in five (22%) in the "mild" range and just over half (56%) were rated as "adequate" (33%) or better (23%) (Figure 2). The proportion of families functioning well in the overall parental capabilities domain increased substantially from Interview 1 to Interview 2. There was an increase of 14% of families functioning with "clear strength", 11% of those functioning with "mild strength" and similar reductions experienced in the proportion of families experiencing "mild

problems" (11%) and "moderate problems" (15%). There were, however, 4% more families in the "serious problems" category on this domain at Interview 2. See Table 3 and Figure 2, pgs.90 and 92.

Family Interactions IFSS workers reported that the most common problem in relation to family interactions subscale was bonding with the child(ren) (19%) (Table 4). "Moderate" and "serious" problems were reported to occur equally in the subscales of expectations of child(ren) and mutual support within the family (11%), but no "serious" or "moderate" problems were reported to occur in the relationship between the parents/caregivers subscale. At interview 2, in relation to family interaction there were not many families that were reported to experience "moderate" or "serious" problems on the family interactions subscales. The most frequently reported "moderate" or "serious" problem was mutual support within the family affecting 11% of families.

The IFSS workers rated the "overall" family interactions (at Interview 1) as "adequate" for most families (59%), although a substantial proportion (29%) was rated as having problems of which most were in the "mild" and "moderate" categories (Figure 3). The proportion of families functioning well in the overall family interaction domain increased from Interview 1 to Interview 2. At Interview 1 no family was reported to be functioning with "clear strength", but at Interview 2, 11% of families were reported to be functioning at this level; and the proportion functioning with "mild strength" increased from 11% to 26% while the proportion of families rated as functioning "adequately" fell by 18%. The only increase (4%) in families experiencing problems was in the category of "moderate problems". See Table 4 and Figure 3, pgs.90 and 93.

Family Safety There were several family safety problems identified by the IFSS workers, primarily emotional abuse (19%), and domestic violence between the parents (19%) followed by neglect of child(ren) (11%), (Table 5). However, the frequency with which the problems were reported to occur suggests a small proportion of families were affected by these types of problems. At interview 2 in the family safety domain the most frequently reported problems were emotional abuse of child(ren) (11%) and neglect of child(ren) (11%), however, there was no evidence of a "moderate" or "serious" problem in relation to sexual abuse of child(ren). Where problems were reported, regardless of subscale, the proportion of families affected was minimal.

In relation to the "overall" Family Safety domain at Interview 1, families were split into one of two categories: either they were rated as having problems (49%) or "adequate"/better (53%) (Figure 4). In the 6-month period between Interview 1 and Interview 2 there were improvements in almost all categories for the overall domain of family safety. The proportion of families functioning with "clear strength" increased to 26% but the largest increase was in the proportion of families functioning with "mild strength" (22% additional families at Interview 2). This finding was reflected in the apparent shift from Interview 1 to Interview 2 in the proportion of families that were experiencing "mild problems" (22% of families moved from this category). There was no change in the proportion of families experiencing "serious problems". See Table 5 and Figure 4, pgs. 91 and 93.

Child Well-Being IFSS workers reported the "moderate" to "serious" problems in relation to child well-being which were mainly centered on the child(ren)'s behavior (26%) followed by the child(ren)'s school performance (19%) (Table 6). The most frequently reported "serious" or "moderate" problem within the child well-being domain was child(ren)'s behavior (15%). There were no "serious" or "moderate" problems reported for the subscales of relationship with sibling(s) and cooperation/motivation to maintain the family.

The vast majority of families (70%), at Interview 1, had an "overall" child well-being rating of "adequate" or "mild strength", while almost one third (30%) were rated as having a problem (Figure 5). There were apparent improvements in the overall domain ratings for the child well-being domain from Interview 1 and Interview 2. At Interview 1 there were no families reported to be functioning with "clear strength" whereas at Interview 2, 26% of families were rated at this level, although the proportion of families functioning with "mild strength" decreased by 7%, but the proportion of families functioning "adequately" remained static. Other changes included a substantial decrease in families functioning with "mild problems" (12%) and a smaller decrease in those experiencing "serious problems" (7%). See Table 6 and Figure 5, pgs. 91 and 94.

Overall Domain Ratings at Interview 2 The findings indicate that, for each domain, the number of families functioning at an "adequate" or higher level outweighed the number of families with problems, at Interview 2. The domain in which most families were functioning well was the "overall" child well-being domain (89%) followed by the "overall" domains of parental capabilities and family interactions (78%) (Table 7). The domain in which families were most frequently rated with a problem (41%) was "overall" environment. See Table 7, pg. 91.

Interview 1 and Interview 2 Comparisons The data are presented here to allow some comparison between the Interview 1 and 2 ratings. Where appropriate either parametric or non-parametric statistical tests were conducted to determine if observed differences were statistically significant. Two sets of inferential statistics were undertaken to determine whether observed changes were statistically significant. T-tests were performed on the overall domains and for the aggregated domain scores for Interview 1 and Interview 2 to determine if statistically significant changes had occurred in the mean rating for the families between Interviews 1 and 2. The overall domain was a single global rating for each subscale, whereas the aggregated domain is based on the sum of all items in each subscale. All analyses included each item in the spectrum ranging from "+2 (clear strength) to –3 (serious problem)".

The t-tests showed that change between Interviews 1 and 2 was significant for each domain (Tables 8 and 9), yet the magnitude varied from 0.5 to 1.1, equal to a "half to one category" change. That is, one category change would be the equivalent of moving from a serious problem to a moderate problem etc. Wilcoxon tests were performed on overall scores to measure whether there was a change in the status of families from "problematic" (mild, moderate or serious) to functional (adequate or mild/clear strengths). There were two significant changes detected, one occurred on the parental capability domain (p=0.033) and the other on the family safety domain (p=0.032). In summary there were significant changes observed across each of the domain ratings from Interview 1 to 2, with parental capability and

family safety showing a "clinically significant" shift in the overall functional status of the group as a whole. See Tables 8 and 9, pg. 94.

