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Manuscripts

The *Family Preservation Journal* is a refereed biannual publication. The *Journal* provides a forum for practitioners, administrators, researchers and educators to present and critically review programs, policy, practice methods, and research findings in the areas of family preservation and family support. The *Journal* is intended to positively impact the type and manner of services provided to families. Research and case studies from those delivering services are encouraged.

Manuscripts should conform to American Psychological Association style, with an optimal length of 18 pages, not to exceed 25 typed, double-spaced pages (excluding tables and figures), with an alphabetical list of references. Also include a diskette copy using WordPerfect v 5.1 or v 6.1, or v 8.0 for PC.

Provide five copies of the manuscripts; the title page only should list the author's name, affiliation, address, and telephone number. The author's name must not appear after the title page; only the title should appear on the abstract and first page of the text. Include an abstract of about 100 words.

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Family Preservation: Walking the Walk

Family Preservation is both a “talk,” a philosophy about services to families, and a “walk;” it entails specific practices that are different from business as usual. The point of family preservation is not only the goal of preserving families—it also is the implementation of a family-centered model of practice. This special issue of the *Family Preservation Journal* focuses on the specific components of family preservation programs—the services, practices, and qualities of this model of practice.

Too often, the issue of family preservation and family preservation services has been argued on the philosophical grounds, the “talk,” with vague gestures to the underlying principles and procedures that are critical to its success. This has resulted in legislatures and agencies adopting the goal of family preservation and placement prevention (primarily for the foster care dollars it might save), without truly understanding or implementing the radical changes in practice that must accompany such a goal. The literature and popular press are rife with stories of family preservation gone wrong when the services offered did not follow any known model of family preservation services.

To further complicate matters, the Adoption and Safe Families Act of 1997 has federalized the notion of rapid change in families, following the successes of family preservation services. Although family preservationists typically have limited their short-term program successes to families reported for acute physical abuse, the Adoption and Safe Families Act has mandated that all families served for child maltreatment (including child neglect, known to need much longer treatment than most family preservation programs recommend) must achieve success by 18 months or be considered for the termination of parental rights. This is generalization run amok.

This issue of the *Family Preservation Journal* therefore presents a special collection of articles on the practice of specific services, practices, and qualities of family preservation services, including feedback from consumers, practitioners, and researchers on the components of this model that are most effective and important to its success. Special attention is given to the complications and contradictions inherent in attempting to practice a family-centered model in a political arena that is not family friendly.

In the first article, DePanfilis and colleagues examine the implementation of strength-based practice with families. How do families and practitioners receive this model of practice? Is a strengths orientation helpful to family practice? What do families consider the most important qualities of practitioners? Of programs? What is most helpful to

families? Answers to these questions, from the consumers themselves, provide important insight to practitioners and administrators interested in being responsive to consumer needs and feedback. Those interested in operating from a strengths perspective now have concrete feedback on the specific elements and implementation of a strengths focus that are helpful and critical to treatment and success.

In a similar vein of research, Cash and colleagues asked consumers and practitioners in Florida to provide insight into the experience of implementing family preservation services under the parameters of the Adoption and Safe Families Act. Which policy directives have been most effectively accomplished? Which ASFA directives are the most difficult to achieve? What elements of a family-centered model of practice are most difficult to effect under ASFA? The feedback from the front line offers concrete criticism about the contradictions that presently exist between child protection and family preservation mandates.

Berry then reviews the policy legislation that had led up to the Adoption and Safe Families Act and the contradictions inherent in current child welfare policy. The largest contradiction, of course, is the introduction of the 18-month deadlines by which to accomplish treatment success. From this review, Berry then proceeds to identify the specific practices that have been identified by the evaluation of best practices to hold the most promise in keeping children safe while keeping families together and in a timely fashion.

Kirk and colleagues make this examination of practices more explicit with their article on treatment fidelity (and infidelity) in family preservation programs. Arguing that the meaning of program success is usually clouded by inconsistencies and vagaries in program implementation, they offer an assessment tool by which to track whether a program is implemented faithfully and consistently. This offering is an important step toward increasing the integrity and accountability of family-based programs nationwide.

Finally, a brief essay by Maluccio on the use of short-term foster care is offered. This review of a British study of parents' and children's reactions to short-term foster care finds that the practice is an important element of an array of services to support and preserve families.

Family preservation is more than just a commitment to the integrity of families, and it is not a commitment to preserving families at any cost. The meaning of family preservation as a model of services entails an approach to families as well as specific practices and

principles of work with families that are known most often to lead to outcomes of family safety and integrity. Good intentions are not enough, nor is calling a program a particular name enough to reach its goal. The articles in this special issue each provide concrete, specific, and practical guidance on how to walk the walk—what specific practices in family preservation programs will keep those of us in this field true to our original intent—to preserve families and keep them safe.

Marianne Berry

Applying the Strengths Perspective to Increase Safety and Well-Being: Views from Families and Providers

Diane DePanfilis, Joshua Okundaye, Esta Glazer-Semmel, Lisa Kelly, and Joy Swanson Ernst

Consensus about the value of the strengths perspective is developing among child welfare and family service practitioners. Yet, few first-hand reports are available from the perspectives of family members and interdisciplinary service providers about the principles most important for engaging and supporting family members to achieve needed outcomes. This paper briefly highlights principles most often cited as key to application of the strengths perspective and compares first-hand accounts from family members and service providers. These views were elicited through focus groups facilitated by a community-based family support program. Implications for strengths-based practice with families are discussed.

Strengths-based practice has been increasingly promoted as a viable service model with diverse populations (Cowger, 1994; DeJong and Miller, 1995; Rapp, 1998; Saleebey, 1996; Saleebey, 1997b; Sullivan, 1992; Tice and Perkins, 1996). In particular, the strengths perspective has been emphasized as a promising approach *with families* for over ten years (DePanfilis, 2000; DePanfilis and Wilson, 1996; Duncan and Brown, 1992; Dunst, Trivette, and Deal, 1988; Dunst, Trivette, and Deal, 1994; Early and GlenMaye, 2000; Gilgun, 1999; Kinney, Strand, Hagerup, and Bruner, 1994; Laird, 1996; Leon, 1999; Ronnau and Poertner, 1993; Russo, 1999; Trivette, Dunst, Deal, Hammer, and Promptst, 1990; Werrbach, 1996; Whitley, White, Kelley, and Yorker, 1999).

Strengths-based practice involves a paradigmatic shift from a deficit approach that emphasizes problems and pathology, to a positive partnership with the family. The focus of assessments is on the complex interplay of risks and strengths related to individual family members, the family as a unit, and the broader neighborhood and environment. This is not to suggest that a practitioner avoids specification of needs of families. A child's most basic needs for food, clothing, shelter, health care, nurturance, stimulation, and safety may be unmet and as a result, helping practitioners become involved. When a child's basic needs are at risk of being unmet, we must understand what conditions

within and outside the family may be contributing as well as what resources exist within and outside the family to enable the family to improve the well being of all its members.

The focus of intervention however is not on correction of a problem but on enabling caregivers to meet the needs of all family members because they in turn will be better able to have the time, energy, and resources necessary for enhancing the well-being and development of the family as a whole (Dunst, Trivette, and Deale, 1988). As emphasized by Hobbs, Dokecki, Hoover-Dempsey, Moroney, Shayne, and Weeks (1984), "families are the critical element in the rearing of healthy, competent, and caring children. We suggest however that families—all families—cannot perform this function as well as they might unless they are supported by a caring and strong community, for it is community (support) that provides the informal and formal supplements to families' own resources. Just as a child needs nurturance, stimulation, and the resources that caring adults bring to his or her life, so too, do parents—as individuals and as adults filling socially valued roles (for example, parent, worker)—need the resources made possible by a caring community if they are to fulfill their roles well." (p. 46).

The purpose of this paper is to report on efforts of a community-based family support program in a poor urban neighborhood to seek the views of family members and service providers about the most important qualities of practitioners and practices of programs that work with families. Since the program (DePanfilis, Glazer-Semmel, Farr, and Ferretto, 1999). DePanfilis, Glazer-Semmel, Farr, and Ferretto, 1999) operates from a strengths perspective, of particular interest was whether participants in focus groups would identify themes to support strengths-based practice. The strengths perspective principles articulated by Kisthurdt (1997) and Salleby (1997a, b) are used as an organizing framework. These principles are consistent with the helping process articulated in most social work texts (Compton and Galaway, 1999; Courmoyer, 2000, Hepworth, Rooney, and Larsen, 2002). Briefly, there are five principles of this perspective. The first is the acknowledgement that all families have strengths, and the primary focus of intervention should be on the strengths, abilities, knowledge, and capacities of individuals and families. The second principle suggests that the relationship between clients and helpers is an essential component of the helping process. The helping alliance is at the heart of most practice models, reinforced by the National Association of Social Workers Code of Ethics (1996), and has been demonstrated to be particularly relevant with families at risk for child maltreatment (Dore and Alexander, 1996; Kenemore, 1993). The third principle emphasizes the importance of the client directing the helping process. This basic tenant of self-determination is a cornerstone of social work practice and is reinforced in the National Association of Social Workers Code of Ethics (1996). The fourth principle suggests that all human beings have the capacity to learn, grow, and change. This principle is core to all helping professionals.

And finally, the fifth principle suggests the importance of meeting the client in their community. This is particularly important for a program focused on preventing child neglect. Families who have children whose basic needs are at risk of being unmet are typically poor and lack access to resources (Gaudin, 1993; Smale, 1995). Further, these families are more likely to be socially isolated, experience loneliness, and lack social support (DePanfilis, 1996). Finally, traditional, in-office, one-to-one counseling by professionals has not proven effective to reduce the risk of neglect (Cohn and Daro, 1987).

Method

As part of an effort to assess the needs of families in a target community, a community-based family support program facilitated focus groups with families and service providers. This program provides early home-based intervention to increase the safety and well being of children and families and to prevent child maltreatment and substance abuse.

Sample

Four separate focus groups were conducted during February or March, 2000: (1) current and past program staff and students (n=10); (2) interdisciplinary community-based providers (n=10); (3) current or past program clients (n=6); and (4) parents being served by a community-based career center (n=14).

The staff and social work student group was comprised of ten women who were an average of 40 years of age (range from 25 to 51 years) with a mean of 9.4 years of professional social work experience (range from 0 to 28 years). They represented European American (70%) and African American (30%) descent with professional degrees at the Bachelor (n=4), MSW (n=4), and PhD levels (n=2).

The community provider group was comprised of six women and four men who were an average of 46 years of age (range from 30 to 60 years) with a mean of 11 years of professional experience with families (range from 0 to 26 years). These group members were invited because of their experience serving families in the community and because of their prior contact with the family support program as either a referral source to the program and/or as a provider to whom the program referred for services. Half of the group was of African American descent and half of the group was of European American descent. Their professional education ranged from a high school degree (n=2), to a masters degree (n=4), to a degree of MD or PhD (n=4). One group member did not identify level of education.

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The client group consisted of six mothers, grandmothers, or great-grandmothers who were an average of 51 years of age (range of 26 to 72 years). All participants were African American with varying educational backgrounds 7th or 8th grade education (n=2), 9th-11th grade (n=1), and high-school graduate and/or associate degree (n=2). One group member did not identify level of education. Two of the six members said that they worked outside the home during some or all of the last 5 years. These caregivers identified caring for an average number of 3.6 children who ranged in age from 4.6 to 11 years of age. All had received services from a community-based family support program, receiving most services in their homes.

The fourth group consisted of 13 mothers and one father who were receiving services through a community-based career center and had not had prior contact with the family support program in question. These parents were an average of 35 years of age (range from 20 to 48 years) with an average of 3.1 children who ranged in ages from 5.7 to 13.4 years of age). All participants were African American with varying educational backgrounds 7th or 8th grade education (n=2), 9th-11th grade (n=8), and high-school graduate (n=2). Seventy-one percent of the members of this group had worked outside the home some or all of the last five years.

Procedure

All four focus groups (Greenbaum, 1999; Krueger, 1997; Morgan, 1997) were facilitated by the same two social work facilitators (an African American male and a European American female). Groups were video-taped with the permission of participants. All participants were provided refreshments, and participants in the two client groups received small thank you gifts.

The groups were asked to think about services provided by the family support program or by other agencies with which they were familiar. The same questions guided the discussion for all group sessions, which lasted an average of two hours each. What services did they think families found helpful? What services were not helpful? What made families want to return to work with an agency after their introduction to the worker or agency? What made families not want to return for services? What did participants think about different ways of working with families? Did they feel that home-based or group models were most useful? Why?

Data were analyzed by compiling notes maintained by facilitators and recorded through video-tapes of each session. Discussion from each group was transcribed and then themes were analyzed from each group. Finally, results were compared across groups to examine similarities and differences in themes. For the purposes of

this paper, results are analyzed by examining how/if participants offered opinions that are consistent with principles of the strengths perspective organized by Kisthardt (1997) and Saleebey (1997a).

Results

Principle 1: Focus on the strengths, abilities, knowledge, and capacities of individuals and families (Kisthardt, 1997).

Themes that supported an emphasis on strengths emerged from each of the four focus groups in participant answers to questions about what makes services helpful to families and what makes clients want to stay involved with services. There were seven sub-themes that emerged: (1) a focus on strengths; (2) recognizing success or progress; (3) avoiding communication that conveys blame; (4) desire for respect; (5) acknowledgement of what is important to the client, including spirituality; (6) emphasis on talents; and (7) feelings that a strengths perspective generates for clients and helpers.

Focus on strengths. Community providers emphasized that looking for strengths and praising personal gifts was the best way to help families accept help. Program staff highlighted that they are most successful in engaging families as partners when they observe something positive about families and share these perceptions during the very first visit. Clients said they were more open to listening when they felt better about themselves and their families after a home visit than they felt before a visit...."she helped me see the good things about my life."

Recognizing success or progress. Everyone agreed on the importance of recognizing even the smallest steps toward success. Clients suggested that they looked forward to another contact if they knew a helper would be proud of their accomplishments. Program staff offered that they had to work hard to let the client define for themselves what success looked like and it was their job to help clients look realistically at the challenges and opportunities in their lives.

Avoiding communication that conveys blame. Both client groups contrasted practitioners who they felt were "nasty" toward them from those who were "beautiful to me." When talking about experiences with another program, one client shared, "I could tell when she walked in the door that she didn't care about me. . . her eyes were going everywhere all around my house. . . trying to find things that were bad for my children.. ..I knew right then that the next time she wanted to visit me, I wouldn't be home."

Desire for respect. Statements from the two provider groups acknowledged the importance of conveying respect and a non-judgmental attitude. "Clients have too often received help that they do not perceive as helpful. . . when we see clients, we have to demonstrate that we care about them as human beings. . . since this attitude may not have been their past experience, it is important to be patient and consistently convey respect in every way." "I remember one client who shared that when I met her for the first time, I may have been the first person who really listened to her and expressed concern for her as a person."

Acknowledge what is important to the client, including spirituality. All four groups identified the importance of recognizing important aspects of the client's lives, in particular spirituality. A program staff person expressed, "sometimes, professional providers discount the most important strength that clients bring because they believe that it isn't appropriate to talk about spirituality or religion." A community provider offered, "a person's spirituality provides the hope that things can get better . . . as helpers, we need to build on the belief that parents can help their child achieve a better future." And from a client, "my worker listened when I talked about my belief in a higher power . . . and the work I did with both helped me accomplish goals for my family."

Emphasis on talents. Both provider groups identified the importance of conveying acceptance of individuals, whatever their conditions are. "Clients can tell when you convey a genuine appreciation of their talents." And from one client, "she made me feel that what I was doing at home was the reason that my little girl is now a straight A student."

How workers and clients feel when strengths are emphasized, rather than pathology. "It is a more rewarding experience to see the strengths in my client, rather than all of the problems." And, as emphasized by another helper, "it helps to remember to be humble . . . there but for the grace of God go I." As observed by one client, "she didn't doubt me for a minute. . . I really felt powerful!"

Principle 2: The relationship between clients and helpers is an essential component of the helping process. (Kisthardt, 1997).

A theme about the importance of interdependence between clients and helpers and a helping alliance evolved from each of the four groups as the facilitators inquired about factors that fostered clients wanting to continue participation in services. Six separate sub-themes supported this principle: (1) process of engagement; (2) confidence in the relationship; (3) perceived competence of the worker; (4) conveying empathy; (5) relationship has meaning; (6) what fosters the relationship.

Process of engagement. As noted by one client and acknowledged by others with laughter, "The first time I met her I could tell she was *good* people. . . I enjoy *good* people . . . you can tell the difference between someone who cares with someone who is just collecting a paycheck." Clients in both groups discussed for some time that they could tell whether they could trust what they were hearing by the attitudes that workers conveyed. With some helpers, they felt "connected" and as emphasized by one client, "some people when they come . . . they bring themselves . . . then I feel we are all part of the same community." Or as emphasized by several clients, "when I called, they actually knew who I was . . . that made me feel very special." One client said, "my Momma taught me the spirit of discernment . . . this means that I can look at a person and can experience the person as a whole." The career center group also emphasized the importance of being professional, "of leaving your own stuff behind when you walk into someone else's home." Community providers emphasized similar ideas, "I try to connect with something that touches the person . . . that touches their heart." Qualities in workers that encouraged the development of relationship came through from all groups, e.g., "warm, genuine, nice, caring, thoughtful, respectful, compassionate, understanding, down to earth."

Building confidence in the relationship. Over time, several approaches helped the relationship develop into a helping alliance. From the career center group, clients suggested that they developed confidence in the helping relationship when workers were "organized, were willing to work too, did things to motivate me, helped me identify barriers to success (more than just being nice), were clear on the purpose of each visit, were straight with me." Family support clients emphasized that they developed confidence in the relationship when "workers listened and helped right away, I could tell she knew what she was doing . . . she was competent, was thorough with the questions she asked, helped me do it for myself (didn't try to do for me), listened to what I really needed . . . over time, we understood each other." Clients and helpers emphasized the importance of confidentiality. As suggested by one client, "I knew she wouldn't go telling my business to others . . . in fact she gave me a paper that said so." Both groups of helpers identified the importance of "starting where the client is, following through on what you say you will do, clearly communicating role and purpose, conveying a partnership in the work ahead, and establishing a safety zone of trust and support." All of these helped to build the helping alliance over time.

Perceived competence of the worker. As implied in the previous section, clients looked for more than people who were just "nice" to them. They felt it important that the person they worked with "knew what she was doing." The program offers the right kinds of services for families, "things that we really need" (not a narrow mission). Clients seemed to say that credibility was established by credentials, human qualities, knowledge, and skill.

Conveying genuine empathy. Clients seemed to be quite sophisticated in their assessment of helpers who offered “false empathy” with those who truly tried to understand the client’s perspective. One client described one worker from another agency who she said “was full of it . . . she actually said that she knew how I felt . . . how could she really know how I felt . . . she don’t live in this neighborhood . . . she hasn’t lived in my shoes.” Clients suggested that “true empathy” is conveyed when helpers “don’t act like they are in a hurry, who really show that they are listening, who use a soothing voice but don’t try to do all of the talking.” It was important that “she listened to me, talked to me, listened some more, she let me know she was really there for me . . . especially when I had a crisis and needed extra help.”

