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# FAMILY PRESERVATION JOURNAL

A Publication of the *Family Preservation Institute*

Summer 1995

## IN THIS ISSUE:

**Family Preservation and Support: Past, Present, and Future**, by Katharine Hooper-Briar, C. Anne Broussard, John Ronnau, and Alvin L. Sallee

**An Examination of Treatment Fidelity in an Intensive Family Preservation Program**, by Marianne Berry

**Intensive Family Reunification Services: A Conceptual Framework and Case Example**, by Elaine Walton, Mark W. Fraser, Catherine Harlin, and Robert E. Lewis

**Intensive Family Preservation Services: Do They Have Any Impact on Family Functioning?** by Roy W. Rodenhiser, Joseph Chandy, and Kazi Ahmed

**Institutionalizing Intensive Family Preservation Services: A Strategy for Creating Staffing Standards Based on Projections of At-Risk Children From Referral Sources**, by Robert E. Lewis

PLUS a review of current resources



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Summer, 1995

### ARTICLES

- Family Preservation and Support: Past, Present, and Future  
*Katharine Hooper-Briar, C. Anne Broussard, John Ronnau, and Alvin L. Sallee* 5
- An Examination of Treatment Fidelity in an Intensive Family Preservation Program  
*Marianne Berry* 25
- Intensive Family Reunification Services: A Conceptual Framework and Case Example  
*Elaine Walton, Mark W. Fraser, Catherine Harlin, and Robert E. Lewis* 51
- Intensive Family Preservation Services: Do They Have Any Impact on Family Functioning?  
*Roy W. Rodenhiser, Joseph Chandy, and Kazi Ahmed* 69
- Institutionalizing Intensive Family Preservation Services: A Strategy for Creating Staffing Standards Based on Projections of At-Risk Children from Referral Sources  
*Robert E. Lewis* 87

### CURRENT RESOURCES

- Kaplan, L., & Girard, J. L. (1994). Strengthening high-risk families: A handbook for practitioners. New York: Lexington.  
*Reviewed by June Lloyd* 113
- Schuerman, J.R., Rzepnicki, T. L., & Littell, J. H. (1994). Putting families first: An experiment in family preservation. New York: Aldine de Gruyter.  
*Reviewed by Anthony Maluccio and Kristine Nelson* 115
- Behavioral Sciences Institute, HOMEBUILDERS Training Division. (1992). Skills for Family and Community Living. Federal Way, WA: Author.  
*Reviewed by Pat Sandau-Beckler* 119



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The *Family Preservation Journal* is a refereed biannual publication. Practitioners, policy makers, evaluators, administrators, and educators are invited to submit articles. Manuscripts should conform to APA style, not exceed 16 typed, double-spaced pages (excluding tables and figures), with an alphabetical list of references. Also include a diskette copy using WordPerfect v5.1 or v6.1 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.

Please submit all materials to: **Family Preservation Journal**, Department of Social Work, New Mexico State University, P.O. Box 30001 Dept. 3SW, Las Cruces, NM 88003-8001.

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## Editorial

After 20 years of development, research and practice, it is time to begin a journal for family preservation and support. There are many exciting opportunities and issues for consumers and practitioners, as well! Last year most states became deeply invested in new collaboration activities across agency lines and with consumers. This is the "high" in which this journal was conceptualized. The need for a family preservation journal has also been made clear by the new Congress which wants to provide orphanages, or the Administration which has proposed residential group homes as the ultimate punishment for children who's parents fail to get off of welfare in two years. These challenges make us more determined to redouble the efforts on behalf of all families and serve as a reminder that we need quality research, dedicated staff and political savvy to help families by employing family preservation values, knowledge and skills.

Ironically, perhaps, we should thank those who play on the fears and myths about the family unit for political gain because they are raising the debate to a national level in a way its proponents have been unable to achieve. We have seen numerous letters to editors in newspapers and magazines supporting family preservation and debunking the current political rhetoric. It is our sincere hope this journal will be a credible and objective voice to the debate on family preservation and, ultimately, help improve services to our families.

As a result of definitional exercises over the past several years, including input from many national experts, we define family preservation as an approach to practice and a philosophy guided by values which uphold the uniqueness, dignity, and essential role which families play in the health and well being of their members. In keeping with this philosophy, programs, policies, and organizations are family focused. As an approach, family preservation provides services ranging from prevention and support to intensive in-home services based upon the family's strengths and needs.

The purpose of this journal is to provide a forum in which practitioners, administrators, researchers, and educators in family preservation may present and critically review their findings, issues, and concerns. In the process, the family preservation culture and approach will be refined and invigorated.

This publication would not have become a reality without the efforts of a number of dedicated and committed people. Among the key contributors are: Dr. Eileen Lally, Donna Kelly, Laura Risenhoover, Roberta Yarbrough, our departmental colleagues, editorial board members, and Tom LaMarre, of Eddie Bowers Publishing, Inc. We also want to thank the authors of the articles in this first issue for the faith they placed in us by writing and submitting their work for a journal which was in the developmental phase. The same is also very true for all of you who have subscribed to the journal.

Each issue will include articles on research, practice, theory development and review of books and training materials including videos, computer programs or any other type of media. We welcome the opportunity to provide this vehicle for advancing the work of so many practitioners and most of all, the families we serve.