How did the Method and Intensity of RWIFSS Contact with Families Relate to their NCFAS Ratings

Time spent with families was measured by face-to-face contact, home visits, telephone contact and "other" contact. IFSS workers conducted an average of 27.6 home visits per family, with the minimum number of visits being five and the maximum 74 per family. The average number of hours spent in face-to-face contact by workers with each family was 38.1 hours (with a maximum of 108 and a minimum of 3 hours). Telephone contact between the workers and families averaged 8.6 hours with a range of 27 hours per family. There was an average of 6.7 "other" contact hours by the IFSS workers.

The relationships between these contact data and the five NCFAS Overall Domain ratings were analyzed to identify correlations. There was one significant relationship detected. 'Home visits' and 'other' contact hours were significantly correlated with parental capabilities, such that a greater number of contact hours was associated with positive ratings of levels of parental capabilities ($r=0.68$; $p<0.01$). When the variables of 'telephone contact' and 'other' contact were combined the findings were replicated: telephone and other contact hours in combination were significantly correlated with parental capabilities.

The Process of Working with Families and Other Agencies

The research explored with IFSS workers their intervention goals, the process of working with clients in day to day interactions and their views on what services were most valued by the families. Of three prioritized intervention goals specified by IFSS workers in their case plans the first goal of intervention for most families was housing (28%) followed by advocacy (24%). A small proportion of families (8%) required support in parenting as their first intervention. The second most common intervention goal was advocacy (24%) followed by support (16%) and housing (12%).The third most common intervention goal related to parenting (20%) and referrals (20%) with a substantial minority (16%) reporting support. When combined, intervention goals around advocacy (56%), housing (40%) and practical and emotional support (40%) appear to have been the dominant focus of intervention. While families accessed services predominantly from RWIFSS, they also received services from other non-government agencies and government departments.

Practical assistance was high on the list of IFSS workers' perception of valued services. This included support with housing, accompanying parents/ caregivers to court or medical visits, letter writing, income support, household budgeting, food vouchers and parenting advice. Other valued aspects of the services were more person-centered such as, emotional support, trusting relationships, and the fact that the service is accessible and confidential. The predominant themes gleaned from the qualitative data from worker interviews clustered around; building trust; acknowledging and addressing the stated needs of the client; bringing to the forefront unstated needs; facilitation of practical assistance; being a sounding board for the family and linking clients with other services.

Building Trust

As part of trust-building with families IFSS workers emphasized that listening to the parent/caregiver and attempting to address expressed needs seemed to be the first step towards building a trusting relationship. To finally be allowed into a family's home was perceived by the IFSS workers as an immense expression of trust in the working relationship, given their prior knowledge that other agencies have been viewed with mistrust and have been stopped at the door.

> *Nicole (worker)*
> *'A development of the trust that it took for them to ask us for help. No matter who went to their house before, they got the doors locked in their face. The trust issue is huge…It takes the family a long time to trust. You just have to take the time to build that up and not be too much in their face when they don't want you there.'*

An important aspect of trust for some IFSS workers was that caregivers felt the worker understood they were not a statutory body whose perceived role, from the caregiver's perspective, is removing children.

> *Alicia (worker)*
> *'I think Jolene [sees RWIFSS] as a different service from DoCS (Statutory Services). 'The good one and the bad one'. I think she understands that I'm here to help her to stay with her children, whereas she sees DoCS as the service that is going to take her kids. So she really expects me to understand where she came from and what she's been through.'*

Being a Sounding Board for the Parent/ Caregiver

IFSS workers noted that a parent/ caregiver would come in off the street to have a 'yarn', or stop the IFSS worker in the street for a brief chat. Being a sounding board for the parent/caregiver allowed the IFSS workers to begin to understand the parent's/ caregiver's whole story, relate that story to their cultural background and to the context of the Redfern-Waterloo area.

> *Rebecca (parent)*
> *'Being a single parent and a first time parent rolled into one is an extremely hard job. I didn't realize that. But with Janet (worker), just knowing all I've got to do is ring and say look I really don't know what the hell I'm going to do here and then she suggests something, gives you a different perspective, a different outlook on, so that's given me different ways to deal with things at home. Just ring Janet and she'll come straight…she's just been a phone call away.'*

Linking Families with Other Services

Linking families with other services is a major role for IFSS workers. Families with multiple needs and difficulties are not easily assisted by a single service provider. One IFSS worker dealing with a family presenting multiple needs reflects on the process.

> *Nicole (worker)*
> *'Coordinating these services has been a huge job. Huge. Even dealing with the different agendas that each service has is a huge job. The school suspended Jeremy's children and didn't even phone us and let us know…Coordinating those services takes every bit of diplomacy you can muster. People get very frustrated because there are so many kids and so many issues going on.'*

IFSS workers referred to the amount of interagency activity involved in families' lives and how the agendas of each agency may have to be suspended in advocating for the family's needs. They were challenged in addressing the needs of the families while navigating the complexity of interagency dependency. In some cases, agencies were not willing or able to take action until a situation had escalated out of control or reluctant to see the family's difficulties in the same way, or at the same level of urgency. Being aware of some of the complexities of a family's situation that may be overlooked by other agencies who are focused on single issues such as housing or child protection, they were in the foremost position to advocate on the family's behalf. In the quote below one IFSS worker notes how some agencies do not pay enough attention to cultural and the more current aspects of the family's needs.