Relationship has meaning to the client and helper. The family support agency clients suggested that they agreed to come to the focus group because they felt it is important that they give back for all that they received, e.g., they feel connected and part of a larger community. Some clients expressed the importance of staying connected, even after services were no longer needed. Practitioners suggested that what motivated them to still do this work (without many tangible rewards) was the connection they felt to their clients in wanting to see them successful . . . and hearing from them from time to time. In contrast to some agencies that perceive coming back as a “failure,” both providers and clients felt it was important to convey the opposite message. “If this is truly a partnership, then staying in touch should be something positive.”

What helps to foster the relationship. Family support program workers emphasized the importance of self-awareness to do this work well. “Awareness of own (worker) boundaries/limits and acceptance of our/their limitations is really important.” There was further discussion about the need to “not take things personal . . . even if your client screams at you when you are ten minutes late.” This may remind the client of someone else in their history that they could not count on. “In order to break through this, you have to be patient.” The timing is also critical. Sometimes there is a breakthrough in a relationship when you don’t expect it. “We need to look for windows of opportunity for building the partnership.”

Principle 3: The helping process is directed by the client.

The basic principle of the client’s right to self determination was emphasized by members of each focus group. In contrast to what clients perceive as some other “helping processes” that dictate to them what they must do and not do, both clients and provider participants in these focus groups identified the importance of clients being “in charge” of deciding about service outcomes and steps to achieve them and in deciding how much of what services they receive and in what ways services are provided. Family support

program providers identified many ways that clients “need to control the process.” “This begins with simple things like how often and where we should meet and also involves selecting outcomes, goals, and tasks that will be the focus of work together.”

Clients in both groups also independently emphasized the importance of knowing best what they need. For example, one program client offered, “I liked when she asked me questions so that I could think for myself what my needs were.” Career center clients suggested that clients need to be “a partner in deciding what services are needed” and suggested “families need to have a say in where they get help.”

Principle 4: All human beings have the capacity to learn, grow, and change (Kisthardt, 1997).

All groups offered support for this concept; however, the comments were stated less directly than with the other principles. Program staff suggested that their role is often helping the family see the changes they are making, even when change may seem “small.” They further suggested that it is really important to provide tangible feedback to clients to reinforce achievement of goals and outcomes . . . “this reinforcement, helps clients tackle even more difficult challenges.” One program client said, “when I started with the program, I saw it as a last resort. . . my daughter was having so many problems I couldn’t believe she could ever change. . . One of the things I learned is that she could change. . . She went from failing in school to the honor roll.” The community provider group suggested that one of the most powerful roles that practitioners have is helping families see that there is hope for a brighter future . . . “that with support and each other, they can keep their family together.”

Principle 5: Help is designed to be provided in the community, not in the confines of a building (Kisthardt, 1997).

Two important sub-themes emphasized the importance of community outreach: (1) importance of knowing about and using community resources and (2) importance of overcoming fears of visiting certain neighborhoods and homes.

Knowing about and using community resources. Both groups of providers suggested that a major role of practitioners was to educate their clients about resources in the community . . . “my job is to help families be good consumers of resources that are available. . . as well as “advocate for my clients to receive services when they are eligible. . . this is an important role with the schools.” A client suggested, “I knew my worker really cared when she waited for hours with me in the clinic waiting room . . . it helps to know that you aren’t alone when you are trying to get help for your kids.” A crucial part of service for many clients was access to emergency resources. “Even though sometimes

I had to wait, I helped keep things together at home because I knew I was not going to be evicted when the check finally came.”

Overcoming fears of homes and neighborhoods. Clients suggested that they worked best with workers who were willing to “walk into their neighborhood with their head high. . .and I always walked her back to her car because I cared for her safety.” Or as suggested by another client, “If she was afraid to come into my home, how could she really understand me. . .I’m not saying we shouldn’t be careful on the streets but it feels good to know that she is willing to come to see me.” Program workers suggested that it was important to be “smart” on the streets (e.g., lock valuables in the trunk, carry a cell phone, park as close to your client’s home as possible, go out with someone else if necessary) but it was also important to put fears aside and communicate respect. . .” say hello to folks on the street, walk with confidence, use humor or whatever it takes to get to know someone and their environment.”

Conclusions

This paper reported on an exploratory study about the ingredients that families and practitioners report as crucial for success in a community-based family support program. Themes that emerged from focus groups helped to support key principles of the strengths perspective. Both clients and practitioners independently offered insights about the principles most important for helping families overcome many risks in their environments.

A significant problem for family interventions is the tendency for troubled families to drop out of treatment (Spath & Redmond, 1995). Most prevention programs struggle with engaging and maintaining the voluntary involvement of the target families, especially when these programs attempt to serve high-risk populations (Larner, Halpern, Harkavy, 1992; McCurdy, Hurvis, and Clark, 1996). For these hard to serve families, it may be more appropriate to examine what services should be offered with family interventions, as well as how, when, and where to offer such services. There is some literature that suggests that a provider’s ability to establish some level of trust during the initial contacts may be more predictive of ongoing participation than the specific services offered by the program (McCurdy, Hurvis, and Clark, 1996). There is also literature that supports the notion that therapy is a collaborative endeavor and as such, more attention should be paid to the role of the therapist in discussions about treatment resistance and dropouts. For example, Dore and Alexander (1996) emphasize the importance of the helping alliance in their review of literature about the effectiveness of family preservation services. Unfortunately, what therapists often do in response to resistance is to become less effective in helping the family (Patterson & Chamberlain, 1994).

The results of this exploration suggest that applying the principles of the strengths perspective may yield a greater opportunity for families to be engaged as partners in the change process to improve the likelihood of achieving successful outcomes. Emphasizing strengths, building a helping alliance, helping clients control the change process, reinforcing the belief that all human beings can change, and actively reaching out to families in their own communities are crucial ingredients to an effective helping process.

Even though this exploration suggests support for using the strengths perspective with families, readers should also recognize the limitations of this exploratory analysis. This study cannot provide support for the effectiveness of the strengths perspective. It only offers opinions from a few clients and providers about the promise of using this approach. However, in combination with other literature cited earlier, it does suggest that using the strengths perspective may be a promising approach in comparison with problem-focused methods for serving high-risk families.

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Changing Tides and Changing Focus: Mapping the Challenges and Successes of One State's Implementation of the Adoption and Safe Families Act of 1997

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In 1997, the Adoption and Safe Families Act shifted from the preservation of families to an emphasis on safety, permanency, and well-being through expediting the termination of parental rights, establishing exceptions to the reasonable efforts clause of preserving the family, and fiscal incentives for finalizing adoptions. The current project assessed the role of a full service array in achieving the outcomes set forth in ASFA. Concept mapping was utilized to elicit information from participants (both urban and rural) regarding the identified research question. Participants recognized family preservation versus safety, community connections, mandates versus reality, and worker recruitment and retention as critical components for meeting ASFA goals. Perceived importance and level of success in implementing these services was also highlighted. Recommendations supported through the data are also provided.

In 1997, the Adoption and Safe Families Act (ASFA) was enacted by the 105th Congress of the United States. ASFA was created "to promote the adoption of children in foster care," with certain guidelines established and defined to promote the safety, permanency, and well-being of children (AFSA, 1997). First and foremost was the emphasis that was placed on the safety of children and on making reasonable efforts to have children remain at home with their families. When reasonable efforts had been made, but yet the child could not stay with his/her family, then the state was to provide services (through the child protection system and the judicial system) that helped expedite permanency for the child. This change in legislation from the 1993 Family Preservation and Support Act to the Adoption and Safe Families Act switched the attention from family preservation and support to promoting a major focus on child safety, permanency, and well-being. The current evaluation assessed the way one state, Florida, has implemented the Adoption and Safe Families Act and specifically addressed the way in which services contributed to being able to achieve the outcomes outlined in ASFA regarding safety, permanency, and well-being.

Historical Legislation as Related to ASFA

Three pieces of child welfare legislation provide a contextual framework for the changes that occurred in the Adoption and Safe Families Act. In 1974, the Child Abuse and Prevention and Treatment Act (CAPTA) (PL 93-247) was passed to provide fiscal support for identifying and treating child maltreatment. While CAPTA was established to identify and treat, the majority of the financial assistance was earmarked for identification (through mandatory reporting laws and establishment of child abuse hotlines) rather than for prevention and treatment of families once they enter the child welfare system. As a result, the child welfare system became overwhelmed with child abuse and neglect reports, and children subsequently were drifting in foster care and services were scarce.

Recognizing the limitations of CAPTA, in 1980, the Adoption Assistance and Child Welfare Act (PL 96-272) was implemented and set forth the following permanency priorities: (1) children remain with their families; (2) adoption; (3) foster or kinship parents establish legal guardianship; and (4) children remain in long-term foster care. Throughout the 80s and 90s, states and programs were seeking ways to achieve these priorities. One programmatic development that received national attention was the Homebuilder's model of family preservation services. These services were intensive, short in duration, and the initial evaluation results were highly positive, showing that between 80-90% of children were able to remain at home with their families, thus achieving the outcomes of PL 96-272.

In 1993, after several previous unsuccessful tries, the Family Preservation and Support Act was signed into law under the 1993 Omnibus Reconciliation Act. For the first time, this legislation provided fiscal support for "the purpose of encouraging and enabling each State to develop and establish, or expand, and to operate a program of family preservation services and community-based family support services..." (PL 103-66). Significant funding was provided to states and agencies for promoting family preservation in the child welfare system. Practice models were developed and implemented. The most theoretically sound conceptual model of family preservation services was provided by Lloyd and Sallee (1994), which depicted the array of both hard and soft services. The family preservation models sought to go beyond the models typically provided to clients in mental health or other social work services (Berry, 1997).

The combined effects of financial support and the reported success of these programs, family preservation programs proliferated throughout the United States. Unfortunately, family preservation services, to their detriment, were heralded as a panacea for treating

and curing all families regardless of the family's situation rather than as one solution in helping children and families (Hooper Briar, Broussard, Ronnau, & Sallee, 1995; McGowan & Walsh, 2000; Terling-Watt, 2000). In this predominate focus on family preservation services, several child death cases where family preservation services had been provided became the attention of the national media (Kelly & Blythe, 2000). Ensuing attacks by critics (Gelles, 1996; MacDonald, 1994) argued that family preservation services left children at the hands of parents who might kill their children, and that the evaluation methods that had been used to validate these family preservation programs were highly scrutinized for their lack of methodological rigor.

The result of the child death cases, findings from the Schuerman and colleagues (1994) study, and media scrutiny, these "camps" polarized the child welfare service system: child safety versus family preservation (McGowan & Walsh, 2000). Concurrently, to avoid this polarization, discussions in the family preservation literature urged child welfare workers, administrators, researchers, and critics to target those services to those families who were at imminent risk of having a child placed in foster care while ALSO ensuring that the child remain at home safely. Advocates of child welfare services urged the child welfare field to not view family preservation services as a panacea of services for all families, but rather as one service option that could be used given the right circumstances (Berry, 1997; Fraser, Hooper Briar, et al., 1995; Pecora, & Haapala, 1991; Pecora, Fraser, Nelson, McCroskey, & Meezan, 1996).

The Adoption and Safe Families Act

It is little surprise that the Family Preservation and Support Act was not only renamed to the Adoption and Safe Families Act, but also that the focus and outcomes changed as well. The Adoption and Safe Families Act worked towards creating a new system that had a predominate focus on child safety, expediting permanency, and focusing on child well-being. ASFA was landmark legislation that provided fiscal incentives for states in ensuring the safety of the children, attempting reasonable efforts to keep the child with his/her family, finding permanent families for their children, and expediting and funding the adoption process. Along with these incentives, ASFA also adjusted standards for the amount of time between the child's removal from the home and either reunifying the child with his/her parents or proceeding, through the judicial system, the termination of parental rights. The time frame that was set for determining if parental rights should be terminated, changed from 18 months (which was set in previous legislation), to 12 months (set in the current ASFA legislation). In a short time, ASFA changed the focus from preservation of the family to expediting termination of the family. Funding for family preservation services decreased as well as the use of family preservation services as one service type in the overall continuum of child welfare services.

In the creation and implementation of ASFA, elements related to best practice were not articulated as they specifically relate to the role of services in achieving these outcomes. In order to provide support to families and children, it is necessary to provide services that are provided quickly, services that are needed, services that may be unique in their approach or delivery, services that are jointly decided upon, and services that are aimed toward helping the family succeed and are provided through open communication with the family. The service continuum is a critical element of the way in which the outcomes of safety, permanency (both in home and out of home), and well-being are ensured.

Current Study

The current research project asked the following question of participants "What are the obstacles and/or barriers associated with implementing a "full service array" to achieve the Adoption and Safe Families Act (ASFA) outcomes of safety, permanency, and well-being?"

Methodology

Sample

The sampling technique that was used was a non-random purposive sample, where participants (foster parents, Department of Children and Families workers, supervisors, and state administrators) were selected by administrators in the Department of Children and Families at each location. Two locations were chosen to conduct the concept mapping session in order to obtain different geographical perspectives (rural versus urban). The two groups were analyzed and are discussed separately in regards to their sample characteristic and findings.

Rural. For the rural group, 10 people participated in the generation of the statements, and nine of the ten participants stayed throughout the afternoon and completed the sorting and rating. The demographic characteristics are presented for only those participants who sorted and rated the statements.

All of the participants were female, and primarily Caucasian (77.8%), with 12.2% being African-American or other. The groups represented were: 33.3% DCF workers/supervisors, 33% foster or adoptive parents, 11% DCF administrators, and 22.2% classified as other. In addition, two participants were also dually identified as adult former foster children. The participants have been in their current role for a median time of 4.5 years, and have been involved in child welfare for a median time of 12 years.

Urban. Of the twelve people who participated in the generation of statements, ten participants stayed throughout the afternoon and were involved in the rating and sorting of the statements. As with the rural group, demographic characteristics are provided only for those who completed the sorting and rating.

The participants were primarily female (90%), and were more diverse in regards to their ethnicity with 30% each from the ethnic groups of African-American, Hispanic, and Caucasian. Fifty percent of the participants have a BS or BA and 50% have a Master's degree. Forty percent were from DCF in the worker/supervisor capacity, 20% were DCF administrators and 40% were community stakeholders. For this concept mapping session, 2 foster parents attempted to participate; however, they were unable to do so as they did not have childcare for all of their children. The median number of years the participants have been involved in their role was 4.83 years, and they have been involved in the child welfare system for 11.29 years.

Instruments/Data Collection Methods

During the concept mapping session, participants were first asked to define "what makes up a full-service array"? As participants generated the services they considered a part of the full-service array, these services were written down and were kept for reference while the question was being asked (See Figure 1 for the definition of full-service array provided by the group representing the more rural area and Figure 2 for the definition of full-service array provided by the group representing the urban area).

- Holistic- systems perspective
- Prevention- primary-voluntary/ secondary-known, yes-no/ tertiary- court ordered
- Case management- assessment and counseling
- Adoption/post-adoption services
- Preservation/family preservation
- Reunification- foster shelter
- Addictions
- Domestic violence
- Mental health
- School system
- After-school/ childcare
- Respite
- Life skills
- Supports-Tangible (i.e., parent education)
- Housing
- Employment
- Medical care

Figure 1: Full Service Array: Rural Area

- Casework service - visits
- Mental Health services
- Transportation
- Assessments
- Community referrals including: mental health services, education, parenting, domestic violence, substance abuse, anger management, economics, housing, med., clothing
- Court services/legal
- Placement - out/home
- Recruitment/training
- FP supports
- Medicaid
- Adoptions
- Educational planning
- Community education/Public service announcements
- Independent living
- Case planning
- Immigration services
- Monitoring/compliance

Figure 2: Full Service Array: Urban Area

Generation of Statements. Participants were then asked to generate ideas through group brainstorming. Participants were also provided with a piece of paper (the question was printed at the top) so that in the event they did not want to share their particular statement they could write the statement on the piece of paper and the group leaders would include the statement in the final pool of statements. Statements were generated in regards to the focal question, "What are the obstacles and/or barriers associated with implementing a "full service array" to achieve the Adoption and Safe Families Act (ASFA) outcomes of safety, permanency, and well-being?" The group had two facilitators who ensured that the statements that were recorded were specific to the question being asked and were clear. This process continued until the group felt that they had exhausted the range of possible statements. Two leaders facilitated the dialogue, while a research assistant recorded the statements for the group by typing the responses into a laptop computer. Table 1 illustrates the number of statements generated for the research question and is broken down by group.

Table 1: Number of Statement Generated by Location

Location	Question #1
Rural	62 statements
Urban	45 statements

During a break, the leaders converted the typed responses onto business cards, where each statement was printed onto a business card. The statements were also merged into rating instruments. A packet of business cards, envelopes for sorting the statements into concepts, and rating instruments was created for each participant.

Sorting. As was mentioned above, each participant was given a set of business cards and 10 envelopes. Participants were asked to sort the statements into conceptual piles that "made sense to them." The piles were placed into a legal sized envelope, and participants were instructed to name the conceptual pile based on the statements that they had placed into that pile.

Rating. After the sorting task was completed, participants were asked to rate each of the statements on a 7-point likert scale based on the scale provided for the focal question. For this rating task, statements were listed in a questionnaire format (See Figure 3 for an example). Two separate ratings were completed. The first rating asked the participants to rate how important each statement was in achieving the ASFA outcomes of Safety, Permanency, and Well-being. The second rating asked the participants to rate each statement regarding how well the state child protection agency has addressed each in its effort to meet the ASFA outcomes.

The number of layers for each conceptual pile, as is shown in the Figures, provides a reference as to the pile's importance or level of being addressed (based on the two rating questions) in relation to the other piles. Those piles with more layers are more important or have been more adequately addressed (based on the two rating questions) than those with fewer layers. Each pile can therefore be conceptually compared to the others in relation to importance and level to which it has been addressed in achieving the ASFA outcomes.

Unique ID# (so no one knows your name)

What is your date of birth? [month _____ /day _____ /year _____]

What is the town or city of your birth? [_____]

Concept Mapping Rating Scale #1a							
Whether or not you have personally experienced the obstacle and/or barrier below, how important do you think overcoming each is to achieving the ASFA outcome of safety, permanency, and well-being?							
<i>Please read each statement, and circle the number on the right which answers best for you. There are no right or wrong answers.</i>							
	1	2	3	4	5	6	7
	Not Very		Somewhat			Very	
1. statements entered here	1	2	3	4	5	6	7
2.	1	2	3	4	5	6	7
3.	1	2	3	4	5	6	7
4.	1	2	3	4	5	6	7
5.	1	2	3	4	5	6	7
6.	1	2	3	4	5	6	7
7.	1	2	3	4	5	6	7
8.	1	2	3	4	5	6	7
9.	1	2	3	4	5	6	7
10.	1	2	3	4	5	6	7

Figure 3: Example of Rating Instrument

Analyses

The data collected were analyzed utilizing Concept Mapping Software (Trochim, 2001), which is a statistical technique designed for the management and interpretation of certain types of qualitative data. The technique utilizes multi-dimensional scaling and cluster analysis in order to derive a visual representation, or map, of the conceptual relationships among a set of qualitative statements. The concept map produced by the computer program depicts clusters of statements, each ostensibly representing some underlying concept.

