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Implementing Intensive Family Preservation Services: A Case of Infidelity

Raymond S. Kirk, Kellie Reed-Ashcraft, and Peter J. Pecora

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, & Koeppl, 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).

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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, Madsden, 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 Institute[1], 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). Hengeller's (et al., 1998) model focuses on antisocial behavior in children and adolescents. MST comprises

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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

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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 Institute[1], 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" services[2], and 24 hour-per-day/7 days-per-week service availability

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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

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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

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> 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.

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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

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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.

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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.

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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

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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 it 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

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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

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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	❑ Child Abuse/Neglect (e.g., based upon seriousness of abuse or risk rating) ❑ Juvenile Justice (e.g., pre-delinquent, adjudicated delinquent-misdemeanor, adjudicated delinquent-felony, adjudicated delinquent-violent felony) ❑ Mental Health (possibly based on a seriousness score from the GAF, SF-24, Behavioral Severity Index, or other standardized measure)
Treatment outcomes sought	❑ Child safety from child maltreatment ❑ Placement prevention ❑ Duration of placement ❑ 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) ❑ Caregiver and family functioning (NCFAS domains and other instrument-based categories, etc) ❑ Child functioning ❑ Social Support

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Other program outcomes	❑ Neighborhood improvements ❑ Integration of certain services ❑ Policy reform ❑ Improvements in funding levels ❑ Improvements in funding methods (e.g., reduced conflicts) ❑ Reductions in administrative barriers to service

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)	❑ ***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) ❑ ***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.) ❑ ***No eligibility criteria*** (Program uses a no-reject intake policy)
Underlying Theory of Treatment	❑ Crisis theory ❑ Behavioral theory ❑ Cognitive theory ❑ Family systems theory ❑ Ecological theory ❑ Others?
Family Assessment Methods	❑ Informal (interview) ❑ Formal/Structured Interview ❑ Detailed protocol ❑ Use of reliable/valid instruments ❑ Specify: _____Assessment done both at intake and closure ❑ Service link to assessed needs: formal link between identified needs and service bundle provided

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

III. Structural Components of the Program Model	
Extent of consumer involvement	❑ None (No youth or caregivers are involved) ❑ Minimal (One youth or caregiver serves on an advisory committee) ❑ Moderate (Two or more youth or caregivers serve on an advisory committee) ❑ Extensive (Three or more youth or caregivers serve on an advisory committee)
Rapid response	❑ Child or caregivers contacted by phone or face-to-face within 24 hours ❑ 24-48 hours ❑ 48-72 hours ❑ Other__? ❑ Child or caregivers must be seen face-to-face within 24 hours ❑ Child or caregivers must be seen face-to-face within 24 -48 hours ❑ Other__?
Caseload size	Number of families per worker (possibly adjusted by the number of children that are the primary focus of service) |____|____|____|____|____|____|____|____|____|____| 1 2 3 4 5 6 7 8 9 10+

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

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Type of Supervision	❑ Face to face ❑ Phone ❑ Group ❑ Email/web
Amount of Supervision	___ Hours of face to face supervision per week ___ Hours of phone supervision per week ___ Hours of group supervision per week

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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