> *Alicia (worker)*
> *'The problem area is Housing. They would communicate with us okay and I could see the worker at the Department of Housing, but there were a lot of policies/rules and red tape that we weren't able to get through…They think in terms of the number of people who live in the house and don't think in terms of the interactions of the family members and their relationships to each other. The worker there was not very understanding at first, but when I met him with Wanda he changed and became more cooperative and helpful. It's just that he was bound by the Housing Dept rules, which need to be more flexible to allow for cultural recognition and change in circumstances regarding the number of people in the family at different times.'*

Supporting Families Practically and Emotionally

Supporting families emotionally and introducing new ways of looking at situations was often bolstered with practical support. However, when one IFSS worker assisted a caregiver in finding suitable housing she experienced first hand the discrimination to which some families were subjected.

> *Nicole (worker)*
> *'I think she saw me as a support in trying to get what she needed. She appreciated being driven around and having someone to actually help her get a house. Because she was Aboriginal a lot of [landlords] didn't want to know her. There was a lot of racism against her. It was the first time I'd ever really seen that.'*

In supporting the family in a practical way the worker was able to acknowledge the everyday practical difficulties Aboriginal families can face with the most basic of necessities. Practical assistance was acknowledged as a high priority by the IFSS workers.

Reviewing the qualitative data from the parent/ caregiver interviews it was evident that the worker was viewed in a positive sense, as a partner, a peer, and a friend. In contrast, they were also perceived as authority figures and a means to an end. Below are excerpts from parent interviews reflecting their varied perceptions.

> *Lisa (parent)*
> *'Very friendly, and she seems to know, she's got an idea what we're going through. So she's giving us some examples…She's told me that if I ever need anything, to give her a call, or leave her a message, which is very comforting. I haven't called her yet, but to know that...just a phone call away.'*

> *Robert (parent)*
> *'It's not hundred per cent perfect, don't trust Alicia (worker), I don't trust Alicia hundred per cent, but I trust her [ninety] percent.'*

Perceptions of Positive Changes: Workers' and Parents' Accounts

The research also explored IFSS workers' perception of positive outcomes in relation to targeted problems and realization of family goals. Some illustrations of benefits identified are cited below.

For Jeremy, the sole parent of the family, the main goal was to gain stable accommodation. At the time of initial contact they were living in crowded conditions with a relative. The IFSS worker also recognized the children's low attendance at school, behavioral difficulties and general hygiene matters which had to be brought to the attention of DoCS.

> *Nicole (worker)*
> *'We now have stable accommodation, which is huge progress. The kids are now at school, generally speaking, 5 days a week. Huge progress. The kids' behavior is improving, a lot less bad days. Dad is more open and receptive to having involvement with services, however, he's still very resentful of having involvement with DoCS.'*

A final illustration of perceived changes comes from IFSS workers highlighting the progress of a family in relation to dealing with children attending school.

> *Michelle (worker)*
> *'He now attends school 4 days a week...Emma attends 4 days at day care as well. Holly seems to have her finances more under control. They've been offered housing and just waiting for relocation...I think she's pushing harder for their education now, whereas before I don't think she saw it as an issue...I feel there has been huge progress in every aspect that we've dealt with. Holly is more motivated and comes more often for the help.'*

Education was valued by many of the families however it was difficult for them to act upon their aspirations for the children. A valued outcome is that the workers were able to facilitate the parent's interest with practical assistance and support.

The research also explored with families whether they experienced any positive changes through the service or accomplished any of their goals. The lack of, or the competition for, available resources were constraining factors in achieving major changes in a relatively short time. However, there seemed to be positive and affirming movements in the families' lives that were attributed to involvement with RWIFSS. Some changes were also attributable to clients' own efforts. This seems an affirmation of the way in which IFSS workers attempt to work with clients. That is, the family does the work and the IFSS worker is there to support and facilitate their effort.

Rebecca (parent)
'Barnardos has made me more confident as a parent. Also enabled me to, realize that I've got someone that will help me that's on my side…It's not as explosive as before. It's a good way to put it. But [my son's] the same as me, so that's where conflict comes in, he's the child and I'm the parent… I found I was literally drowning. And it benefits him so much being on the better than the worse, which I'm more happy about… the hints that I've had in the first six months from Janet (worker), now has shown me a way to deal with things more confidently.'

In the case of Tina, the IFSS worker had attempted to help raise her self esteem, work with alcohol related issues and introduce her and her child to community activities.

Tina (parent)
'Yeah I got more motivation to get up and do things for the baby and get out there… before I used to go to the pub and all that, I got more motivation…I go to the barbeque on Fridays, I never used to do that before… Yeah more family orientated…Yeah that there's better things out there that you can do with the kids… Day care, yeah, it helps.'

Lisa and Tony had their children briefly removed. Their involvement with the IFSS worker during the experience of brief removal of their children into care made the couple more aware of their own and their children's needs.

Lisa (parent)
'Overall it's been really positive. They gave us some examples, more structure, how to help with the relationship between myself and the kids and Scott and me and the other family and friends that are around us… And Janet came in, she used her examples, and she changed it so it would help us, which is really good. We tend to talk about things more, which is what I should have done before all this happened (children being removed/short term).'

Discussion of Findings and Implications for Practice

In the research reported on outcomes from family support interventions through RWIFSS a clear pattern of vulnerability was evident in the profile of families served. The program served families with serious parenting stress and child protection concerns, limited economic resources and social supports. Factors contributing to their stress were contextual such as single parenthood, unemployment, incomplete education, lack of or inadequate housing, and living in poverty. Additional stress came from children having learning and behavioral difficulties. Other factors included the parents' own experience of abuse, racism and mental illness. Their needs were interrelated, cumulative and evolving. They were also involved with multiple services and agencies. This points to the need for comprehensive assessments at first contact and at later points in working with families as new stresses emerge and new needs and priorities come to the fore. A multi-pronged and coordinated response to families is crucial to effective service delivery. Both the provision of information to families on services available and the flow of information between services are emphasized. The significance of facilitating access to networks of complementary services is acknowledged (Nelson, 1990; Campbell, 2004).