Specifically, in concept mapping, a multidimensional scaling analysis creates a map of points that represent the set of statement brainstormed, based on the similarity matrix that results from the sorting task. The output from the two-dimensional multidimensional scaling is a set of x-y values that can be plotted, as well as some diagnostic statistical information. The hierarchical cluster analysis is subsequently conducted to represent the conceptual domain in concept mapping. This analysis is used to group individual statements on the map into clusters of statements that presumably reflect similar concepts. The end product is the cluster map, which shows how the multidimensional scaling points were grouped.

A bridging value is also computed for each statement and cluster as part of the concept mapping analysis. The bridging value tells whether the statement was sorted with others that are close to it on the map or whether it was sorted with items that are farther away on the map. The bridging value helps to interpret what content is associated with specific areas of the map. Statements with lower bridging values are better indicators of the meaning of the part of the map in which they are located, rather than statements with higher bridging values. A bridging value always ranges from 0 to 1. The program also computes the average bridging value for a cluster. Clusters with higher bridging values are more likely to “bridge” between other clusters on the map. Clusters with low bridging values are usually more cohesive, easier to interpret, and reflect the content well in that part of the map.

The software permits the evaluators to specify the number of clusters desired in the solution. Starting with the default solution (8 clusters) generated by the computer software, the statements within each cluster were reviewed. Possible solutions with greater and fewer numbers of clusters were successively reviewed in a similar manner. At each step, a decision was reached by the evaluators as to whether splitting or combining the clusters improved the conceptual clarity and overall bridging factors.

The evaluators then assigned a name to each cluster, based on the statements included in the cluster, as well as the names given by session participants. The individual statements within each cluster were also examined to assist in discussing the interpretation of the underlying concept represented by the statements.

Results

Each of the maps and analyses (per each rating question) are presented below for the two sites separately: rural and urban. The first part of the discussion shows the conceptual map and highlights the type of statements that were associated with each cluster. Additional discussion is provided on each of the ratings. Finally, discussion is provided comparing and contrasting the two sites on the responses to each question. Please refer to the full-service array for each site (Figure 1 and 2).

Rural Concept Maps

A seven cluster concept map, as shown in Figure 4, was produced for the first question that was posed to the rural group. The following cluster names were either provided by the participants or were generated by the consultants based on the statements in the concept "piles." These concepts were Tally vs. Reality; Family Safety vs. Family Preservation; Legal hold-ups slow down permanency; Service system barriers; Challenges to child well-being; Urban vs. Rural; and Out-of-home placements. Each of these concepts will be discussed below within the context of the question.

Tally vs. Reality: The Tally vs. Reality concept statements were associated with issues of performing the job in the field versus the policies that are from the state office of DCF, which is located in Tallahassee, Florida. The statements and their grouping suggest that a major obstacle in implementing a full-service array is associated with the notion of performing the job in reality versus performance measures set by the state and federal government. Specifically, the issues of performing the job when there are few incentives for the workers, constant caseworker turnover, and the lack of professionalism in the front-line staff arose.

Family Safety vs. Family Preservation: The second concept, highlighted through the statements associated with it is the difficulty in balancing child safety versus family preservation. This obstacle was described in statements such as the "mindset that it is always in the best interest of child to stay with family," "being able to define who the client is," and "conflict between reunification and safety." Each of these statements points to the struggle that caseworkers and others involved in the system have in trying to achieve the ASFA outcomes, when it is unclear how to best achieve these.

Specifically, trying to ensure the safety of the child, while still operating under a model that promotes preservation of the family is a potentially incompatible task.

Legal hold-ups slow down permanency: The legal system is discussed as being an obstacle to achieving the outcomes of ASFA. Specifically, it was noted that the judges and attorneys need to be involved in training programs on the specific issues of doing child protection work and trying to work with families within the time constraints set forth in ASFA. Participants perceived the court system to be disconnected from the realities of casework.

Service System: The service system cluster had a range of responses that included "lack of awareness of available services" to "lack of client buy-in" and "disconnect between assessment and referral for services." Other statements in agreement with these, pointed to issues of client resource deficits as obstacles to service participation. Other issues highlighted in this concept address the possible prescriptive nature of services, rather than providing services based on client need and/or the lack of jointly created case plans.

Challenges to Child Well-Being: The challenges to child well-being are associated with current restraints of the system and services available. Participants identified challenges of being able to match children to appropriate foster homes, providing a full array of services to meet the child's needs, involvement of children in their case plans, and determining the most appropriate level of placement.

Urban vs. Rural: The Urban vs. Rural concept addresses the issues of providing a full-array of services in a rural area compared to being able to provide them in an urban area. There is a considerable difference between the two, according to participants, in their level of funding, the number and types of available services, and the supports that are available to help families and children take advantage of these services.

Out-of-home placements: The concept of out-of-home placements addresses the difficulties in ensuring quality out-of-home placement for children when they have been removed from their home. Participants named the challenges of having high quality foster homes and plenty of them, maintaining current "good" foster parents, providing adequate supports for retaining foster parents, screening foster parents for their appropriateness in being foster parents, and providing incentives for foster parents. Each of these issues points to the barriers associated with helping workers and foster parents achieve ASFA outcomes.

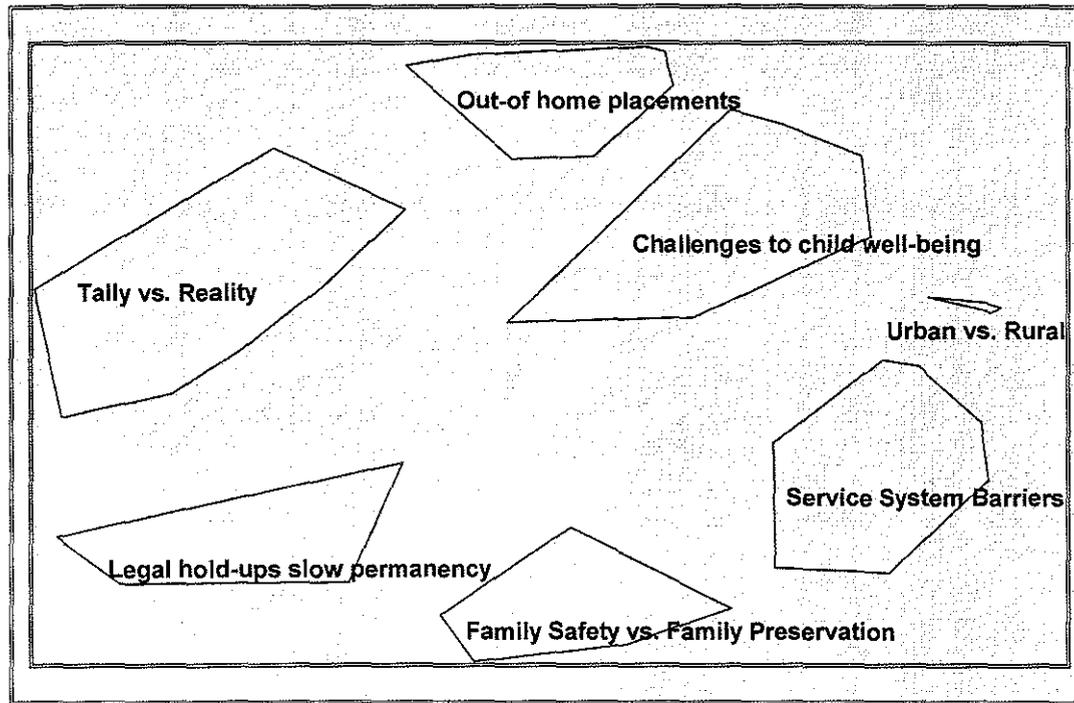


Figure 4: Rural Cluster Map

Rural- Rating of Obstacles

Each participant was asked to rate each statement (obstacle or barrier) as to its importance in overcoming in regards to being able to achieve the ASFA outcomes. Each concept, as illustrated in Figure 5, is presented with the average rating score stated in the parentheses preceding the concept. As the scale indicates, 1 is not very important, while 7 is very important. The highest average on this question was 5.49, whereas the lowest is 4.89—thus, all the concepts generated are of at least minimal importance. A larger number of layers of a concept indicates that the concept was rated as very important, or whatever is denoted by the provided rating scales. The obstacles that are the most important to overcome include (based on average priority rating) Tally versus reality (5.49), Legal holdups slow down permanency (5.43), Urban versus Rural Funding (5.28), Challenges to child well-being (5.22), Service system barriers (5.15), Family safety versus family preservation (4.93), and Out of home placements (4.89).

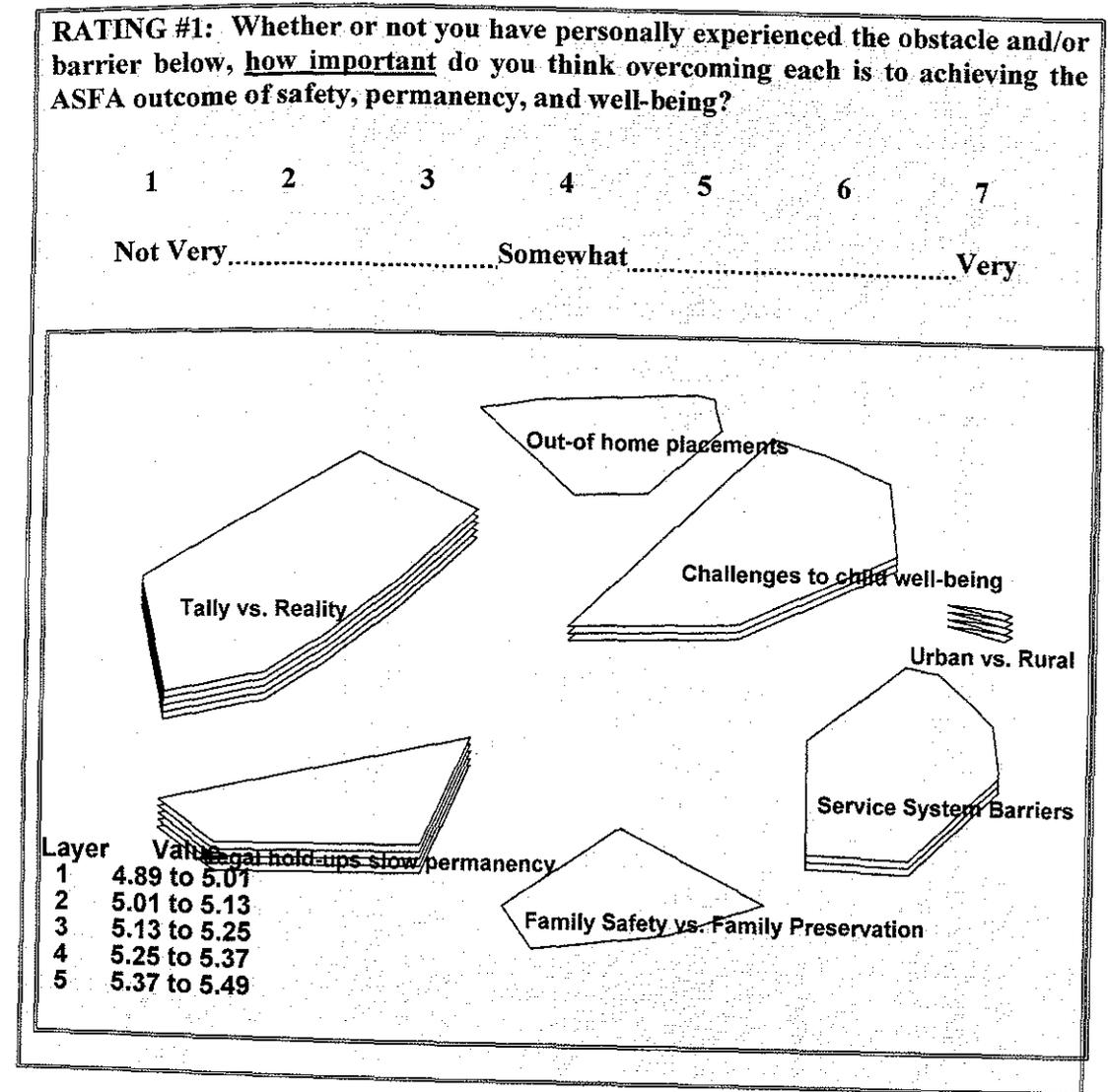


Figure 5: Rural Rating #1 Map

Rural - Rating of DCF Success

For the second question, the same rating scale applies as above, where 1=not very successful 7=very successful. Again, conceptual piles with more layers indicate that DCF had a higher level of success and the reverse for piles with fewer layers. This question asked participants to rate how well DCF has addressed each obstacle. The range of scores for this question was from 3.11 to 2.35, which overall indicates that DCF has not addressed each of these in a systematic way as they relate to ASFA outcomes. The ones that the participants identified as having somewhat addressed were (as shown in Figure 6): Family Safety versus Family Preservation (3.11), Services system barriers (2.95), Urban versus Rural funding (2.75), Out of home placements (2.72), Legal holdups (2.51), Challenges to child well-being (2.42), and Tally versus reality (2.35).

As each of these numbers shows, DCF is not perceived as responding on the whole to many of these issues, as the average scores for each concept are on the lower-end of the scale. Participants identified that the concept of family safety versus family preservation has been met better than the other concepts. This clearly illustrates the areas of difference between those issues identified as important to achieving the ASFA outcomes and the assessed efforts put forth by the state.

Urban Concept Maps

Similar to the previous group, the participants in the urban group also were asked to define what a full service array encompasses. They were instructed to generate all the services they could think of that would form the basis of the full service array continuum from which the statements for the question could be based upon (See Figure 2).

For the question in the urban group, the best bridging solution, as illustrated in Figure 5, produced 6 concepts. These were each named, as were those in the rural concept mapping session, by the participants and/or the consultants with participant input. The concept "pile" names were Inconsistencies between legal, policies, and procedures; Workload barriers; Inadequate level of skill; Personnel challenges; Community connections; Balancing ethics and mandates. Each of these is discussed below in relation to the statements that were sorted with the pile.

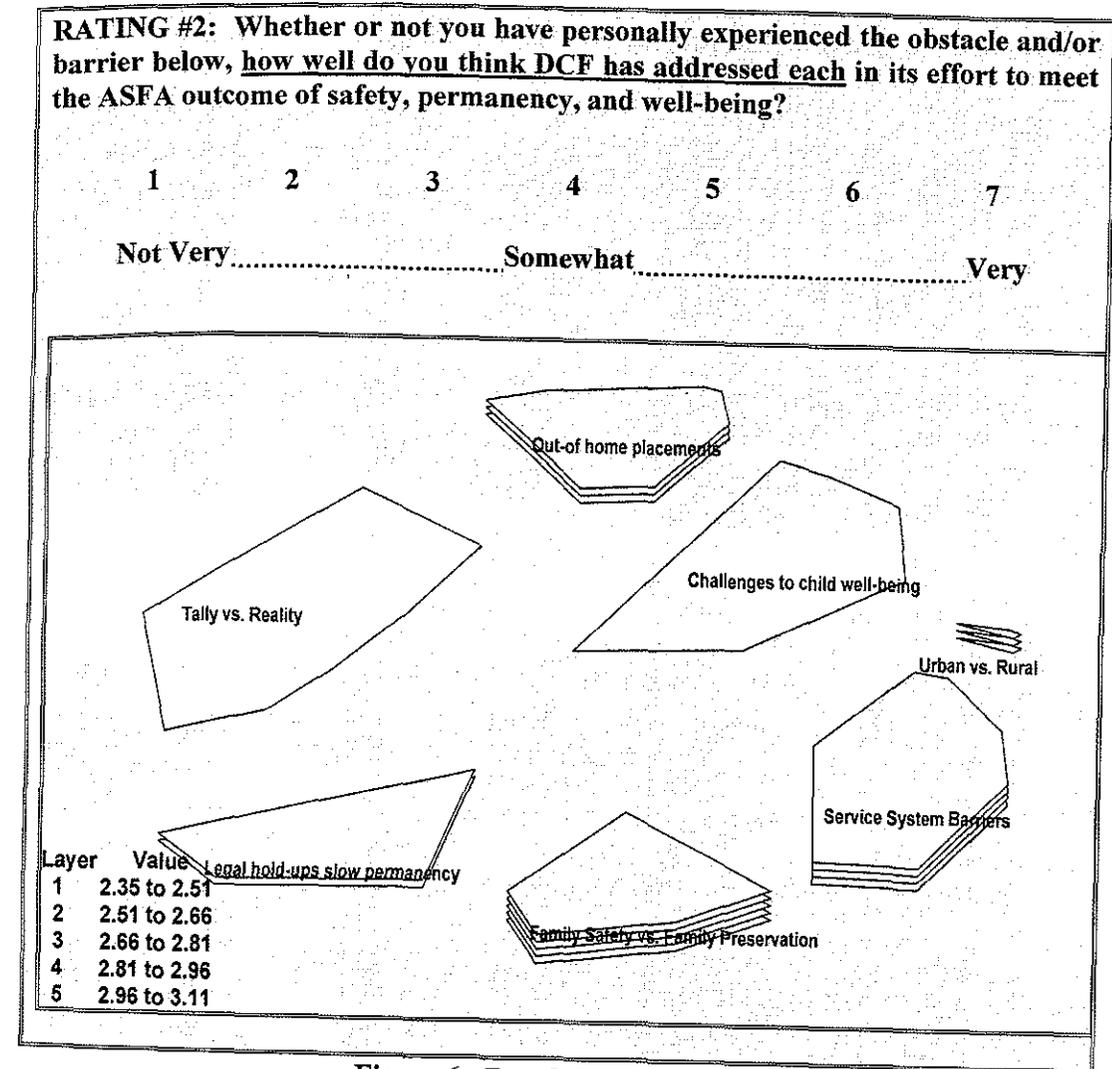


Figure 6: Rural Rating #2 Map

Inconsistencies between legal mandates and policies and procedures. The statements contained in this pile are associated with the inconsistencies the system and worker experience between what is legally mandated and the department's policies and procedures they must follow. A sample of the statements included in this pile are "procedures/policies constantly changing," "documentation requirements changing," "inconsistency between ASFA and reality," and "legislative mandates without appropriate funding." These barriers highlight the problems workers and other service providers experience when trying to work within all the different systems. Furthermore,

these noted inconsistencies may impede the workers and systems in being able to implement a full-service array given the confusion surrounding the inconsistencies.

Workload barriers. Workload and caseworker turnover are barriers that significantly affect the services that can be provided. Caseworkers are given increased case loads, without financial incentives, and are expected to work in a field that is considered difficult at best. Issues such as unrealistic expectations and continual increase in caseload create a system that leads to caseworkers managing their caseloads in the best way possible. Those who struggle with this level of management are more likely to resign, thus creating a cycle of worker turnover.