Focusing both on ecological factors and internal change (McCurdy & Daro, 2001) interventions were multidimensional, encompassing assistance with concrete needs such as housing, finances, food, responding to concerns about domestic violence and abuse, personal and institutional racism, child behavioral problems, mentoring children, parent education, enhancing formal and informal support networks and general supportive counseling. Acknowledging the hierarchy of family needs and the significance of responding to concrete and practical interventions in reducing family stress and improving parenting environments is reinforced in the literature (Ryan & Schuerman, 2004; Chaffin et al, 2001). There is a strong need to keep social disadvantage and social exclusion in focus and address the structural dimensions of parenting environments through universal and targeted services.

The systematic recording and assessment of family strengths and areas of concern facilitated by the NCFAS framework enabled the identification of baselines in relation to the major domains of Environment, Parental Capabilities, Family Interactions, Child Well-Being and Family Safety in Phase 1 of the evaluation. Against these baselines there were identified gains reflected in improvements in scores on 'strength' ratings, and changes in the positive direction in terms of the degree of 'moderate' and 'serious' problems in Phase 2. In relation to contributory factors, encouragingly, there was evidence of a significant relationship between amount of worker time spent in home visits and other contact and improvements in Parental Capabilities. Overall the NCFAS data has afforded a useful multi-dimensional measure of needs and change in this cohort of families. The five domains provided a focused scope for assessment of strengths and problem areas, including opportunity for in-depth examination of specific capabilities in each domain. This enabled assessment of strength acquisition and problem reduction.

A substantial number of families were referred by statutory protective services to address child protection concerns. National trends reveal disproportionate numbers of Aboriginal children on Care and Protection Orders – seven times higher than the rate for other children. As a result of this over representation of Aboriginal children in care systems and the intergenerational trauma resulting from the 'stolen generation' (AIHW, 2005;

Stanley et al, 2003; Fernandez, 1996) Aboriginal families have become distrustful of statutory authorities and welfare agencies. Much of the initial intervention by IFSS workers was around building trust and culturally sensitive and committed work to enable families to reengage with agencies. The role of cultural awareness and competence in working with indigenous communities has been stressed (Bacon and Gillman, 2005; Libesman, 2004; Murray et. al., 2004). Littell and Tajima (2002) also found that trust was difficult for populations such as Afro-American families who also appear to be over-represented in child welfare systems. Hussain (2006) and Denby and Curtis (2003) point to the positive outcomes for clients resulting from culturally competent systems of service delivery particularly in terms of enabling clients to feel empowered, and decreasing their anxiety and distrust in formal systems. Most Aboriginal families in this study were able to build trust and 'work with' workers where statutory services had difficulty in positively engaging with them. The more accessible workers were to families through being culturally competent, local, transparent and sensitive in the way they challenged clients, the more likely clients were to participate in decision making and remain engaged with services

The difficulty in relating to systems of care is not isolated to Aboriginality. Similar to findings of Littell and Tajima (2005) this research highlighted substance abuse, mental illness, domestic violence, marginal housing and general isolation as impacting on parents' ability to engage with services. Littell (2001) and Becker et. al. (2002), note that clients are more likely to engage with programs when the process is collaborative. Broadhurst (2003), McCurdy and Jones (2000), Chand and Thorburn (2005) and Quinton (2004) found that irrespective of models of intervention the relationship between the worker and families made a major contribution to service outcome, a finding reinforced in this research where it becomes apparent that 'working with' the family is the central objective. Accounts from clients acknowledged positive impacts on family interactions and parenting environments, attributing these gains to IFSS workers in addition to their own hard work. The flexible responsive orientation of workers is suggestive of rich possibilities for change reflected in the joint problem solving elaborated in the accounts of workers and families. While case plans were formulated on the basis of initial assessments the process of sequencing goals and developing strategies was a negotiated process involving families enhancing their active collaboration, problem recognition and their intention to change, processes considered to be predictive of improvements in family functioning (Littell & Gervin 2004). Parents valued worker qualities such as listening, being non-judgmental, accepting and empathic and being accessible, reinforcing observations of previous research (McCurdy & Jones, 2000; Ribner et. al., 2002). To sustain these attributes in the workforce, policies to promote staff training, supervision and manageable caseloads are crucial.

There is a wide literature that touches on the tensions inherent in the interface of family support and child protection (Gibbons, 1995; Hayward & Cameron, 2002; Whittaker, 1997). RWIFSS workers in attempting to integrate a family support orientation with protective goals attempted to maintain a level of transparency by discussing with the family when it was in the best interests of children and the family to notify authorities about child protection concerns. This experience of partnership introduced a strong sense of balance to families' wariness arising from previous contact with formal statutory services. Fear of loss of autonomy and control was a strong theme in their previous involvement with services. Family support services that support families in their efforts to meet child protection and safety needs through an inclusive and partnership approach are crucial to positive outcomes

for children. Family based services may not always achieve the goal of preventing child removal, and to envisage that child placement, in the short term, could always be prevented in families with multiple and entrenched problems may be unrealistic. As documented in previous research and in this study, family based services, while not always achieving the expected outcome of preventing placements in all instances, have been successful in reducing family stress, enhancing child wellbeing, schooling outcomes and ameliorating the effects of poverty and social exclusion (Statham & Holterman, 2004; Macleod & Nelson 2000; Gray, 2003; Fernandez, 2004).

This study contributes to our understanding of the service delivery and outcome of service. There are however limitations. The sample size was small limiting the ability to find significant effects. The limited analysis of relationships between specific services and outcomes are correlational, the current study being non-experimental. A long follow-up period would have enabled the identification of families needing ongoing support to sustain outcomes achieved. This research had a follow-up element built in and used workers' conceptions of parenting needs and problems in addition to parents' assessments of their needs and difficulties. This enabled triangulation of both accounts generating fuller data on the micro processes and outcomes of the service. Follow-up studies are urgently needed to enhance knowledge building in the area of intensive family based services and early intervention.