Inadequate level of skill. This concept had statements related to training issues, of keeping new workers in the field longer, as well as training of foster parents. Additional statements discussed inexperienced caseworkers, inexperienced attorneys and the lack of appropriate supervision.

Personnel challenges. The concept of personnel challenges included such statements as caseloads too high, high staff turnover, insufficient pay for the work that is done, unrealistic workload demands, and inexperience among case workers and attorneys. Participants perceived these ideas as barriers to being able to provide a full-service array in working towards achieving the ASFA outcomes.

Community connections. As service arrays are being provided through a myriad of community agencies, access to these services is critical. The participants identified transportation, waiting lists, unequal distribution of services, and numbers of skilled providers as barriers to implementing a full-service array.

Balancing ethics and mandates. The participants identified a number of statements that concern how they balance the ethics and values of their profession within the mandates of the system. Related to this are statements that discussed cultural issues, the best interests of the child, and working between agencies. The participants discussed the problems with competition and turf guarding and how this, at times, goes against the outcomes of safety, permanency, and well-being.

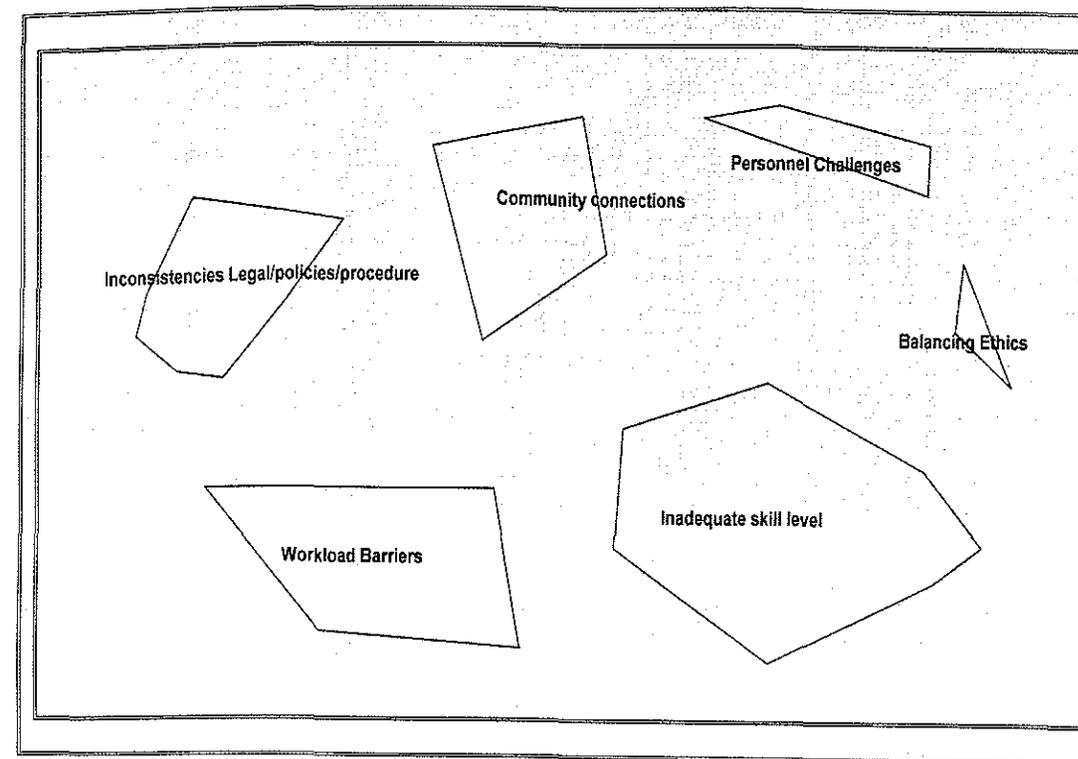


Figure 7: Urban Cluster Map

Urban – Rating of Obstacles

The participants in the urban area identified personnel challenges (5.90) as the biggest obstacle as it relates to achieving ASFA outcomes. Other important concepts included overcoming inconsistencies between legislation, policies, and procedures (5.66), Inadequate skill level (5.59), Community connections (5.44), Workload barrier (5.31), and Balancing ethics and mandates (5.34). The participants identified most of these as important barriers to overcome in working to achieve the ASFA outcomes. This is evidenced by the average scores of each concept being above 5. The map representing these ratings can be seen in Figure 8.

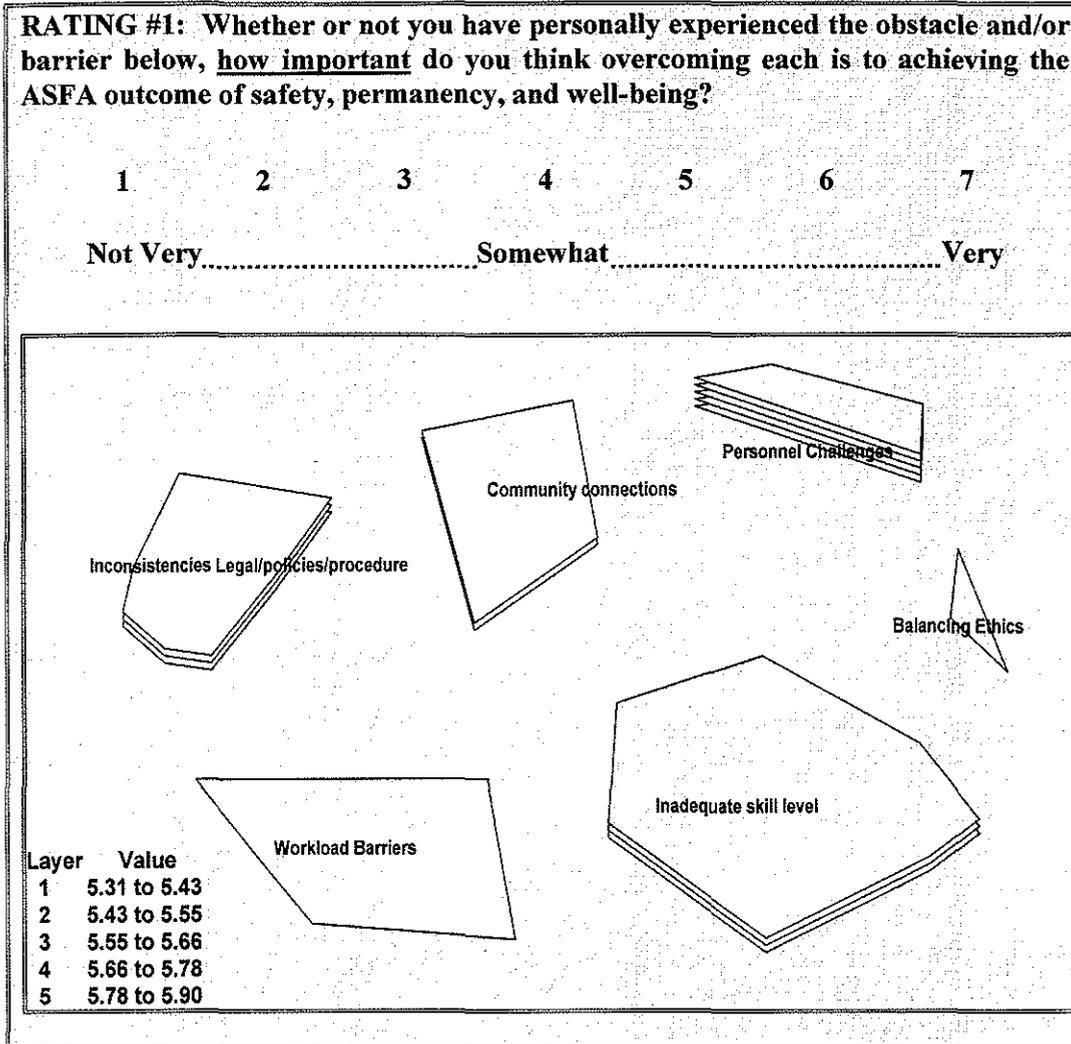


Figure 8: Urban Rating #1 Map

Urban—Rating DCF Successes

In regards to how well DCF has responded to these concepts, participants feel they have responded to the concept of balancing work and ethics (3.68) and workload barrier (3.59) issues better than the others. The other concepts are presented in descending order as to the level in which DCF has addressed these concerns/concepts. The concepts and their ratings, as shown in Figure 6, are as follows: inadequate skill level (3.30),

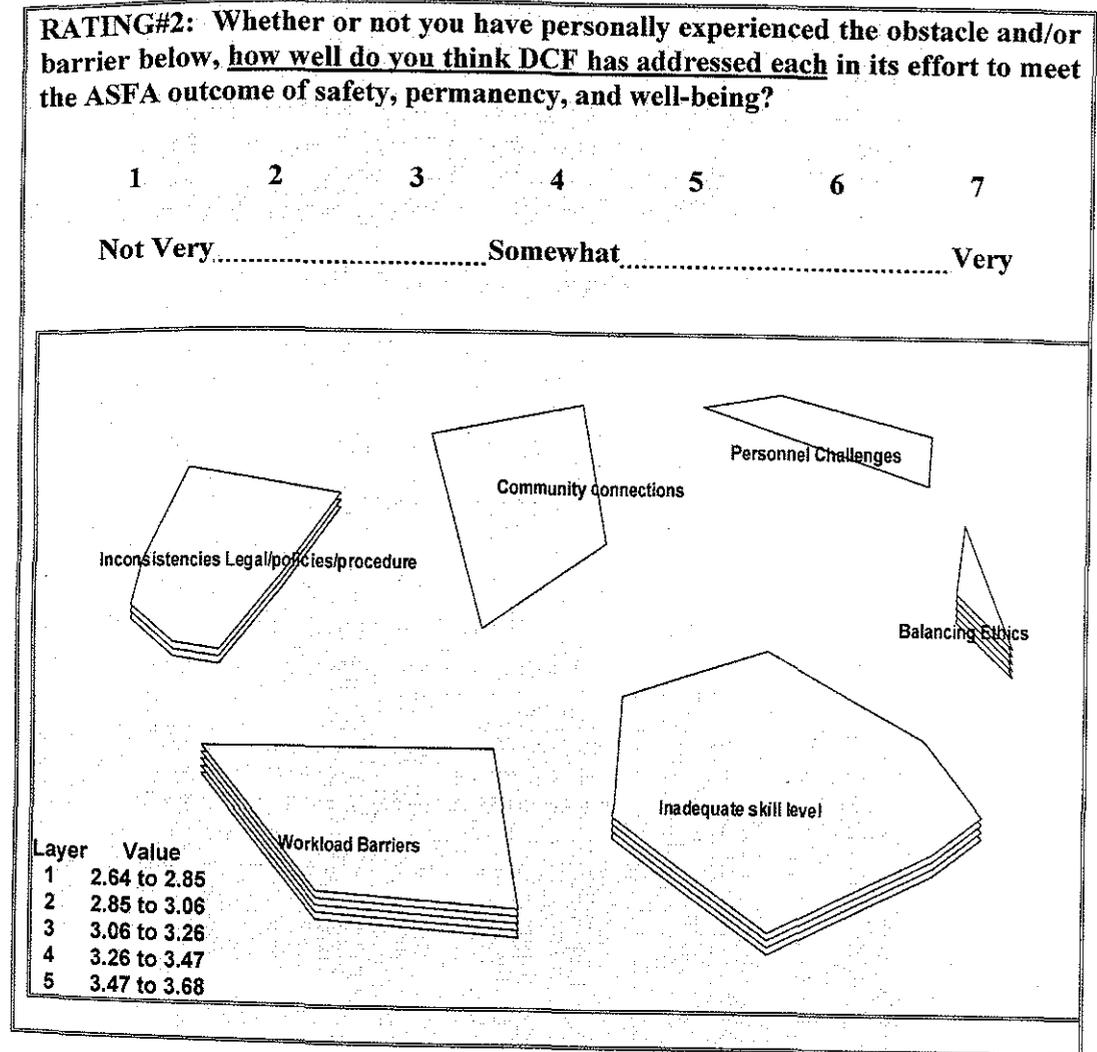


Figure 9: Urban Rating #2 Map

inconsistencies between legal/policies/procedures (3.09), personnel challenges (2.81), and community connections (2.64). The average ratings of each concept demonstrate that while some of the issues are being addressed, there is still a substantial need to address these issues in regard to how they help workers, staff, foster parents, and others in their ability to achieve the ASFA outcomes.

Comparison of the Two Sites

There were several similarities between the statements and concepts generated from both the rural and urban groups. Both groups highlighted the notion of responding to state and federal mandates and how these become a reality in providing casework services. The reality of working with families and children is what DCF workers do, on a daily basis. Both groups stated a certain level of frustration of being able to meet the state and federal mandates that may not necessarily fit into their current situation or within the context of the services that can be provided. For example, the 12-month time frame on determining parental rights may be an issue for some workers when the mother or father has substance abuse issues. If this family happens to live in a rural area, a substance abuse program that is also empathetic to the co-existing goals of the child welfare program may not be available to these families. Workers are, therefore, faced with trying to meet these specific mandates without having the support to assist these families. Additionally, in the current age of accountability and the new tracking systems that are being implemented in Florida will highlight those workers who are not meeting the ASFA requirements, while not necessarily being able to indicate the conditions that may be related to the family and workers not being able to meet the mandates.

Participants, in both sites identified the tension between family reunification at all costs versus child safety. As a result of this dissonance, workers may be affected in the decisions that they make and the types of environments that children are left or placed in. This tension is situated in the middle of the lack of clarification of reasonable efforts in the ASFA legislation and a lack of sound decision-making tools. Caseworkers are left to make decisions, specifically as they relate to removing a child and/or reunification of a child with his or her parents, without a lot of legislative and practice support.

Funding was a critical issue for both groups, as many stated, that they simply were required to do too much with too little. Participants also discussed the issue of having a full-service array and some of the barriers to implementing such. The specific issues noted were lack of client buy-in, lack of transportation, too many places to go for services, unrealistic service or case plans, and unequal distribution of services. For services to be most effective, they must be accessible, assessment driven, and outcome oriented.

Finally, personnel issues, such as worker turnover, too high caseloads, and too low pay are issues that are at the very heart of the people who provide these services. The workers and those who provide the services are in essence doing a lot with a little, and experience a high degree of burnout. Unless strategies are implemented that address

recruitment of employees who will more than likely stay and retention of employees who have or are staying, the worker turnover and caseload explosion will continue.

Limitations

It is important to note that the findings presented in this report represent the opinions, thoughts, and feelings of those participants who were involved in the focus group/concept mapping session, and cannot necessarily be generalized that all DCF administrators, employees, staff, foster/adoptive parents have these same opinions. These ratings give just one picture of what needs to be addressed and how they have been addressed. Additional evaluation methods can and should be employed to gain a triangulated view of the importance and the needs that are being addressed. It should also be noted that the sample selection was nonrandom and the size of the groups was not optimal. However, it was believed that the positive aspects of this project outweighed these limitations.

Recommendations and Conclusions

Within the context of this discussion and the discussion statements generated by the participants of both groups, the following recommendations are made:

Reality versus Mandates

Both the rural and urban groups discussed the disconnect between Reality and Mandates. The primary recommendation centers around empowerment and communication between all participants at all levels. This could occur through forums, discussion groups, web-based chat rooms, or internet-based list-serves. The other aspect of this concept, is the notion of administrators and legislators not having day-to-day contact with front-line work. It would be helpful for workers to document, through time studies, what it is that they do, how they spend their day, and what are the demands that they encounter and overcome.

Family Preservation versus Child Safety

Unfortunately, as Kelly and Blythe (2000) noted, these two notions of child safety versus family preservation have been treated as mutually exclusive. The alternative is to understand that child safety and family preservation can be actualized and can be successful. As Kelly and Blythe, Cash (1998), and Berry (1997) argue, several key issues need to be taken into account in the provision of child welfare services. These issues include targeting of family preservation services to those for whom services will be most

appropriate. Second, ask the courts for assistance in considering family preservation or reunification services when families have made significant gains toward the goals on their case plans. Finally, it is important to understand the role of treatment fidelity and the evaluation of processes and outcomes. Family preservation has been highly criticized because of model drift and being a service panacea for child welfare services. Family preservation services need to continue to be evaluated for both processes and outcomes in order to understand treatment fidelity and the relationship of treatments to outcomes.

Best Interest of the Child

It is absolutely necessary that workers be provided with the best decision support tools available to make decisions about which children can safely remain in their homes, which families should be preserved, and which families should be reunited. These issues, however, should not be addressed at one point in time, but rather support tools should be created that can follow a case over time and can provide workers with a guide for when a situation may become too dangerous for a child or when it is okay to reunify a child with his or her family. By using and relying upon decision support tools that have been validated and tested for reliability with this population, workers will have a theoretical and practical foundation on which to base their decisions; they won't be simply left with the issue of trying to "eyeball" or guess about children and families. The implementation of this, however, is based upon the training that is provided, the supervision that is given, and the willingness on the worker to implement and use the decision tools to their fullest capacity.

An additional recommendation is to create handbooks and provide training on issues of implementation of policies (both federal and state) and procedures that were created by DCF. These would assist workers and other staff members in understanding the importance of the policy and/or procedure, while also allowing for them to understand (if at all possible) why this policy/procedure is needed and how it relates to their practice.

Funding

Investigators, front-line providers, foster parents, and others have noted the increasing demands of their work and the stagnation of the rewards and financial incentives. The current system has inherent issues of generating perpetual worker and foster parent turnover. The recommendation, therefore, is based on lobbying for children's issues to be a top priority and to have the financial structure and incentives to support the policies and workload that the system is facing.

Community Connections

In a time where communities have been charged with taking the torch and helping each other and the federal government oversight is supposedly decreasing, connections in the community must be created and maintained. Partnerships should be explored where agencies will no longer compete for the same client base and same pots of money, but rather they will each find their own niche and try to decrease, in a systematic and organized way, the problem of child maltreatment.

Worker Recruitment/Retention

Florida is on its way to trying to incorporate new funding into the child protection system, specifically as it relates to qualified and tenured workers. One of these implementations is related to the use of Title IV-E funding that would provide financial incentives (via stipend and tuition remission) for child welfare workers to go back to school and obtain their MSW or to provide incentives to social work students to work for DCF once they have graduated with their MSW.

Defining Roles and Ownership

The issue was raised regarding the roles of DCF and how these roles are played out in the community. One of the primary recommendations associated with defining roles is to create open lines of communication among DCF and the community and community providers. This could be done through a similar avenue that is currently being pursued with the implementation of the community-based care models—via the community stakeholder group. Other attention could focus on the way in which the media portrays DCF to the public. It might serve DCF well to find media networks that will cooperate and work to help present the positive side of DCF and the way in which the community can respond to child maltreatment.

Achieving Goals

The critical juncture happens when assessments have been completed and services provided—what are the outcomes? Has the child and/or family met its goals? Whose goals are these? And who set these goals? These issues are critical in understanding the importance of the ASFA legislation and providing a concrete reason for why child protection work is so needed. In order to understand the model of services and their relation to outcomes, it is necessary to understand the role of assessments, how assessments inform service delivery, and how these both lead to outcomes. There is a critical balance that each worker must find when working with families and children—

can this child remain safely in this home, should this family be reunified, should parental rights be terminated, and is this child going to be adopted or is there another alternate solution? The recommendation for achieving goals centers around the need to evaluate and document the decision making points and the services that are offered and accepted by the clients.

Evaluations

Enough cannot be said about the importance of conducting evaluations of the programs and processes. Evaluation is a critical, but often forgotten component of service delivery systems. Best practice models need to be evaluated within the context of the services and with the specific population. As research evidence supporting good child welfare practice is recommended, participants at all levels of services to children and families will have more confidence in the ability of agencies and caseworkers to be effective and efficient. Only then will perceptions of success increase from the levels seen here.

Conclusions

Overall, the concept mapping sessions produced a significant amount of data that reflects one state's implementation of the Adoption and Safe Families Act. The participants identified a range of important issues and obstacles. When asked how DCF has met these needs, the scores were somewhat low and reflected room for improvement. The participants clearly identified that balancing family preservation and child safety were critical; however, they also perceived these as obstacles in identifying and implementing a full-service array. The issues that have been reflected in the literature regarding the abandonment of family preservation services for child safety were also reflected in this evaluation (Kelly & Blythe, 2000). States must continue to work toward ensuring that one type of service model is not provided to all, while also ensuring that the service continuum is allowed to be just that—a continuum of services (from prevention to adoption) that meets the variety of needs of all families and children (Hooper Briar, et al., 1995). Only a continuum of services will be able to reach the greatest number of families and help families in the ways in which they need help.

The results of this evaluation show that DCF has some areas to work on in regard to meeting the ASFA outcomes. However, the evaluation does show that DCF is on its way in accomplishing some of these. It is important to note, that without this or other types of evaluations, it is difficult to know what areas need to be addressed and what solutions might be generated by those who know the system the best: clients, workers, administrators and researchers.

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Promising Practices to Engage Families and Support Family Preservation

Marianne Berry

The Adoption and Safe Families Act of 1997 (ASFA) is the latest legislation in two decades of important child welfare policy in the United States. The Adoption and Safe Families Act has served to shorten the period of time that caseworkers and families have to show that families are making progress toward family preservation, with permanency decisions being made after 12 months, rather than 18. The importance of engaging and motivating families in services has therefore increased. The practice directive of ASFA can be summarized as "Act Smart, Fast, and Accountable." Using findings from largely correlational research, concrete recommendations are made to ensure that practices to preserve families are smart, fast, and accountable, particularly critical given these new timeframes.

The Adoption and Safe Families Act of 1997 (ASFA) is the latest legislation in two decades of important child welfare policy in the United States. While ASFA serves to better specify when and under what conditions "reasonable efforts" to preserve a family are *not* required, the Act does little to better specify the policies and practices that constitute "reasonable efforts." This manuscript has two purposes: (1) to review the policies and resulting population trends that led up to and resulted in the passage of the Adoption and Safe Families Act of 1997, and (2) to review the tentative research evidence that identifies the practices that are most often associated with family preservation outcomes and show promise in engaging families in reasonable efforts to preserve their families, until more definitive research findings are produced.

Important Legislation in Child Welfare

In order to understand the impact and the influence of the Adoption and Safe Families Act of 1997 (P.L. 105-89), it is helpful to review four important pieces of child welfare legislation that preceded it and are still largely in effect. The Adoption and Safe Families Act was implemented as a response to the state of a child welfare system that had evolved from these prior pieces of legislation and the resulting state and agency policies. These four pieces of legislation (very briefly) were (1) the Child Abuse Prevention and Treatment Act of 1974, (2) the Indian Child Welfare Act of 1978, (3) the Adoption

Assistance and Child Welfare Act of 1980, and (4) the Family Preservation and Family Support Act of 1993.

The Child Abuse Prevention and Treatment Act of 1974

The Child Abuse Prevention and Treatment Act of 1974 is the federal legislation that mandated the reporting of child abuse. It also put into place public education efforts to increase awareness of the signs and effects of child maltreatment. Not surprisingly, after CAPTA was implemented, the numbers of reported cases of child abuse increased greatly, with the concomitant stresses on the child welfare system from such an influx of families reported for child maltreatment. CAPTA had not included funding for services in line with the increased reporting that resulted from increased public awareness and mandated reporting; the majority of funding went into supporting reporting and investigations of child maltreatment (Pecora, Whittaker, & Maluccio, 1992).

After CAPTA was implemented, the numbers of children placed into foster care increased significantly, reaching near 500,000 children in out of home care by 1978 (Tatara, 1989). CAPTA legislation, of course, was not the sole contributor to the increasing foster care rolls; increasing stressors on families throughout the 1960s and 1970s had continued to feed children into the child welfare system, but CAPTA's new mandate on reporting and investigations increased the necessity of a formal response to these family stresses, and that response often took the form of foster placement.

The Indian Child Welfare Act of 1978

During the 1960s and 1970s, a very large proportion of Native American children were in foster care, many in non-native foster homes. In response to growing criticism of this dissolution of Indian families by non-Indian entities, The Indian Child Welfare Act of 1978 gave tribes exclusive jurisdiction for children on reservations. To help maintain connections between Native children and their families, preference is given to placing children in extended family, followed by foster homes that are approved by the tribe, followed by Indian foster homes and institutions. Standards for these homes are set by the tribes.

There have been numerous problems with the implementation of the Indian Child Welfare Act, largely due to insufficient fund allocation. Studies in the 1980s, a decade after the implementation of the Indian Child Welfare Act, found that over 50% of Native American foster children were still placed in non-native homes (Plantz, Hubbell, Barrett, & Dobrec, 1989).

The Adoption Assistance and Child Welfare Act of 1980

In the second half of the 1970s, federally funded demonstration programs (e.g., the Oregon Project – Lahti, Green, Emlen, Zadny, Clarkson, Kuehnel, & Casciato, 1978 – and the Alameda Project – Stein, Gambrill & Wiltse, 1978) were attempting new strategies to decrease the need to place children in foster care and to return children home from foster care more quickly. As a result of these demonstration programs, six years after CAPTA, sweeping federal legislation known as the Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272) was enacted, which could be argued to be the most significant piece of child welfare legislation in the late 20th century.

The Adoption Assistance and Child Welfare Act of 1980 put into place a system of prioritized outcomes for children served by child welfare agencies—a set of priorities based on the pursuit of outcomes that offered children permanence of place and *maintenance of family connections*. The four prioritized outcomes for children are (1) remaining with biological and/or extended family, (2) adoption, (3) guardianship, and (4) long-term foster care. This order of preferred placements was prioritized by outcomes that are thought to be in the best interests of the child, with maintenance of family relationships being seen as critical to positive child development. Adoption became a second choice after “reasonable efforts” to preserve the biological family had been made, but took priority over other, less permanent and family-like relationships.

Public Law 96-272 came on the heels of public and professional concern in the 1970s about the rising numbers of children in foster care with no real plans for a home more permanent than foster care. There were declarations in the 1970s as to the importance of permanence for children and the poor developmental outcomes of frequent disruptions in children's families and the place they called home (Goldstein, Freud, & Solnit, 1973; Fanshel & Shinn, 1978). The prioritized outcomes listed above, and reasonable and expedient efforts to move children to one of those permanent outcomes, were the order of the day.

After the Adoption Assistance and Child Welfare Act of 1980 was implemented, there were decreases in the number of children placed into foster care, and many of the children in foster care went home. States and agencies sought out a variety of means by which to keep children and families together to meet the prioritized outcome of preserving families. It was during the 1980s that family preservation programs proliferated across the country. The parameters of these programs were largely drawn from lessons learned from the demonstration programs in Oregon and California and by

the Homebuilders program in Washington State (Kinney, Haapala, & Booth, 1991). Family preservation was a booming business.

During the 1980s, communities and families experienced substantial social and economic changes—increases in poverty, homelessness, substance abuse, AIDS, violence, and teen parenting (Maluccio, Abramczyk, & Thomlison, 1996)—increasing social stress and other pressures on families. However, adoptions of older children did not increase substantially in the wake of the 1980 legislation (Barth & Berry, 1988). Toward the end of the 1980s, foster care rolls therefore began to grow again, leading to increasing pressure on agencies and states to keep children at home.

The Family Preservation and Family Support Act of 1993

In the early 1990s, family preservation programs had proliferated enough that legislation was passed to formalize the provision of these types of services. This act was passed as part of the Omnibus Reconciliation Act of 1993, and provided nearly \$1 billion in new funds for either family support or family preservation programs over five years. This Act specified more clearly the types of programs that would meet the criteria of meeting reasonable efforts to preserve families.

Most of these new monies went toward family support programs. As family preservation programs also proliferated, however, increased scrutiny of these programs, and some highly publicized child deaths, created a new pressure for the system to ensure children's safety (Ingrassia & McCormick, 1994). Scientific research and public media had documented numerous positive outcomes of the Adoption Assistance and Child Welfare Act of 1980 (a temporarily decreasing foster care census, and the proliferation of programs to empower, preserve, and strengthen families) and also numerous examples of devastating outcomes (including highly publicized child deaths, a newly increasing foster care census, and a relatively small effect on the numbers of children freed for adoption, given the increase in foster care census) (Barth & Berry, 1994). All of this attention resulted in a call for new legislation to better emphasize and assure children's safety and positive development—the Adoption and Safe Families Act of 1997.

The Adoption and Safe Families Act of 1997

The Adoption and Safe Families Act does more to promote timely dispositions of child welfare decisions than any legislation since the Adoption Assistance and Child Welfare Act of 1980. Where the 1980 Act specified that a case disposition must be reached after the child had been in care for 18 months, ASFA reduces that time frame to 12 months

(P.L. 105-89, Section 302). Additionally, child welfare agencies can be pursuing an adoption for the child at the same time as they are pursuing efforts to reunify a child with his biological family (called "concurrent planning"). Further, the Act specifies a list of conditions that do not require agencies to provide reasonable efforts to preserve or reunify (P.L. 105-89, Section 101):

- (1) the parent has subjected the child to aggravated circumstances (e.g., abandonment, torture, chronic abuse and sexual abuse),
- (2) the parent has murdered, manslaughtered, or aided or abetted in the death of another child, or committed a felony assault that results in severe injury to a child, or
- (3) parental rights have been involuntarily terminated for another child.

The Act further specifies that a state's discretion in protecting children's safety is not constrained by these conditions, and that the child's health and safety must be paramount in all determinations and provision of reasonable efforts.

States must file a petition to terminate parental rights and move toward adoption if any of the following apply (P.L. 105-89, Section 103):

- (1) the child has been in foster care for 15 of the last 22 months,
- (2) the court determines the child to be abandoned,
- (3) the court determines that the parent has committed a previous child murder.

There are other sections of ASFA that are important as well, including methods of increasing incentives to adopt, and the development of plans for adopting across jurisdictions. The Act renamed the Family Preservation and Family Support Act of 1993 the Promoting Safe and Stable Families Act of 1997, and includes reunification services *and* adoption promotion services as part of that Act.

The two key emphases of the Adoption and Safe Families Act appear to be the increased speed with which permanency decisions must be made, and the decreased pressure to preserve families. This has unnecessarily fueled a whirlwind of values (Barth, Goodhand, & Dickinson, 1999) or a competition of sorts between the programs of adoption and family preservation over who best serves the interests of children (Chalker, 1996; Gelles, 1996; Rappaport, 1996).

This whirlwind of values has contributed to confusion in practice as to when and how to pursue reasonable efforts to keep families together, and most importantly, identifying the services and resources that are sufficient to meet the test of reasonable efforts to preserve

families. It is the intent of this paper to better specify reasonable efforts under ASFA, and these practices can be summarized as "ASFA: Act Smart, Fast, and Accountable."

Protection Versus Connection

A review of the legislative history, above, clarifies the reactive nature of policy development in the United States child welfare system. Each law has been formed in response to problems and populations that have arisen over the past thirty years. Each piece of legislation results in some positive outcomes for children and families, but also produces some unintended or unforeseen consequences, which are then addressed in further legislation. The pendulum of public legislation swings back and forth between efforts to strengthen and support family integrity ("connection" efforts) and efforts to protect children at the expense of family integrity ("protection" efforts).

Practitioners, judges, legislators, and the general public are still confused and outraged by the conflicts in values of overlapping legislation and the seeming lack of a clear agenda in over forty years of professional child welfare services to guide choices and decisions that meet the best interests of a child. Since the Adoption Assistance and Child Welfare Act of 1980 (PL 96-272) and the resulting national and local efforts to preserve families and family ties, and more recently with the passage of the Adoption and Safe Families Act 1997, which emphasized safety of children and notes several exceptions to preserving families, tensions have increased over when and whether to keep children in "risky" families and whether to emphasize protection or connection (Berry, 1997), or in other words, the degree or extent to which reasonable efforts to preserve families must be made.

Best Practices Toward Providing "Reasonable Efforts" to Preserve Families

Social workers, judges, therapists, and anyone who cares about children and families wrestle with difficult choices and controversial arguments about how much of an effort and what form of efforts are reasonable (and sufficient) in an attempt to preserve families. The answers to these arguments are not always clear, nor should they be. The best practice and the best solution are determined by the circumstances and strengths of each situation and the individuals involved. Scholars of the research base for family preservation services will agree that it is difficult to identify with certainty what the critical elements of family preservation services are, or to what degree certain practices enhance outcomes. A thoughtful review of research evidence, however, can contribute to thoughtful solutions, however, in that objective evidence on the practices and policies

associated with good outcomes (being broadly defined) provides a base of knowledge with which to consider specific choices of action.

The Adoption and Safe Families Act hastens the call for greater specificity in what constitutes "reasonable efforts" to preserve families before determining that termination of parental rights and adoption are appropriate (Clinton, 1996). Ironically, while this will help to increase the clarity of service planning and contracts with biological families, this initiative has been proposed in hopes of doubling the number of special needs children removed from their birth families and placed for adoption by the year 2002 (Kroll, 1997). Better specificity of reasonable efforts, therefore, will thus contribute to a better understanding of when to choose adoption over continued efforts toward family preservation in any particular family or community.

Better clarification and specificity of the structure and nature of services that have been empirically established to lead to reduction of child maltreatment are also critical to any effort to preserve families (Berry, 1997) or to determine that they cannot succeed with services. Such specification of "reasonable [and effective] efforts" will thus contribute to knowing the conditions (such as service structures, client conditions, and environmental conditions) under which efforts to preserve families are likely to be effective or ineffective (Berry, 1997; Littell, 1997). Again, in the absence of clear predictive outcomes research in this field, we are left to rely on correlational data associating specific services or practices with good or bad outcomes for families. Until such predictive models are produced, we offer these best practices.

Best Practices in Supporting and Maintaining Families

The five key elements of best practices in providing reasonable efforts to preserve families can be summarized in five steps:

<p>Time Matters Results get Results Uncommon Solutions for Common Problems Stand Beside, Not Between Tell the Truth</p>

Time Matters

Spend one-on-one time in the family's home. Spending direct service time with families is critical. Research on family preservation services has provided hard evidence that the amount of time spent with a family in the home has a direct association with the

prevention of child placement. When a greater proportion of service time is spent by the primary service worker in the family's home, placement is significantly less likely (Berry, 1992; 1997). In Berry's (1992) study of 367 families in a family preservation program, when more than 50% of service time was spent in the family's home, rather than the office, no children were placed into foster care. Placement rates increased with an increased proportion of service time being spent in the agency or working with collaterals on a case. The contribution of direct time that is spent between the caseworker and the family in the family's home cannot be overestimated.

Allow time for progress to occur. Even good services cannot rush good outcomes. A critical element of the Adoption and Safe Families Act of 1997 concerns the shortening of time to a permanency hearing for children from the current 18 months to 12 months (Alexander, 1997; Kroll, 1997). Research in both adoptions and family preservation informs us that, while expedience is a factor that is in the best interests of children's sense of continuity and permanence, outcomes are less than satisfactory when services and preparations of children and of family are rushed or incomplete as a result (Barth & Berry, 1994; Kamerman & Kahn, 1989). In response to ASFA requirements, Mary Lee Allen of the Children's Defense Fund has said, "There are dangers in imposing accelerated, arbitrary time-lines on the states without the assurance of services to the children and their families. Services that deal with substance abuse, mental health, and domestic violence are important because timelines without these assurances will undercut the [Act's] efforts" (Alexander, 1997, pg. 14). We cannot rush to judgment at the expense of effective services.

Neglect takes longer to influence than physical abuse. Research in family preservation services, and in child protective services before that, has made clear that physical abuse is more easily treated than is child neglect (Berry, 1997; McCroskey & Meezan, 1997). In general, physical abuse cases are served earlier in the life of a family, with neglect cases going unserved until conditions are severe. This contributes to the chronicity that is more likely in neglect cases than in those of physical abuse. Neglect cases are also more likely to be exacerbated by other chronic problems of substance abuse and poverty. All of these contributing factors make it unlikely that neglectful behaviors can be remedied within a 12-month or 18-month timeframe. It is expected that the termination of parental rights for families charged with child neglect will increase substantially under ASFA, unless better models of treatment are proposed for this population of families.

Results Get Results

Provide quick and early solutions to problems that are easily solved. Research on family preservation services and in adoption services as well point to the importance of early progress with families. When a caseworker can help solve problems (even small problems) early in the life of a case, families report that they feel more likely to engage in services, that they feel they can trust their caseworker, and they are more likely to expect and work toward more positive outcomes throughout their service relationship (Barth & Berry, 1988; Berry, 1997; Lewis, 1991). Families of all types who receive simple and effective services at the very beginning of their work with the agency are more likely to engage in the service relationship, and make progress on case goals more quickly (Berry, 1997; Lewis, 1991).

Concrete services, provided early in a case, are found to be especially effective in preventing placement (Lewis, 1991), and in engaging families. This finding applies to work with foster and adoptive parents, as well (Barth & Berry, 1988; Berry, 1988). Given that financial stressors are almost always underlying the presenting problems that brought a family to services, concrete services that can readily engage families can include material goods and services such as help with transportation, household furnishings and repair services, help with utilities and landlord negotiations, and house cleaning. Families have expressed a willingness to engage in services when they saw that caseworkers could make real changes in the family's situation right away (Fraser, Pecora, & Haapala, 1991; Kinney, Haapala, & Booth, 1991). Meeting these concrete needs can also help to diffuse the economic stresses that are a primary contributor to child maltreatment.

Be cautious about ending social relationships. Social isolation is another key contributor to child abuse and neglect (Polansky & Gaudin, 1983). It is important that caseworker efforts to decrease family stress also maintain important relationships (even though some social relationships are viewed as detrimental to a family's situation). If case plans or court orders include plans to end specific dangerous friendships or relationships, it is important that caseworkers help to locate and begin other supportive friendships and relationships at the same time, to avoid contributing further to the family's social isolation. There are several model programs that focus on building social skills and social networks with this population of families (Lovell, Reid, & Richey, 1992; Rickard, 1998).