In summary the analysis does not claim momentous changes. In such a community experiencing entrenched and multiple disadvantages including institutional abuse there has to be a balanced appraisal of outcomes. The IFSS workers were modest in identifying changes and were aware of the significant role they played in facilitating outcomes. As one worker expressed in an interview "it's two steps forward and one step back."

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87·Elizabeth Fernandez

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Table 1: Family Difficulties - Presenting Problems

Presenting Problem	1st	2nd	3rd	Total (1 – 3)
	%	%	%	%
Environmental issues	32.0	8.0	4.0	44.0
Behavioral/control issues in relation to the child/young person	12.0	16.0	8.0	36.0
Parent with mental health problem	12.0		4.0	16.0
Domestic violence	8.0	4.0	12.0	24.0
Parent with a drug/alcohol problem	8.0	12.0	12.0	32.0
Concerns about restoration of a child from care	4.0			4.0
Financial problems/debts	4.0	12.0	12.0	28.0
Suspected abuse/neglect	4.0		4.0	8.0
Parenting difficulties		16.0	16.0	32.0
School problems		16.0	4.0	20.0
Teenage pregnancy/parenthood			8.0	8.0
Other	4.0	4.0	4.0	12.0
Not specified	12.0	12.0	12.0	36.0
Total	100.0	100.0	100.0	

N=25

89·Elizabeth Fernandez

Figure 1: NCFAS Domains and Subscales

Domain	Environment	Parental Capabilities	Family Safety	Family Interactions	Child Well-Being
Subscale	• Housing stability • Safety in the community • Habitability of housing • Income/employment • Financial management • Food and nutrition • Personal hygiene • Transportation • Learning environment • **Overall environment**	• Supervision of child(ren) • Disciplinary practices • Provision of developmental/enrich-ment opportunities • Parent(s')/caregiver(s') mental health • Parent(s')/caregiver(s') physical health • Parent(s')/caregiver(s') use of drugs/alcohol • **Overall parental capabilities**	• Absence/presence of physical abuse of child(ren) • Absence/presence of sexual abuse of child(ren) • Absence/presence of emotional abuse of child(ren) • Absence/presence of neglect of child(ren) • Domestic violence between parents/caregivers • **Overall family safety**	• Bonding with the child(ren) • Expectations of child(ren) • Mutual support within the family • Relationship between parents/care givers • **Overall family interactions**	• Child(ren's) mental health • Child(ren's) behavior • School performance • Relationship with parent(s)/caregiver(s) • Relationship with sibling(s) • Relationship with peers • Cooperation/motiva-tion to maintain the family • **Overall child well-being**

Table 2:   Frequency of Moderate or Serious Problems in the Environment Domain Subscales at Interview 1 & 2

	Int 1 %	Int 2 %
Housing stability	37	19
Safety in the community	44	30
Habitability of housing	41	19
Income/employment	11	4
Financial management	44	15
Food and nutrition	11	7
Personal hygiene	15	4
Transportation	11	4
Learning environment	44	15

Table 3:   Frequency of Moderate to Serious Problems in the Parental Capabilities Subscales at Interview 1 and 2

	Int 1 %	Int 2 %
Supervision of children	26	15
Disciplinary procedures	30	11
Provision of development/enrichment opportunities	19	11
Parent(s')/Caregiver(s') mental health	15	11
Parent(s')/Caregiver(s') physical health	4	4
Parent(s')/Caregiver(s') use of drugs/alcohol	19	19

Table 4:   Frequency of Moderate to Serious Problems in the Family Interactions Subscales at Interview 1 and 2

	Int 1 %	Int 2 %
Bonding with the child(ren)	19	7
Expectations of child(ren)	11	7
Mutual support within the family	11	11
Relationship between parents/caregivers	0	4

91·Elizabeth Fernandez

Table 5:   Frequency of Moderate to Serious Problems in the Family Safety Subscales at Interview 1 and 2

	Int 1 %	Int 2 %
Physical abuse of child(ren)	4	4
Sexual abuse of child(ren)	4	
Emotional abuse of child(ren)	19	11
Neglect of child(ren)	11	11
Domestic violence between parents	19	7

Table 6   Frequency of Moderate to Serious Problems in the Child Well-Being Subscales at Interview 1 and 2

	Int 1 %	Int 2 %
Child(ren)'s mental health	7	4
Child(ren)'s behavior	26	15
School performance	19	7
Relationship with parent(s)/caregiver(s)	15	4
Relationship with sibling(s)	4	0
Relationship with peers	11	7
Cooperation/motivation to maintain the family	11	0

Table 7: NCFAS Strengths (Ratings 0 to 2) and Problems (Ratings –1 to –3) at Interview 2