Advocate for relevant services in the community. Finally, relevant therapeutic services, including services for substance abuse, mental health, and domestic violence, are critical to good outcomes for families experiencing child maltreatment. The poor

availability of these services leads to long waiting lists or prohibitive restrictions on eligibility, which are exacerbated by the short timeframes imposed by the Adoption and Safe Families Act. Agencies and states that wish to preserve families will concentrate efforts on developing and supporting community-based therapeutic services for this population.

Uncommon Solutions for Common Problems

Build and support community resources that will support all families. Schuerman and colleagues (1994) at the University of Chicago have lamented the multiple objectives involved in family preservation as being “expected to solve major social problems, one case at a time,” (pg. 241) in that intensive work with families to keep them together and reduce the dangers to children involves mobilizing a number of resources and skills with families. These resources and skills go beyond better parenting skills to issues such as poor housing, inadequate day care and health care, and inadequate family income. Moving reasonably and expediently from efforts to preserve a family into timely decisions that a family cannot be preserved and the child would be better served by adoption can only be fairly implemented when birth families have the opportunity to access those kinds of resources (Littell, 1997).

Many communities simply do not have the resources with which to support their members. In his report to the New York Division of Family and Children Services, titled “The Community Dimension of Permanency Planning,” Fred Wulczyn (1991) used census tract mapping the City of New York to identify, on a household-by-household basis, those households experiencing teen pregnancy, high rates of poverty, infant mortality, and/or child removal. He found that these problems clustered in communities, and that in certain communities, in excess of 12% of all infants were placed in foster care before their first birthday. Expedient decisions to terminate parental rights may be in the best interests of those infants, given the immense social stress under which their families live, but reduction of a cohort of children in a community by 12% each year cannot be a “reasonable effort” to preserve families affected by community impoverishment. This speaks to the importance of community development in any service system, and of creating supports when there are few or none.

An individual family assessment is performed for a reason. When caseworkers are asked to document the time they spend on a variety of case activities, initial assessments comprise a large proportion of the service time spent with a family. These assessments are intended to be thorough so that an individualized service plan will follow and be relevant to the specific needs of a family. When service plans are examined, however, it

is often found that service plans are fairly consistent from family to family within an agency, with an emphasis on individual counseling, referral to parent education, and other forms of parent training (Berry, 1997; Berry & Cash, in press). When services are individualized to the needs presented by a family, outcomes are indeed better (Berry, Cash, & Brook, 2000).

Consider the virtues of unconventional families. Research has long discounted some conventional views on what makes a good family. Family preservation studies have found that families previously considered too risky for preservation can remain together safely, without any recurrence of maltreatment, when appropriate and timely services are provided (Fraser, Pecora, & Haapala, 1991; McCroskey & Meezan, 1997). Research again and again finds that family preservation services, as currently packaged (as a short-term intensive service) are more effective in preventing placement and in preventing recurrence of maltreatment with physical abuse cases (often considered the more “risky”) than they are with physical neglect cases (Berry, 1997; McCroskey & Meezan, 1997).

Research in both foster care and adoption has documented that the most successful families are often those headed by poorly educated parents (Barth & Berry, 1988; Meezan & Shireman, 1985) or those with lower incomes (Partridge, Hornby & McDonald, 1986). In a more recent long-term outcome study of adopted children with special needs, Erich and Leung (1999) found that more highly functioning families were those with a greater number of children, those not attending family therapy, those who participated in religious activities, and those with less parental education. Research findings support the language of the Adoption Assistance and Child Welfare Act of 1980 that emphasizes adoption of children previously considered unadoptable, and the support of parents and families who may have uncommon, unconventional, or varied abilities to meet a child’s needs.

Stand Beside, Not Between

Make decisions with, not for, families. Judges and social workers will agree with the general statement that most of the parents of children in foster care or served by child welfare agencies are there because they have shown poor judgment in parenting. Therefore, it stands to reason that some of the focus of services should be on helping parents to develop better judgment in parenting. This is often accomplished by referring parents to parent education classes. Research on services has found that parents are often far removed from making judgments about their family while they are receiving parent education classes or other child welfare services (Berry, 1988; Lindsey, 1994a; Stein, Gambrell & Wiltse, 1978).

Caseworkers can work with families to make decisions and judgments about the best course of action, rather than making these decisions on their behalf. Although the decision-making process is slowed by including parents, the payoff of teaching parents how these decisions are made (identification of the problem, brainstorming solutions, thinking through potential consequences, making the choice of decision) will result in longer term gains as parents learn the process by which to make decisions throughout their family's life. These decisions can include placement choices, continuing care of the children, and development of case objectives and service plans.

Encourage and support contact and relationships between family members. Perhaps the best predictor of family preservation (or reunification) once a child has been placed into foster care is the amount of visitation between biological parents and child that occurs while the child is out of the home (Courtney, 1995; McDonald, Allen, Westerfelt, & Piliavin, 1996). This is a prime opportunity for caseworkers to stand beside, not between, children and their families. While the protective instinct often leads one to limit parental access to the child who has been maltreated, research identifies far worse outcomes for children who have not had access to their parents during this time (Courtney, 1995; Hess & Folaron, 1991). Again, a child's out-of-home placement is an opportunity for caseworkers to help biological parents learn and practice better parenting skills, and parents can best practice those skills with their family.

Better specification of how to share care across people who have an attachment or affiliation to a child will also contribute to better and more expeditious decision making for children (Barth, 1993), the point of both the Adoption Assistance and Child Welfare Act of 1980 and the Adoption and Safe Families Act of 1997. Shared care can take the form of open adoption, kinship care arrangements, and most dramatically, a relatively new and untested form of service called family group decision making or the family group conference (Hardin, Cole, Mickens, & Lancour, 1996; Welty, 1997). In family group conferences, members of the birth family, extended family, supportive networks to the family, and professionals meet together to identify and discuss options and help determine the best plan for the children, including adoption. These shared decisions help to model good decision-making skills, and ensure greater adherence to the final choice (Welty, 1997).

Support and maintain connections with foster families, when needed. When children must be placed into out-of-home care, research demonstrates that children's outcomes during this time are best when connections are maintained between the foster family and the birth family (Palmer, 1995). Children's anger about the removal is decreased; anxiety

is decreased; somatic problems are less frequent; and rebellious behaviors are decreased (Palmer, 1995).

Biological parents' feelings of ambivalence toward parenting can increase while a child is out of the home (Hess & Folaron, 1991). A child's removal can result in immediate reduction of family stress, increased space in the family home, and increased time and resources for other family members, which can cause parents to waffle in their commitment to reunification. Supporting family connections to the child in care can help to decrease that ambivalence and foster continuing connections to the child in care.

An early study of foster parent adoption (Meezan & Shireman, 1985) interviewed foster parents who decided to adopt their foster child and those who chose not to adopt. One of the key differences between these families was that those foster parents who decided to adopt had spent more time with the biological parents of their foster child. This surprising finding is not clearly explained by the data collected in this study, but it could be that more contact leads to more comfort with the child (and his/her birth family), which could speak to the benefit of shared care, rather than a risk of increased conflict or confusion. More research is needed to explain this phenomenon.

Tell the Truth

Locate and share clear and accurate information. Good decisions almost always emphasize fairness. As much of the research in family preservation is finding, preserving families is not dangerous, on balance (Lindsey, 1994b; McCroskey & Meezan, 1997; Schuerman, Rzepnicki, & Littell, 1994). Building on the research base in each area, the burden for social services agencies and for social policy appears to be on increasing and emphasizing clarity and fairness for all parties at all steps of any service process, be it family preservation, adoption, foster care, or other options. Good information about services and options, timely information on service goals and how to best achieve them, and continual information on children's and families' progress and are critical to fairness, and critical to good outcomes, evidence shows (Berry, 1997; McCroskey & Meezan, 1997).

Research from the field of adoptions and from the field of family preservation is finding that good outcomes are best achieved when families feel that they can trust their service provider and the information they are getting. Barth and Berry (1988) found that adoption disruptions were more likely when adoptive parents were "surprised" in some way by some behavior or condition of their adopted child, when they felt that the adoption agency or worker had not been fully forthright in the information about the child. Similarly, Fraser, Pecora and Haapala (1991) found that family preservation was

more likely (than foster placement) when birthparents felt that they could trust their caseworker and felt that they were treated fairly.

The Five Steps

These five steps toward family preservation are reasonable and associated with the prevention of child placement. While they do not meet with criteria of "clear and convincing evidence," we believe these findings have been consistently identified in associational studies with enough frequency that they should be adopted and tested with more rigorous evaluative methods. Some of these steps require little more than worker attention; others necessitate agency or community-based efforts; efforts which are constrained, rather than enhanced, by ASFA timelines. Guidelines that are based on more service time or more community assets are a difficult proposition under the current ASFA framework and will require substantial advocacy work to accomplish and implement.

Each of these five steps serves to attain family preservation by enhancing the likelihood of family cooperation and engagement in effective services. The acronym for these five steps is therefore TRUST. Enactment of these steps in a series of reasonable efforts will help to engage families early in the treatment process by building experiences of trust and cooperation between caseworker and family. Trust and positive working relationships have been made even more critical by the shortened timeframe in which caseworkers must demonstrate progress toward case goals of safety and permanency.

Strengthening All Permanent Options

The Adoption and Safe Families Act of 1997 has served to more clearly specify the conditions under which agencies and states must work to preserve families, and under what conditions reasonable efforts to preserve families are not necessary. The Act still does little, however, to further specify what practices constitute "reasonable efforts" to preserve families. This has left the specification of reasonable efforts to others to delineate.

A wide-ranging research base has suggested that a few key practice efforts, largely supportive rather than punitive in nature, can, when reasonably applied, produce positive family preservation outcomes. But a policy and service structure can meet the goal of ensuring the welfare of a country's children through a number of means, some more benevolent than others. "While all are concerned about the fate of children, the extent to

which policy should be punitive or supportive to achieve parental and familial self-sufficiency is the focus of debate" (Maluccio, Abramczyk, & Thomlison, 1996, pg. 295).

Better knowledge of, and provision of, effective service strategies, or promising practices, appears to be a more supportive approach than many alternatives being proposed by critics of efforts to preserve families. Gelles (1996), in his book *The Book of David*, subtitled "How preserving families can cost children's lives," recommends that biological parents identified as having abused or neglected their child be assessed as to their motivation or readiness for change using a standardized measure of the Stages of Change (Prochaska & DiClemente, 1984). Parents scoring in areas of unreadiness would then not be treated and children could be expediently freed for adoption, thus not prolonging periods of danger or uncertainty for the child.

Readiness for change is a complicated construct, however, that may be more reflective of a parent's prior service history and lack of hope than of his or her remediability (O'Hare, 1996). But a parent's readiness for change will continue to be an important consideration in this new era of shortened time frames for family progress. The burden is on social service workers, rather than families, to instill hope and employ tactics to engage resistant or unmotivated clients (Rooney, 1992).

The tactics and strategies delineated here are presented in hopes of moving the practice of reasonable efforts to one that is evidence-based, proactive rather than reactive, and supportive rather than punitive to families. Family preservation can remain an effective and critical component of a continuum of services and outcomes to assure protection and family life for children, if concrete and timely practices are incorporated into practice and policy, and tested with rigorous evaluative methods.

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Implementing Intensive Family Preservation Services: A Case of Infidelity

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The importance of treatment fidelity in evaluations of all human service programs, including intensive family preservation services (IFPS), is examined in this article. Special attention is focused on the issue of treatment fidelity in IFPS programs attempting to adhere to a specific program model (Homebuilders®), and on the problems that lack of treatment fidelity has caused for research that has been conducted on this and other program models. Attempts to address the issue of treatment fidelity in other program areas offer models for constructing treatment fidelity assessment tools for IFPS. The authors suggest a schema for assessing treatment fidelity in evaluations of IFPS programs that should help to explore relationships among different approaches to IFPS, the consistency with which they are being implemented, and the outcomes that result.

Introduction

Studies designed to evaluate the effectiveness of human service programs have become a hallmark of constrained funding at both the state and federal levels. To evaluate these programs effectively, a number of issues must be addressed, including the issues of "treatment fidelity." Treatment fidelity has been defined as:

The degree of achievement of application of intended treatment. This would include adherence to the techniques that constitute theoretically driven therapies; to specific, session-by-session content and process elements of manualized treatment protocols; and to individual session outlines based on assessment information from the child and family in treatment (Koocher, Norcross, & Hill III, 1998).

When applied to human service programs, treatment fidelity is a particularly salient issue in studies with experimental or quasi-experimental designs, where the goal is to determine the effectiveness of the overall program and/or various elements of the program. Treatment fidelity has been addressed in a number of human service fields, including education (Fagley, 1984; Suen, 1992); health promotion (Conrad, Conrad, &

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Walcott-McQuigg, 1991; Kalichman, Blecher, Cherry, & Williams, 1997); juvenile justice (Henggeler, Melton, Brondino, Scherer, Hanley, & Jerome, 1997); learning disabilities (Gresham & Macmillan, 1998; Gresham, MacMillan, Beebe-Frankenberger, & Bocian, 2000); physical disabilities (Black, Danseco, Evangeline, & Krishnakumar, 1998); psychotherapy (Hilsenroth, Ackerman, & Blagys, 2001); and school psychology (Reimers, Wacker, & Koepl, 1987).

Although the field known as “intensive family preservation services” (IFPS) only has existed for the past few decades among an array of human service programs, the desire to evaluate its effectiveness has been continually present. Further, treatment fidelity has been identified as an issue adversely impacting past and present evaluations of IFPS programs (Kirk, 2001; Pecora, Fraser, Nelson, McCroskey & Meezan, 1995), including those directed at delinquent youth (Schoenwald, Henggeler, Brondino & Rowland, 2000). In this article, the authors discuss the continued emphasis on IFPS as a human services program and as one of the key child welfare service approaches. The importance in examining the issue of treatment fidelity in studies of IFPS is discussed. In addition, problems that have arisen due to the lack of treatment fidelity (“treatment infidelity”) in IFPS and similar studies are identified. Finally, utilizing work from related human service fields, the authors propose a schema for evaluating treatment fidelity in future studies of IFPS.

Intensive Family Preservation Services: A Key Approach in Child Welfare

It has been observed recently that the phrase “family preservation” can be viewed as both a specific program model for intervention or a more general approach to serving families in the child welfare system (McCroskey, 2001). When discussing policy, family preservation as a general philosophical approach is consistent with federal law, beginning with the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272). Although recent federal laws emphasizing adoptions and accelerating the process of termination of parental rights (e.g., Adoption and Safe Families Act of 1997, or P.L. 105-89) focus on the small number of child welfare cases that cannot be resolved through placement prevention or reunification, these recent laws do not dismantle the basic tenets of P.L. 96-272 with respect to placement prevention and reunification. Indeed, barring a sweeping overhaul of federal policy, the practice-guiding philosophy and primary goals in child welfare for the foreseeable future are likely to emphasize child safety and family preservation/reunification (American Humane Association Children’s Division, American Bar Association, Center on Children and the Law, Annie E. Casey Foundation, Casey Family Services, the Institute for Human Services Management, and The Casey Family Program, 1998; Child Welfare League of America, 1997; Pecora, Whittaker, Maluccio & Barth, 2000).

If family preservation is the philosophical approach upon which child welfare policy is based, it is essential to conduct research to learn if family preservation services “work,” recognizing that there may be various practice approaches to family preservation. More specifically, policy analysts, administrators, practitioners, and researchers all need to know if the operations performed in the name of family preservation lead to the desired outcomes for children and families that are stated in the guiding policy: child and family safety as well as family continuity. Answering this question with research rigor requires a clear definition of each distinctive family preservation program, and the subsequent evaluation of these family preservation programs using a variety of research and evaluation methods.

In order to conduct research on the effectiveness of a program, be it family preservation or any other program, a precise understanding of all of the program operations is necessary because the program operations comprise the “independent variable” in the research study or program evaluation using an experimental or quasi-experimental design. In order to associate program outcomes with a program, one must have confidence that workers are following the prescribed service model closely, delivering the service with the intended intervention type, length of treatment, and “dosage levels” to the proper (intended) service recipients. Thus, the term “program treatment fidelity” is the degree to which any program complies with these requirements. It is the authors’ contention that treatment fidelity, or infidelity, has plagued efforts to conduct research on intensive family preservation services since its inception.

History and Structure of Intensive Family Preservation Services

The origins of family preservation have been traced back to the 1900s with the “friendly home visitors” (Bremner, 1970-71), and certainly much more closely to the “multi-problem” or intensive family therapy efforts in the 1950s (e.g., Geismar & Ayers, 1958; Reed & Kirk, 1998), but its coming of age as a formal program was most notably marked by the emergence of the Homebuilders program in the mid 1970s (Kinney, Madsen, Fleming & Haapala, 1977). The Homebuilders™ model was fully “operationalized” in 1991 with the publication of *Keeping Families Together: The Homebuilders Model* (Kinney, Haapala & Booth, 1991), and then further specified by the training, worker certification and quality assurance efforts (termed QUEST) by Behavioral Sciences Institute¹, the parent agency of Homebuilders.

More recently, other intensive intervention models have been developed. Notable among them is Multisystemic Treatment (MST) developed by Henggeler and colleagues (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). Henggeler’s (et al., 1998) model focuses on antisocial behavior in children and adolescents. MST comprises

nine components defining its intervention approach, including: assessing problems within a systemic context; identifying and using strengths as a vehicle for change; promoting pro-social behavior; focusing on the present; addressing problems sequentially; linking interventions to the developmental stages and needs of the youth; requiring frequent and ongoing involvement of family members; continuously evaluating progress and removing barriers to successful outcomes; and, promoting treatment generalization and long-term maintenance through empowerment. (Adapted from Henggeler, et al., 1998, p.23)

While the Multisystemic Therapy (MST) model of services is even more heavily researched than the Homebuilders model and there are data with respect to how this model has been implemented with varying degrees of fidelity, (Henggeler, Pickrel, & Brondino, 1999; and Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998), it has not been as extensively implemented in child welfare at this time. Because the Homebuilders model also is a well-defined intensive family preservation services (IFPS) model and has been the subject of many evaluation studies, it is the focus of this discussion for purposes of detailing the problems associated with poor treatment fidelity as it relates to evaluation of IFPS programs.

The components of treatment fidelity for the Homebuilders model are quite straightforward (Kinney, Haapala & Booth, 1991). Families that are in crisis and where one or more children are at imminent risk of removal due to child abuse or neglect (intended recipients) receive intensive services (10+ hours during the first week and 6+ hours per week thereafter), have access to workers 24 hours per day 7 days per week for up to 6 weeks (dosage), receive services from workers carrying low caseloads (two families at a time), who are supervised by staff with supervision caseloads of four or fewer caseworkers. The workers also respond to the initial referral within 24 hours, and they deliver a wide variety of clinical (soft) and concrete (hard) services to clients in their own homes or other settings of the family's choice, in a manner that accommodates the family's schedule. This is the prescribed Homebuilders program model.

Problems in Evaluating IFPS and Similar Service Models

Several studies of Homebuilders programs were conducted in the early 1990s. The results on the effectiveness of intensive family preservation services at preventing out-of-home placements were, at best, equivocal. The problems associated with studying new programs that are still implementing the model and other problems associated with treatment fidelity have been well discussed by those conducting the research (Feldman, 1990; 1991; Schuerman, Rzipnicki, Littell & Chak, 1993; Yuan, McDonald, Wheeler, Struckman-Johnson & Rivest, 1990). Other researchers have cited a number of

problematic design and implementation issues associated with these same studies (Fraser, Nelson & Rivard, 1997; Heneghan, Horwitz & Leventhal, 1996; Pecora, Fraser, Nelson, McCroskey & Meezan, 1995; and Rossi, 1991; 1992). With more than 25 years of intensive family preservation program experience and more than a decade of rigorous research on the model, and with the findings of that research affected negatively by the lack of treatment fidelity, it might be expected that much more progress regarding IFPS treatment fidelity would have occurred. Unfortunately, an examination of the most recent national study of intensive family preservation services (DHHS, 2001) indicates that the issue is far from resolved.

The designers of this most recent study employed a rigorous experimental design and endeavored to address directly many of the issues and shortcomings of previous research. For example, study designers selected three sites where intensive family preservation programs purportedly followed the Homebuilders model. Training staff from the Behavioral Sciences Institute¹, where Homebuilders was developed and the model formalized, provided the initial training at each site. The programs were considered to be mature and well developed. Given the selection procedure, the training that was provided, and the maturity of the programs in the study, treatment fidelity might have been expected to be high at these sites.

While the treatment fidelity among the three sites was higher than in previous studies, the authors of the DHHS report point out some serious shortcomings in the individual site's adherence to the characteristics of the Homebuilders model. For example, in one site, less than half (44 percent) of the referred families received an in-home contact within 72 hours (i.e., within 3 days of referral), which is much more liberal than the Homebuilders stated 24-hour requirement. Only a little more than ¾ (78 percent) had such a contact within the first week. Of families receiving face-to-face visits during the first week, they received an average of 5.1 hours of service. Only one percent of contacts occurred on weekends. Families in the second site fared slightly better with 73 percent receiving an in-home contact within 72 hours and 88 percent within the first week, with those families averaging 6.5 hours of service. However, only 6 percent of contacts occurred on weekends. In the third site, 57 percent received an in-home contact within 72 hours and not quite ¾ (73 percent) had contact within the first week. Families in this site received the highest average number of contact hours (8.3 hours), but only nine percent of contacts occurred on weekends. (See DHHS, 2001, Interim Report, Chapter 7.6)

It is not clear from the Interim Report whether weekend services were not requested or were less available than expected. What is clear, however, is that the three sites in the study do not appear to be adhering to the characteristics of rapid response, intensive and "front loaded" services², and 24 hour-per-day/7 days-per-week service availability

envisioned by the Homebuilders originators, even if they are maintaining a level of responsiveness and service intensity that is higher than most other services in their respective sites.

As in the previous studies, there also is strong evidence in this study that the majority of families receiving the service did not meet the eligibility criteria for services: being at imminent risk of child placement. Thus, in spite of diligent efforts by the designers of the study, and while perhaps less serious than problems encountered in earlier research, treatment fidelity remains a serious problem in interpreting the findings from the DHHS study.

It is fair to ask whether the problems associated with treatment fidelity in intensive family preservation services are limited to the Homebuilders model (or closely associated models) or if other family preservation models experience these problems. It also is fair to ask if treatment fidelity problems are limited to the structural components of family preservation (rapid response, time-limited service, low caseloads, etc.) or if fidelity problems also occur with specific service components, such as counseling, skills training, provision of basic necessities, advocacy, etc. With respect to both questions, the answer appears to be “no” — other kinds of family preservation programs and other interventions in related fields are experiencing the same challenges.

Specific types (e.g., counseling, skills training, assessment) and durations of services provided under various family preservation program models have infrequently been the foci of research studies (for exceptions see for example, Berry, 1992; 1995; Fraser, Pecora, & Haapala, 1991), and at least several of the larger experimental studies of IFPS have examined service provision at least at the nominal or dichotomous level (DHHS, 2001; Schuerman, Rzepnicki, & Littell, 1994; Yuan, McDonald, Wheeler, Struckman-Johnson, & Rivest, 1990).

Berry (1995) examined treatment fidelity with respect to both program model specifications and the provision of treatment in a family preservation program that was less intensive than the Homebuilders model. The program model under study included 20 hours per month of in-home client contact for a time period of up to 4 months. Caseworkers were to carry a caseload of 7 families, and they were expected to provide a wide variety of services depending on identified family needs. With respect to program model fidelity, Berry (1995) found, among other things, that families received only a fraction (about 20%) of the in-home service time expected under the model, and less than 40% of the cases were closed within the specified time period of 4 months (only about 73% were closed at the end of 5 months). With respect to services, although there was some attempt to match services to risk factors at intake, the amount of service was not

related to these same risk variables. Further, certain types of service were provided to only a small proportion of families identified as needing them. In addition, concrete services (often seen as central to family preservation interventions) were rarely provided.

In an earlier study of IFPS, Fraser et al. (1991, p. 102) found significant differences between the Utah and Washington sites in terms of length of service, intensity and type of in-person versus phone contact. The review of studies conducted both on IFPS and on less intensive models suggests strongly that the problem of treatment fidelity transcends both structural and service-related components of intensive family preservation, as well as other family preservation services models.

However, family preservation is not alone in facing the issue of treatment fidelity. While multi-systemic treatment (MST) has been provided in family situations that primarily involve juvenile delinquency, this intervention also has been implemented where child maltreatment has been present.³ Henggeler and colleagues (Henggeler, Pickrel, & Brondino, 1999) recently discussed the negative effects of low treatment fidelity on the treatment outcomes of MST provided to delinquents with co-morbid substance abuse problems. Their work focused specifically on the transportability of MST across client types, hypothesizing success based upon previous research and theory. However, this study was the first involving MST administered by independent third parties not under the direct supervision of the MST program developers. As a result, the authors anticipated the possibility of treatment fidelity problems and gathered multiple measures on that variable.

The researchers found that the desired MST treatment outcomes were less positive for the intended recipients than found in their previous studies. Several hypotheses were examined to explain the weak treatment effects. In contrast to other hypotheses, analysis of treatment fidelity data produced statistically significant decrements in adherence to the components of MST as defined by the developers of the model. This finding led the authors to conclude that low treatment fidelity was responsible for the weak results.

In a more recent article, the same research team found that treatment model adherence can be improved when clinical supervision and adherence-monitoring procedures are fortified (Schoenwald, Henggeler, Brondino, & Rowland, 2000). This bodes well for other kinds of IFPS programs. In fact, referencing Homebuilders, in their recent review of family preservation research, Yoo and Meezan (2001) suggest,

...results of the outcome studies based on it [Homebuilders], it is easy to suggest that the past be buried and that the model be abandoned. The better suggestion, however, is to determine the

service components of the model that might contribute to specific outcomes, and compare them to other practice models that utilize these service components but differ in other ways from the original Homebuilders approach. In other words, if the various interventions tested in family preservation services can be 'unbundled,' it would be possible to reconfigure them by taking potentially important components from various models and then test for service effectiveness. (p. 29)

While Yoo and Meezan (2001) do not highlight treatment fidelity *per se*, there are numerous indirect references in their review to the same issues addressed in this discussion. Due to the issue of weak treatment fidelity, the authors of this article contend that too much validity has been attributed to much of the published research on IFPS and other family preservation services. In many instances, it is impossible to interpret weak treatment effects because central aspects of the program model were not implemented consistently.

Disentangling the effects that program variability has had on outcomes is made even more difficult because strong research designs rarely have been used. Furthermore, the task of enforcing tighter standards of treatment fidelity is one that proponents of all distinct program models should be held to, not just proponents of the Homebuilders model. In fact, as suggested by Yoo and Meezan (2001), the task should be shared among all family preservation service providers and researchers. Every program administrator, supervisor, and evaluator should adopt a taxonomic approach to defining treatment fidelity—hopefully a taxonomy that will have core components that are common to the variety of programs purporting to be family preservation.

We have two cautions about this overall goal: First, in evaluating IFPS programs, we need to be clear about the limitations of this intervention approach to addressing human needs and problems that have their roots in family poverty and other larger societal deficits. Second, advocates of treatment fidelity assessment must address the reality that some aspects of most intervention models will need to be tailored somewhat for special communities and families. For example, some Native American scholars have criticized IFPS program designers and researchers for not being more aware of the unique aspects of working with Native American families and the use of deficit-oriented practice assessment tools and research measures (see for example, Red Horse, Martinez, Day, Day, Poupart, & Scharnberg, 2000). Thus, IFPS models must be consciously revised (for example, so they include talking circles, traditional healing ceremonies, and more clan involvement), documented, and then measured to help ensure that the essential aspects of that particular intervention model are being implemented consistently.

Selected Treatment Fidelity Measures from Related Fields

Similar program implementation issues have been encountered by mental health administrators and researchers. These issues have led to the development of tools by a number of researchers for assessing treatment fidelity among mental health service providers. Three such efforts are those of Gary Bond and colleagues (2000) (Psychiatric Rehabilitation Fidelity Toolkit), Teague's Dartmouth Assertive Community Treatment Scale (Teague, Bond & Drake, 1998) and Burchard's Wraparound Fidelity Index (2001, <http://www.uvm.edu/~wrapvt/>):

The Wraparound Fidelity Index (WFI) is an interview that measures the quality of wraparound services that a family receives on a case-by-case basis. The WFI is composed of brief, confidential telephone interviews that assess adherence to eleven core elements of wraparound from the perspectives of parents, youth, and resource facilitators (case managers). The elements of Wraparound that are assessed by the WFI include:

1. Child and Family Team
2. Community-Based Services and Supports
3. Parent and Youth Voice and Choice
4. Cultural Competence
5. Individualized Services
6. Strength-based Services
7. Natural Supports
8. Continuation of Care
9. Collaboration
10. Flexible Funding
11. Outcome-Based Service

The WFI measures these elements by having each respondent (parent, youth, and resource facilitator) rate four questions or items that are regarded as essential for each element. Each item is scored on a quantitative scale, such as 0 = No, 1 = Sometimes/Somewhat, and 2 = Yes. Because there are four statements for each element, a respondent's total element score can range from 0 to 8.

Occasionally, items have been reverse-scored because they have been asked in the negative. There are 3 standardized forms of the WFI that can be used to record and score the ratings of the items; one for the parent, one for the youth, and one for the resource

facilitator. (See <http://www.uvm.edu/~wrapvt/WFI.htm>, p. 1 and <http://www.uvm.edu/~wrapvt/>).

Each of these fidelity measurement tools is intended to assist practitioners and researchers attempting to compare effectiveness across programs purporting to use the same treatment model. They also are intended to assess the extent to which an intervention model is being true to design and consistently implemented across treatment teams or individual workers.

More closely related to the field of Family Preservation services, Henggeler and Borduin (1992) developed a fidelity scale that focuses on adherence to the multi-systemic treatment (MST) model. The items for that scale are listed in Exhibit 1. Although MST has been most widely implemented with youth involved in the juvenile justice system, strengthening parenting behaviors that would prevent child abuse and child maltreatment recidivism have been addressed in some MST field trials as well.³

Exhibit 1. Items on the MST Adherence Measure

1. The session was lively and energetic.
2. The therapist tried to understand how my family's problems all fit together.
3. My family and the therapist worked together effectively.
4. My family knows exactly which problems we were working on.
5. The therapist recommended that family members do specific things to solve our problems.
6. The therapists' recommendations required family members to work on our problems almost every day.
7. My family and the therapist had similar ideas about ways to solve problems.
8. The therapist tried to change some ways that family members interact with each other.
9. The therapist tried to change some ways that family members interact with people outside the family.
10. My family and the therapist were honest and straightforward with each other.
11. The therapist's recommendations should help the children to mature.
12. Family members and the therapist agreed upon the goals of the session.

13. My family talked with the therapist about how well we followed her/his recommendations from the previous session.
14. My family talked with the therapist about the success (or lack of success) of her/his recommendations from the previous session.
15. The therapy session included a lot of irrelevant small talk (chit-chat).
16. We didn't get much accomplished during the therapy session.
17. Family members were engaged in power struggles with the therapist.
18. The therapist's recommendations required us to do almost all the work.
19. The therapy session was boring.
20. The family was not sure about the direction of treatment.
21. There therapist understood what is good about our family.
22. The therapist's recommendations made good use of our family's strengths.
23. My family accepted that part of the therapist's job is to help us change certain things about our family.
24. During the session, we talked about some experiences that occurred in previous sessions.
25. The therapist's recommendations should help family members to become more responsible.
26. There were awkward silences and pauses during the session.

Source: (Henggeler & Borduin, 1992, p. 88). Reprinted with permission.

Proposed Development of a Taxonomic Schema for Family Preservation Services

Bond and colleagues (Bond, et al., 2000) have developed an excellent tool kit for developing fidelity assessment instruments for psychiatric rehabilitation. Some of the most important lessons from their toolkit for developing such measures are highlighted below, and then some criterion categories that might be useful for IFPS program fidelity are presented.

Exhibit 2 shows the major steps that should be followed for building fidelity assessment tools. These steps are similar to those followed for the development and psychometric testing of most other instruments.

Exhibit 2. Steps for Developing a Fidelity Measure

1. Define the purpose of the fidelity scale
2. Assess the degree of model development
3. Identify model dimensions
4. Determine if appropriate fidelity scales already exist
5. Formulate fidelity scale plan
6. Develop items
7. Develop response scale points
8. Choose data collection sources and methods
9. Determine item order
10. Develop data collection protocol
11. Train interviewers/raters
12. Pilot the scale
13. Assess psychometric properties
14. Determine scoring and weighting of items

Source: Bond et al., 2000, p. 24.

Because of their utility in guiding these kinds of instrument development efforts, a few selected details for each of the steps are included here that would contribute to the development of a treatment fidelity tool for IFPS. Readers are urged to carefully review the full toolkit by Bond et al., (2000) when developing this type of instrument.

Step 1. Define the Purpose of the Fidelity Scale

The first step in developing a fidelity measure is to define its purpose... The goals of a fidelity scale will influence the tactics used to develop the scale. For example, if the goal is to develop a scale for demonstrating model adherence in a randomized controlled trial, then the methods used will likely be more comprehensive, identifying features that make the model unique, and features that distinguish the model from services received by control groups. The evaluator is more likely to consider multiple

measures, to conduct detailed reliability studies, and to administer the fidelity scale repeatedly. Conversely, if one is conducting a low-budget, statewide survey, where the goal is to ensure that sites achieve a minimal level of compliance to a program model, then a more pragmatic strategy is likely to be employed.

Step 2. Assess the Degree of Model Development

... the next step is to assess the degree of model development. If the program in question is well defined, then this suggests the use of *confirmatory methods* (Step 3). If the program is not well-defined, then *inductive methods* may be more appropriate.

The assessment of the adequacy of a program model includes a literature review. First, review the literature on the particular program model to identify the important dimensions in the model as well as provide a more coherent understanding of the definitions of the constructs therein. (In this chapter, we use a variety of terms—*principles, components, elements, and ingredients*—to refer approximately to the same thing.) Second, the evaluator should review any existing literature on fidelity measures that have been designed for the particular program. This could help to determine whether there is an existing scale that can be used, or modified, or whether a new scale should be developed. The literature may also indicate particular dimensions that are difficult to assess or suggest which data sources are most appropriate (e.g., use of client self-report for a drop-in center).

A review of the literature will help to determine the degree of *model clarity, model specification, model differentiation, model comprehensiveness, and model consensus*. *Model clarity* refers to the extent to which the program model has clearly articulated principles of operation. An example of a program principle is “rapid job search.” *Model specification* refers to the degree to which the model has explicit behavioral guidelines for operation. For example, the model specification for the principle of assertive outreach might be “at least 3 contacts per week at the consumer’s home.” *Model differentiation* refers to a distinctive feature of a program model that sets it apart from other models and approaches. The use of a total team approach differentiates ACT from intensive case management. *Model comprehensiveness* refers to the extent to which a model provides adequate guidance for commonly occurring situations. Many theoretical models are inadequate by virtue of the fact that they do not tell what to do in important circumstances. For example, consider the fact that many case management models do not explain how to handle the management of the consumer’s income. *Model consensus* refers to the degree of agreement with which publications in the field share a description of a model. “Clinical case management” is an example of a model lacking model

consensus. (Bond, Williams, Evans, Salyers, Kim, Sharpe, & Leff, 2000). (Reprinted from Bond et al., 2000, pp. 24-25.)

As evidenced by these guidelines, the process of developing fidelity assessment measures requires a major commitment of time and expertise. But given recent MST evaluation findings that inconsistent implementation leads to less positive treatment outcomes (Schoenwald, et al., 2000), the effort needed to build these instruments seems reasonable.

Exhibit 3 presents a foundation for the kinds of criterion measures that might be most useful to the development of a treatment fidelity tool for IFPS. The main fidelity categories are arranged vertically in the first column of the matrix, and the "continua" comprising the measurement strategies for each category are contained in the remaining columns to the right of the fidelity categories. For fidelity areas that are categorical in nature, check boxes and lists are provided. For those measurement categories that are easily conceptualized as ordinal (e.g., risk level), interval, or ratio (e.g., caseload size; number of weeks of service provided), possible Likert-type scales are suggested. Clearly, these are only sample criterion areas. More time would need to be invested in transforming these areas into a useful fidelity measurement tool following the steps outlined by Bond and others.

The use of such a fidelity measurement tool would aid both program administrators and researchers. Administrators might check the fidelity of their own programs by comparing the results of a program self-assessment to similar assessments conducted by other programs. Program designers or model developers might promulgate a suggested set of fidelity "markers" using the instrument, thus establishing a set of fidelity standards. Program administrators could then compare their implementation efforts to the standards and be more assured of model fidelity.

Researchers would benefit by having the same fidelity markers available, in that between-program differences could be identified that may be related to differences in effectiveness. Earlier in this paper, components of both MST and Homebuilders IFPS were summarized using the language and terms of the respective model developers (Henggeler, et al., 1998; Kinney, et al., 1991). Although there are similarities evident between the two, a review of those summaries reveals that MST is described in terms that are largely philosophical or process-oriented (e.g., assessing problems systemically; identifying and using strengths, focusing on the present; etc.), whereas IFPS is described in terms that are largely structural (e.g., timelines for response, length of service, caseload sizes, etc.). If a fidelity tool were available for both models, researchers would

know more about structural components of MST and processes associated with IFPS, and between-model comparisons would be more easily accomplished.

These are but two examples of the use of the proposed fidelity instrument, and both are responsive to Yoo and Meezan's (2001) suggestion that researchers strive to identify the most important components of various models. Further, experimentation with modified program models is not only permissible, but essential to the advancement of our knowledge about treatment effectiveness. Intended modifications of models could be documented as part of such experiments, and evaluations of their effects would be greatly simplified, less speculative, and in all probability, more accurate and productive.