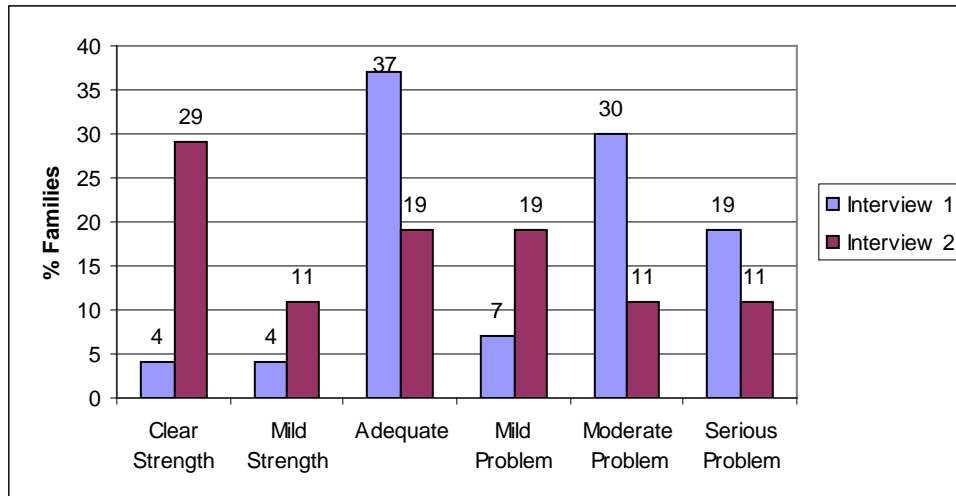| N=45	Strengths %	Problems %	Incomplete data %
Overall environment	59	41	
Overall parental capabilities	78	22	
Overall family interactions	78	18	4
Overall family safety	74	22	4
Overall child well-being	89	11	

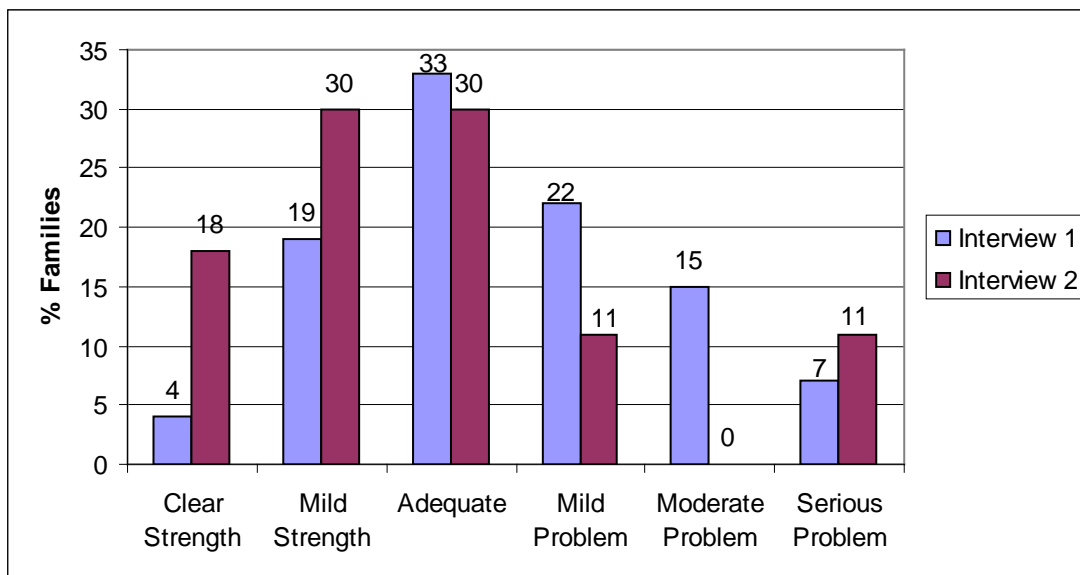**Figure 1: NCFAS Overall Environment, Interview 1 Compared with Interview 2**

Figure 2: NCFAS Overall Parental Capabilities, Interview 1 Compared with Interview 2
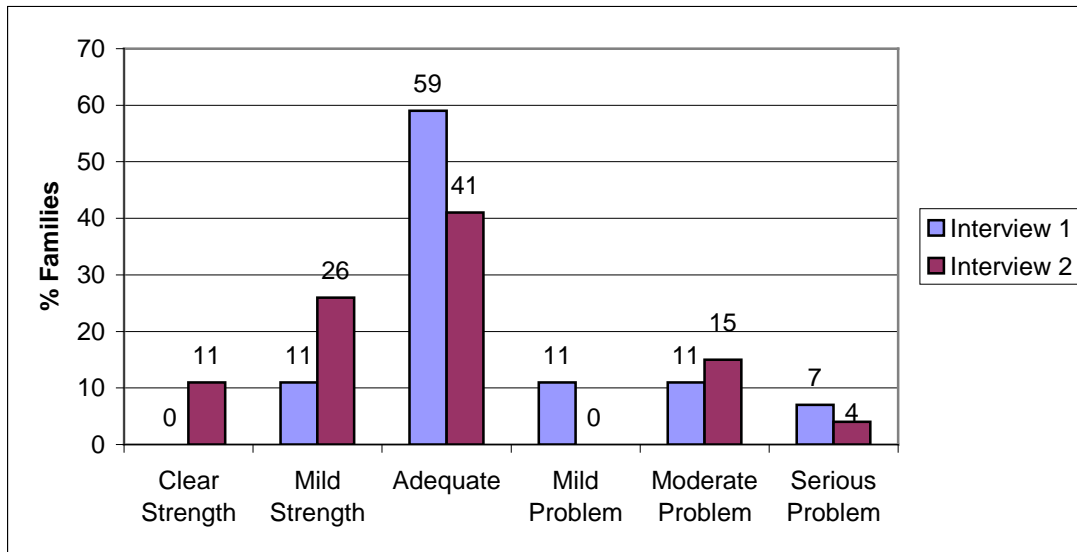
93·Elizabeth Fernandez

Figure 3: NCFAS Overall Family Interactions, Interview 1 Compared with Interview 2
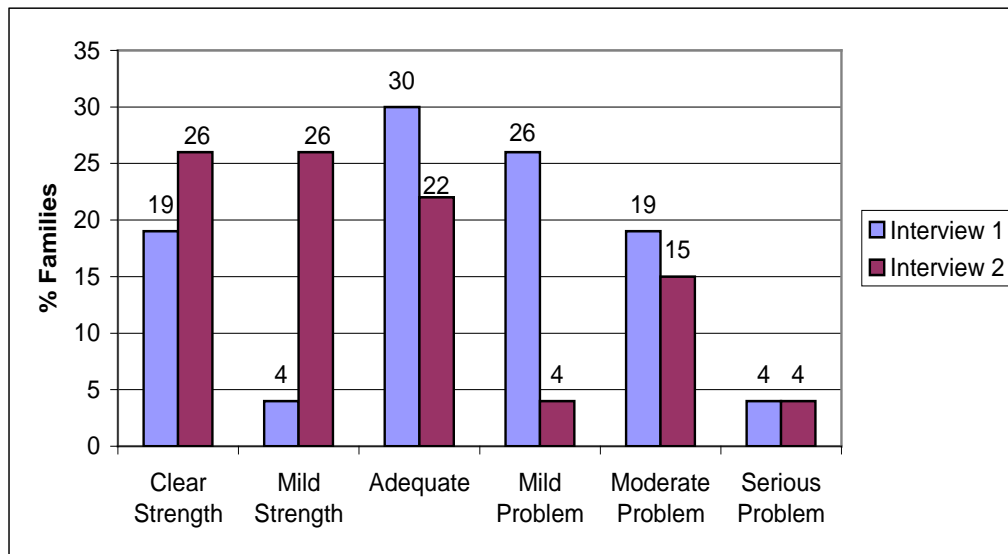

Figure 4: NCFAS Overall Family Safety, Interview 1 Compared with Interview 2
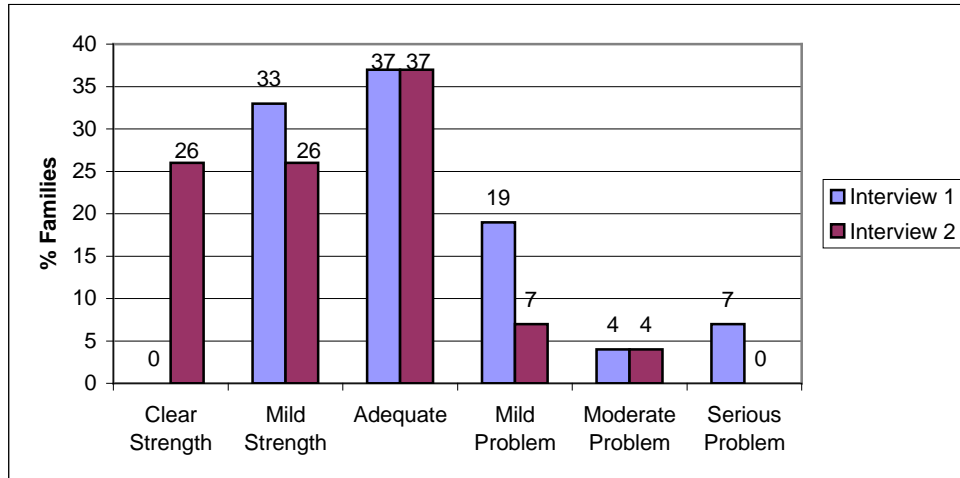
Figure 5: NCFAS Overall Child Well-Being, Interview 1 Compared with Interview 2

Table 8: Comparison of Interview 1 and Interview 2 Overall Domain Scores

Overall domain scores	mean difference	sd	t-value	df	p-value
Environment	1.10	1.3	-4.20	26	0.000
Parental capabilities	.70	1.1	-3.43	26	0.002
Family interactions	.54	.76	-3.61	25	0.001
Family safety	.65	1.4	-2.46	25	0.021
Child well-being	.78	1.3	-3.23	26	0.003

Table 9: Comparison of Interview 1 and Interview 2 Aggregated Domain Scores

Aggregated domain scores	mean difference	sd	t-value	df	p-value
Environment	.67	.59	-5.75	25	0.000
Parental capabilities	.42	.63	-3.51	26	0.002
Family interactions	.56	.61	-3.85	16	0.001
Family safety	.32	.80	-2.08	25	0.048
Child well-being	.81	.65	-4.15	10	0.002

Parents Too Can Evaluate Family Preservation Services - or –Involving Parents In Evaluation of Family Preservation Services*

Anthony N. Maluccio

In line with the long-standing emphasis in the human services on involving clients in program evaluation, in this essay I focus on principles and strategies for involving parents in evaluation of family preservation services. In particular, I delineate the crucial roles that parents can play as partners in the helping process within a family-centered context.

Involving families – especially parents – in program evaluation has been a central feature of family preservation services ever since their emergence years ago as a powerful movement in the human services. This movement has drawn from various theoretical perspectives – in particular, a strength-oriented view of social work practice that stresses the involvement of clients or consumers in evaluation of services that they receive.

According to such a view, clients are explicitly regarded as persons with assets and potentialities and as partners in the helping process (Cf. Vecchiato, Maluccio and Canali, 2002). For this reason, it is essential that practitioners obtain on a regular basis the clients' feedback regarding their helping efforts. By doing so, practitioners are not only tuned into their clients' perspectives but also can enhance their clients' self-esteem and autonomy and their sense of power and control over their life situations.

Parents as Partners

The emphasis on obtaining client or consumer feedback implies a view of parents (and other family members) as resources on their own behalf – and as partners in the helping process – rather than as carriers of pathology. Such a view is enhanced through attention to the following practice principles, among others.

First, in assessment as well as intervention, there is a focus on the family: in most cases the child can best be helped by regarding the family, as much as possible and appropriate, as the central unit of service and the focus of attention. Consequently, practitioners focus on providing comprehensive, community-based services that help families restructure and enrich their environment "so that it is more suited to their needs and qualities and more conducive to their positive functioning" (Maluccio, 2000: 169).

Second, there is explicit attention to the child's and family's strengths, and parents as well as children are regarded as interested in – and striving to achieve – competence in their every day functioning. Toward this end, practitioners actively seek and use opportunities to help children and parents practice and refine their skills as human beings – and as family members in particular.