Exhibit 3. Sample Criterion Areas for Assessing Program Fidelity in Family Preservation Services

Criterion Area	Measurement Scale Approaches
I. Organization and Consumer Focus	
Client definition	<ul style="list-style-type: none"> <input type="checkbox"/> Child Abuse/Neglect (e.g., based upon seriousness of abuse or risk rating) <input type="checkbox"/> Juvenile Justice (e.g., pre-delinquent, adjudicated delinquent-misdemeanor, adjudicated delinquent-felony, adjudicated delinquent-violent felony) <input type="checkbox"/> Mental Health (possibly based on a seriousness score from the GAF, SF-24, Behavioral Severity Index, or other standardized measure)
Treatment outcomes sought	<ul style="list-style-type: none"> <input type="checkbox"/> Child safety from child maltreatment <input type="checkbox"/> Placement prevention <input type="checkbox"/> Duration of placement <input type="checkbox"/> Restrictiveness of placement that results from the service using the ROLES or similar scale (e.g., birth family, foster family, group home, residential treatment, incarceration) <input type="checkbox"/> Caregiver and family functioning (NCFAS domains and other instrument-based categories, etc) <input type="checkbox"/> Child functioning <input type="checkbox"/> Social Support

Other program outcomes	<input type="checkbox"/> Neighborhood improvements <input type="checkbox"/> Integration of certain services <input type="checkbox"/> Policy reform <input type="checkbox"/> Improvements in funding levels <input type="checkbox"/> Improvements in funding methods (e.g., reduced conflicts) <input type="checkbox"/> Reductions in administrative barriers to service
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II. Services Framework and Services Provided

Eligibility for Service: (Include exclusionary factors; e.g., child is a danger to him/herself or others, severe and untreated substance abuse that endangers children)	<input type="checkbox"/> Imminent Risk (Determination method: Non-substantiated allegations, repeated allegations, certain conditions present and family deteriorating re: support/resources, score on a risk assessment scale, etc) <input type="checkbox"/> Non-Imminent Risk (Determination method: Non-substantiated allegations, repeated allegations, certain conditions present and family deteriorating re: support/resources, score on a risk assessment scale, etc.) <input type="checkbox"/> No eligibility criteria (Program uses a no-reject intake policy)
Underlying Theory of Treatment	<input type="checkbox"/> Crisis theory <input type="checkbox"/> Behavioral theory <input type="checkbox"/> Cognitive theory <input type="checkbox"/> Family systems theory <input type="checkbox"/> Ecological theory <input type="checkbox"/> Others?
Family Assessment Methods	<input type="checkbox"/> Informal (interview) <input type="checkbox"/> Formal/Structured Interview <input type="checkbox"/> Detailed protocol <input type="checkbox"/> Use of reliable/valid instruments <input type="checkbox"/> Specify: _____ Assessment done both at intake and closure <input type="checkbox"/> Service link to assessed needs: formal link between identified needs and service bundle provided

Types of counseling or other "soft" services provided:	<input type="checkbox"/> Counseling <input type="checkbox"/> Anger management treatment <input type="checkbox"/> Parenting skills treatment <input type="checkbox"/> Household financial management treatment <input type="checkbox"/> Client advocacy <input type="checkbox"/> Other:
Types of concrete ("hard") services provided:	<input type="checkbox"/> Cash <input type="checkbox"/> Transportation <input type="checkbox"/> Home maintenance <input type="checkbox"/> Utilities <input type="checkbox"/> Vehicle repair <input type="checkbox"/> Appliances <input type="checkbox"/> Other:

III. Structural Components of the Program Model

Extent of consumer involvement	<input type="checkbox"/> None (No youth or caregivers are involved) <input type="checkbox"/> Minimal (One youth or caregiver serves on an advisory committee) <input type="checkbox"/> Moderate (Two or more youth or caregivers serve on an advisory committee) <input type="checkbox"/> Extensive (Three or more youth or caregivers serve on an advisory committee)																					
Rapid response	<input type="checkbox"/> Child or caregivers contacted by phone or face-to-face within 24 hours <input type="checkbox"/> 24-48 hours <input type="checkbox"/> 48-72 hours <input type="checkbox"/> Other_? <input type="checkbox"/> Child or caregivers must be seen face-to-face within 24 hours <input type="checkbox"/> Child or caregivers must be seen face-to-face within 24 -48 hours <input type="checkbox"/> Other ?																					
Caseload size	Number of families per worker (possibly adjusted by the number of children that are the primary focus of service) <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> <td style="text-align: center;">4</td> <td style="text-align: center;">5</td> <td style="text-align: center;">6</td> <td style="text-align: center;">7</td> <td style="text-align: center;">8</td> <td style="text-align: center;">9</td> <td style="text-align: center;">10+</td> </tr> </table>												1	2	3	4	5	6	7	8	9	10+
1	2	3	4	5	6	7	8	9	10+													

Duration of Service	<table border="1"> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table> <p><4 weeks 4-6 wks 7-12 wks 13-18 wks 18-24 wks</p> <p>Under what conditions is there flexibility for any time limits?</p>	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____		
Service Intensity	<p>___ Average # of Hours of face to face contact per week</p> <p>___ Average # of Hours of phone contact per week</p> <p>___ Average # of Hours of phone contact during weeknights/weekends</p> <p>___ Average # of hours of face-to-face contact during weeknights/weekends</p> <p>___ Hours of supervision per case per week</p> <p>___ Hours of administrative/record keeping per week per case</p>					
Staffing design	<p><input type="checkbox"/> Solo therapist</p> <p><input type="checkbox"/> Therapist and case aide</p> <p><input type="checkbox"/> Use of paired therapists</p> <p><input type="checkbox"/> Use of trained substance abuse or other specialists to bolster work of primary therapist</p> <p><input type="checkbox"/> Treatment team assembled on the basis of assessed needs</p> <p><input type="checkbox"/> Other:</p>					
Staff Qualifications	Minimum qualifications for treatment staff					
Supervisor Qualifications	Minimum qualifications for supervisory staff					
Staff and supervisor training	<p>___ Number of hours of orientation</p> <p>___ Number of hours required per year of in-service</p>					
Staff training content	Key required training content areas:					
Supervisor training content	Key required training content areas:					

Type of Supervision	<p><input type="checkbox"/> Face to face</p> <p><input type="checkbox"/> Phone</p> <p><input type="checkbox"/> Group</p> <p><input type="checkbox"/> Email/web</p>
Amount of Supervision	<p>___ Hours of face to face supervision per week</p> <p>___ Hours of phone supervision per week</p> <p>___ Hours of group supervision per week</p>

Conclusion

The development work for a fidelity measurement tool will not be easy or inexpensive. However, the indefensible alternative is continuing to deliver IFPS programs inconsistently and continuing to conduct research virtually preordained to produce equivocal findings. Both federal and state legislatures and administrators will continue to look for effective human service programs and will try to eliminate ineffective programs. IFPS and other family preservation program administrators and practitioners continue to work diligently to prevent family disruption and to promote reunification while federal mandates impose increasingly strict timelines and procedural mandates, such as accelerated terminations of parental rights.

These programs deserve the support of evaluators and researchers to test the efficacy of their programs. At the same time, practitioners and administrators must be willing to adhere to whatever specific program models they choose to implement in order to conduct the necessary evaluations and other research. Treatment fidelity is a prerequisite to these activities, and the treatment fidelity schema proposed herein would help all stakeholders contribute to the demonstration of effective, evidence-based family preservation service models.

Notes

1. The Behavioral Sciences Institute recently changed its name to the Institute for Family Development, and may be contacted through their web site: www.institutefamily.org.
2. Front-loaded services reflect an emphasis upon delivering more services at the beginning of family treatment than towards the end of the service period.
3. For MST studies focusing on child maltreatment, see for example, Henggeler et al., 1998, pp. 239, 248-249).

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Note: Portions of the analysis of the recently published federal study of family preservation services (DHHS, 2001; available at: <http://aspe.os.dhhs.gov/hps/fampres94>) have been presented in an editorial piece authored by Dr. Ray Kirk: *A Critique of the Evaluation of Family Preservation and Reunification Programs: Interim Report* (2001); available at: <http://www.nfpn.org>). Special thanks to Dr. Gary Bond and Dr. John Burchard for their consultation and sharing of materials related to treatment fidelity.

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Supporting Families through Short-Term Foster Care—An Essay Review

Anthony N. Maluccio

Aldgate, J. and Bradley, M. (1999). *Supporting families through short-term fostering*. London: The Stationery Office.

This essay reviews a British qualitative study of short-term foster care from the perspectives of birth parents, children, foster parents, and social workers. Respondents highlighted the value of short-term foster care as a family support service and also offered many recommendations for improving service delivery. The study provides useful implications for restructuring child welfare services in the United States and for promoting cross-national collaboration in future research activities in the area of child and family services.

As in the United States, short-term foster care (or accommodation in the British context) is increasingly being used in the United Kingdom. This is in line with the principles embodied in The Children Act 1989 (England and Wales), which emphasizes partnership between child welfare authorities and birth parents to promote the welfare of children placed in out-of-home care or at risk of placement in such care. But how effective is short-term fostering in preventing long-term family breakdown? How useful is it as a family support program in the continuum of services available for children in families at risk of disruption? How can its effectiveness be enhanced?

In their intensive study, *Supporting Families through Short-Term Fostering*, Jane Aldgate and Marie Bradley (1999) examine short-term foster care in England from the perspectives of those most closely involved in it: birth parents, children, foster parents, and social workers. Using a qualitative-exploratory design, the authors trace the progress of a purposive sample of the above participants in 60 cases located in four local social service departments ranging from urban areas to smaller towns to rural settings. The researchers conducted informal, in-depth interviews with birth parents, foster parents, social workers, and children at two points in time (Aldgate and Bradley, 1999: 29):

- When the offer of short-term accommodation had been made and had been accepted by the family

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- At a retesting after at least nine months had elapsed and the accommodation was ongoing or sooner if the arrangements had ended earlier

In addition, outcome measures were obtained through standardized tests with parents (Levinson's tri-dimensional locus of control test) and children (Kovacs Children's Depression Inventory).

The findings show that most parents felt that the service had helped to meet their needs, particularly in regard to offering time off from the children, strengthening their relationships with spouses or partners, and improving their own health and employment prospects. At the same time, parents expressed their concern about their social isolation and a longing for help to rebuild their links with relatives and with the community. The majority of children also liked the experience of short-term fostering, especially the attention provided by the foster parents, the feeling that they were treated as individuals, and the opportunities to play with other children in the foster family. However, most of the children resented being away from home. As found in other studies, they longed to return to their parents as soon as possible (Bullock, Gooch, and Little, 1998).

As for the foster parents, fostering provided an important source of income, but many of them expressed a number of concerns, notably in regard to their inadequate preparation for working with "demanding" parents and "aggressive" children; the frequent comings and goings of children; and the sometimes abrupt ending of the placement. Social workers, on the other hand, rated the service positively and felt competent in training and supporting carers and in empowering parents. They seemed to feel less adequate in working with children and unclear in consulting children regarding decision-making, a role that was required by the statutes.

In light of the paucity of research on client and worker perception of child welfare services in the United States, this well-organized and well-executed study is critical and useful, as it offers a number of messages for policy, practice, and research. In particular, it reinforces the importance of policies and strategies that empower families, promote continuing parent-child relationships while the child is in care, and treat short-term fostering as a *family support service*. Increased emphasis on such supportive services for vulnerable families could help deal with the danger of accelerating permanent removal of children from their families, which, as Pelton (1999) has charged, is often a consequence of current welfare reform legislation and programs.

In the area of practice, the study highlights the role of the social worker as a family support specialist and "care manager," the use of short-term fostering as a therapeutic

intervention for parents and children in appropriate cases, and the value of locating foster care services in the neighborhoods in which birth families live. In regard to research, there are implications for finding ways to promote the therapeutic use of parent-child visiting, strengthening the role of foster parents as consultants to the birth parents, engaging children in care in decision-making on their behalf, and promoting family reunification.

Although short-term fostering was found to be sufficient in most cases, there were situations in which more intensive and extensive services were needed to avert or deal with risks. For this reason, Aldgate and Bradley (p. 216) conclude:

Short-term accommodation, therefore needs to be available as one of a broad range of services for families under stress. Only by offering a large menu of family support services can there be more choices for families. Creating choice is in itself the foundation of community-based social services to promote the welfare of children in need.

The above conclusion is consistent with the recommendations made in recent years by various scholars in regard to improving or restructuring child welfare services in the U.S., empowering children and families, and enhancing child welfare outcomes. (See for example, Barbell and Wright, 1999; McGowan and Walsh, 2000; Pelton, 1992; and Waldfogel, 1000). In the long run, cross-national collaboration with researchers in England and other countries can help us achieve these goals. Attention to the work of Aldgate and Bradley can help stimulate such collaboration in the immediate future.

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Failed Child Policy—An Essay Review

Anthony N. Maluccio

Hutchinson, J.R. (with C.E. Sudia) (2002). *Failed Child Welfare Policy—Family Preservation and the Orphaning of Child Welfare*. Lanham, MD: University Press of America.

This essay reviews Failed Child Welfare Policy (Hutchinson, 2002), in which the author argues that the public child welfare system has failed to meet the needs of children and families coming to its attention. She recommends using the available—and limited—resources to reorganize and reconstruct the service delivery system with emphasis on family-centered services.

Introduction

The public child welfare system in the United States has long been under attack for failing to provide adequately for the needs of children and families coming to its attention. In *Failed Child Welfare Policy—Family Preservation and the Orphaning of Child Welfare*, Janet R. Hutchinson (2002) presents the latest critique, in collaboration with Cecelia Sudia. Hutchinson writes from her extensive experience in the field of family preservation as project director for many years at the University of Iowa's National Resource Center on Family-Based Services, while Sudia contributes in two chapters her perspective as a senior member of the Children's Bureau, U.S. Department of Health and Human Services, until her recent retirement.

Hutchinson introduces the key points in her argument early on in the book (x-xii and Chapter Seven):

- the family preservation movement has largely “failed” in its efforts to serve families with children at risk;
- the public child welfare system has been abandoned and essentially “orphaned” by the social work profession;
- the fields of social work, family therapy, and public administration must work together to “reclaim” child welfare; and
- the role of federal and state governments in family and child services should be “reconstructed.”

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Summary of Contents

In developing the above arguments, Hutchinson begins by describing in Chapter One the child welfare system's inability to meet the "overwhelming" federal and state mandates "to guarantee the safety of abused and neglected children" (p. 27). Building on a typical child maltreatment case in a protective service agency, she highlights such common factors as inadequate resources, poor preparation of—and support for—child welfare staff, and diminishing support from traditional advocates among professional social workers, schools of social work, and professional organizations.

In Chapter Two, Hutchinson collaborates with Sudia in describing a range of potential alternatives to foster care, including family therapy and family-based services. She concludes, however, that such alternatives have not been incorporated into service delivery in child welfare, due in part to the continuing influence of bureaucratic and administrative structures adopted in the 1930s by federal and state governments and the resulting emphasis on removal of children from their birth families. In Chapter Three, she argues that agencies "need both will and imagination" to introduce innovations and challenges to "bureaucratic constraints and risk-averse cultures" that currently characterize the service delivery system (p. 64).

In Chapter Four, authored by Sudia, there is a comprehensive presentation of the history and functions of the Children's Bureau. The key point is that historically there has been "very little interest in the family unit." (p. 92). Moreover, the opportunity to establish a *family focus* was lost due to fragmentation of the Bureau's mission and structure. As a result, the staff of the Children's Bureau has increasingly been laboring under severe constraints, particularly since the Reagan administration:

Hostile Administration appointees, the failure to fund sound research and evaluation studies that would provide empirical guidance to policymakers in Congress and the states, and the constant reorganizations and consequent undermining of child welfare expertise among the agency's few remaining specialists have rendered the Bureau largely ineffective (p. 92).

As the Children's Bureau's role in the field of child welfare was subsequently reduced, various national organizations and private foundations became more active in efforts to shape the delivery of child and family services and to advocate on behalf of children and families at risk. In Chapter Five, Hutchinson describes in particular the activities of the Edna McConnell Clark Foundation of New York, which during the 1980s and early 1990s pursued a national strategy of funding family preservation services along the lines of the Homebuilders model that had been introduced in the 1980s in the state of

Washington by the Behavioral Sciences Institute (Kinney, Haapala, and Booth, 1991). The Homebuilders approach focused exclusively on the use of behavior modification and social learning theory, in contrast to the family systems or ecological approach promoted by the previously mentioned National Resource Center on Family-Based Services.

In Chapter Six, Hutchinson moves into another area, as she describes a range of studies of child welfare and family-based practice. She also reviews methodological issues encountered by researchers in evaluative studies of child welfare services as well as family-based practice evaluations. She notes that the results of such evaluations are inconclusive, and adds that:

. . . underfunding, endemic to virtually every element of child welfare, plagues efforts to understand the truth of outcome claims by program developers, as well (p. 118).

In conclusion, in Chapter Seven, Hutchinson offers suggestions for restructuring the child welfare system through a variety of changes in social work, family therapy, and public administration. Additionally, she advocates the "reconstruction" of the roles of federal and state governments, through such means as establishment of a "regional human services authority with a goal of eliminating redundancy and filling service gaps" (p. 147). Above all, she argues for replacing "the inadequacies of the child welfare discourse with a family-centered discourse" (p. 150) involving the three previously mentioned professional disciplines of social work, family therapy, and public administration.

CRITIQUE

As reflected in the above summary, *Failed Child Welfare Policy—Family Preservation and the Orphaning of Child Welfare* represents a comprehensive—if somewhat rambling—review of a timely topic. Hutchinson and Sudia describe in depth not only the recent development and main features of family preservation but also the rise and fall of the child welfare service delivery system in the United States, notably at the federal and state levels. They also offer pertinent suggestions for improving services, such as organizing programs around the family rather than children or parents as individuals, and also promoting better integration with other community helping systems. It would have been useful, however, if they had provided further details regarding their recommendations. For example, given the obstinacy of the service delivery system as they describe it, how could child welfare and family services be better organized and delivered? How could the recurrent issues and rigidities that they so clearly point out be

confronted? How could interdisciplinary leadership and collaboration be promoted? How could federal and state policies be improved?

Finally, while emphasizing the failures in the child welfare and family preservation arenas, Hutchinson has overlooked or neglected to consider some of their positive features. These include, among other examples, programs in various states and communities to reunite children in out-of-home care with their families; preparation of adolescents for independent living; open adoption and adoption of children with special needs; foster family care services for young unmarried mothers and their children; services to prevent out-of-home placement of young children; and selective use, at least in some agencies, of group and residential care for adolescents. In particular, as described by Roberts and Early (2002) among others,¹ emerging in various settings are good examples of family-centered, neighborhood-based programs such as those supported in recent years by the Annie E. Casey Foundation. These programs are proving to be effective, as they offer focused services with adequate and varied supports to vulnerable families and children and, consequently, good potential to prevent out-of-home placement.²

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¹ See, for example, Adams & Nelson (1995); Maluccio, Ainsworth, & Thoburn (2000); Wells and Tracy (1996); and Yoo and Meezan (2001).

² These and other programs have been described in such journals as *Child Welfare*, *Children and Youth Services Review*, and *Family Preservation Journal*.