Third, the primary role of social workers is defined as that of a catalyst who seeks to enable the family to identify or create and use necessary resources. Above all, practitioners

"become experts in methods of environmental modification, use of existing community resources and natural helping networks, creation of new resources that

may be needed by their clients, and mobilization of family members' own resources" (Maluccio, 2000: 171).

Finally, children and youths themselves are actively involved in the helping process, as they can have much to say about planning and implementing services on their behalf – as long as they are encouraged by practitioners to express their views.

Family-Centered Practice

As implied in the preceding section, maintaining a principal focus on the child *within a family-centered context* is essential. The family's own environment serves as "the arena in which practitioners intervene to help strengthen communication, parenting skills, and parent-child relationships" (Maluccio, Pine and Tracy, 2002: 24). As Germain and Bloom (1999) and others have emphasized, the family has the potential to provide resources throughout the life cycle, especially as its members are sustained through various services and supports. As Berry (1997: 187) has indicated, realizing such potential requires:

> "an array of services extending from preventive, educational and family support services to a range of treatment and placement options for those families who need them."

Selected guidelines for implementing such a family-centered approach to practice include:

- Focusing assessment and intervention on the family's transactions with key aspects of its environment – particularly the kinship system, schools, community institutions, and social networks.
- Consistently regarding the child's and family's safety as paramount – and making a vigorous effort to provide a safe environment for the child.
- Creatively combining concrete and clinical services in order to strengthen the family and promote the competent functioning of its members. In this regard, children in out-of-home care and their families typically need extensive help, as they must cope with the impact of separation and the challenges of becoming reunited with each other (cf. Palmer, 1995).
- Using such services to address not only the child's developmental needs but also the family's survival and developmental needs.
- Being responsive to the values and requirements of families from communities of color, immigrants, gay and lesbian families, and other "socially excluded families" (cf. Hatzivarnava-Kazassi, 1996).
- Involving parents in planning responsibly for their children through family treatment services as alternatives to out-of-home placement or as a means of speeding up reunification of placed children with their families.
- Viewing foster care or residential placement of a child as part of the overall service rather than as *the* service – and complementing it with intensive family supports.
- Actively involving the family's extended kinship system as well as self-help groups in the provision of services for parents and children.

Conclusion

As they seek to provide individualized services in case after case, practitioners can also contribute to the overall improvement of family preservation services. Toward this end, they can be attuned to what they can learn directly or indirectly from the families. To do so, they can obtain client feedback during the process of service delivery as well as at its conclusion. As I found in a study nearly three decades ago, "client feedback can enhance social work practice and service delivery, contribute to theory building, and enrich the education of future practitioners" (Maluccio, 1979: 227).

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PROMOTING FAMILY CONTINUITY – PERSPECTIVES FROM ITALY

Anthony N. Maluccio

In this essay I review a recent research study from Italy, "Le Radici nel Futuro – La Continuita' della Relazione Genitoriale oltre la Crisi Familiare," edited by Paola Dallanegra (2005). The contributors focus on "Spazio Neutro," a multi-purpose child welfare agency in southern Italy that facilitates parent-child visiting and relationships between children placed in out-of-home care and their families. They delineate and illustrate, through comments from family members, selected principles and strategies for maintaining such continuity throughout the out-of-home placement.[*]

The emphasis on promoting continuity in the relationships between young people in out-of-home care and their birth families, particularly the parents or other significant parental figures, has long been a hallmark of child welfare services – in Italy as in other countries. However, implementing such a feature in the reality of practice can be complex as well as challenging.

The contributors to this volume address this challenge by focusing on establishing "*Radici nel Futuro*" – or "roots in the future" – for children and youths who come to the attention of the child welfare system in Italy. By the above phrase they mean maintaining and promoting continuity between birth parents and their children throughout their brief or long-term separation from each other. Paola Dallanegra, the editor, is a social worker who directs *Spazio Neutro*, an agency established in the early 1990s by the city and province of Milan (Italy) explicitly for the purpose of facilitating parent-child visiting and relationships between young people in out-of-home care and their birth families.

The principal contributors to *Le Radici nel Futuro* are staff members and consultants in the above-noted agency or its affiliates. Following a comprehensive review of Italian laws, policies and regulations pertaining to the rights and responsibilities of parents and children, in the opening chapter Dallanegra describes the functions and experiences of *Spazio Neutro*. Of special interest is the evolution of its focus – from initial emphasis on birth parents to extensive consideration of the needs and roles of members of the extended family.

In subsequent chapters the contributors describe and analyze diverse aspects of parental and family continuity. In this regard, they rely on apt quotes from parents, young people and others; on direct observations of family functioning; and on review of the impact of social work intervention by staff members. The quotes are fascinating, and the contributors analyze their significance through references to psychological and sociological perspectives and studies. Building on varied case examples, the contributors

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[*] In a related volume, Gramaglia (2005) describes his study of the perceptions of families regarding health and social services offered through their children's schools. The respondents emphasize, among other aspects, that most parents expect – and use – such services as they seek to cope with their multiple life challenges.

99· Anthony N. Maluccio

delineate valuable principles and suggestions for coping with the many practical as well as emotional demands on staff members.

In the final chapter, the editor and her associates assess the effects of services on the young people and their families. Their evaluation focuses on the individual and family characteristics of the subjects and the reasons for their placement in out-of-home care; the process and quality of services that were provided; the perspectives of children and the adults responsible for them; and the outcomes of intervention.

In conclusion, Paola Dallanegra and her associates offer pertinent recommendations for ensuring that young people in out-of-home care can continue to have – and profit from – ongoing connections with their families of origin. In conjunction with American studies such as those by Martin (2000) and Webb (2003), this volume contributes much of value to child welfare practitioners, administrators and researchers in the U.S.A.

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