John Ronnau, Alvin L. Sallee

*Opinions expressed in this journal are those of the authors and do not necessarily reflect the position of the Family Preservation Institute or New Mexico State University.*



## Family Preservation and Support: Past, Present and Future

by

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### Abstract

As the family preservation and support movement evolves rapidly, this article overviews the past, present and future of this approach to policy and services. Building upon several decades of practice experience and research, and now federally funded, program designers are searching for ways to implement system wide change with an array of services all from a family focus, and strengths perspective. Critical issues facing the movement are discussed and a set of benchmarks to judge our future success is presented.



Families. Everyone has had one; everyone wants one, and woe to anyone who disagrees. No subject in our society provokes such emotion as the term "family." Policy makers and politicians of all persuasions invoke the term "family" to support their causes. At a personal level, families elicit the most basic feelings possible for each individual member. Families come in all shapes and sizes, all colors, cultures and preferences--each unique and part of the total fabric of our society.

This is the backdrop for those professionals, concerned citizens and consumers who attempt to bring answers to the multiplicity of questions and dilemmas facing families in our society today. When does society intervene in a family? What institutions should be strengthened in order to better support families? How do we develop a consensus on family policy? What models and techniques work with families and under what circumstances? How do we evaluate and substantiate our efforts?

In other words, where have we been, where are we now, and what might the future hold? What successes have we had, and what critical challenges still face family practitioners and consumers?

Of course, volumes of literature and years of research are required to answer all of these questions. What lies before you is the modest attempt of four persons (who are experienced as family preservation practitioners, academic professors and researchers, consumers, and social workers) to provide a glimpse of the past, present and future of this movement called "family preservation and support."

We must consider the following.

- (1) What is family preservation; an approach and philosophy, or a new model program?
- (2) What are the philosophical, theoretical and value bases for family preservation practice?
- (3) What has evaluation and research on family preservation and support taught us to this point?
- (4) What impacts do all the various forms of policy have on families?
- (5) What benchmarks can we use to measure our success in the future?
- (6) What do collaborative services look like, and how do they work?

The trail we follow diverges into many pathways. Some are clear and well traveled, while others are barely visible. Some courses seem contradictory, or circular, perhaps, because where we want to go is still unclear. Hopefully, what we provide here will help clarify where we want to go with family preservation and support and what trail signs we need to recognize to stay on course.

Family preservation and support is an approach to practice and a philosophy guided by values which uphold the uniqueness, dignity, and essential role which families play in the health and well being of their members. In keeping with this philosophy, programs, policies and organizations are family focused. As an approach, family preservation provides services ranging from prevention to intensive in-home services based upon the family's strengths and needs (Ronnau & Sallee, 1993). With the passage of the Family Preservation and Support provisions of the Omnibus Budget Reconciliation Act of 1993 (PL 103-66), approximately \$1 billion became available to states over a five-year period (GAO, 1995). Thus, "each state is faced with the challenge of conceptualizing and implementing system-wide family preservation and family support services" (Lloyd & Sallee, 1994, p. 3). These intensive efforts to build family preservation and support programs and policies signify a challenge to practitioners, families, policy makers and communities to bring about a paradigm change. Numerous initiatives over the past twenty years, including this journal, can provide many lessons to guide this transformation.

The need for systemic application of services was recognized in the permanency planning movement in the 1970's. The Adoption Assistance and Child Welfare Act of 1980, Public Law 96-272, highlighted each child's right to a safe, permanent home. As the law was implemented, a disquieting fact emerged. Many parents were unable to make the changes being required of them, given the traditional types and levels of child welfare services at that time (Lloyd & Sallee, 1994). Therefore the number of family preservation programs has increased dramatically (Biegel & Wells, 1991; Nelson & Landsman, 1992; Nelson, Landsman & Deutelbaum, 1990). Family preservation is being used successfully in a number of arenas, including health care (COFO, Family Policy Report, 1992), juvenile delinquency (Schwartz, AuClaire, & Harris, 1991), substance abuse (Jordano, 1991), severe emotional disabilities (Yelton & Friedman, 1991), the poor (Ronnau & Marlow, 1993), and the elderly (Marlow, 1991; Raschko, 1991). While it is apparent that the "time is right" for family preservation and support, expansion into new arenas increases the need for this promising approach. By responding to the need and spanning the domains of policy and practice, family preservation and support services heighten the challenge of definition and focus. Consequently, research and theory integral to policy and practice development have lagged.

## The Past

Since the first White House Conference on Children in 1909, our nation has struggled to advance family supports in order to keep children and families together. Consider some of the benchmarks in this one-hundred year agenda. We created mothers' pensions during the progressive era, with the belief that no child should be placed in an institution merely because the sole caregiver was at work. In fact, historically, it was believed that no mother should be expected to be both a full-time parent and employee. Mothers' pensions were succeeded by Aid to Families with Dependent Children (AFDC), first known as Aid to Dependent Children during



the depression, followed by special needs grants in the 1960's, flex funds, intensive family services, and skill based family capacity building in the 1980's and 1990's. Over the course of this century, we have come to recognize that, despite the best intentions, the state often fails to be the best parent (Fanshel & Shinn, 1978; Horejsi, 1979; Eastman, 1979; Poulin, 1985; Sallee, Eastman & Marlow, 1989). We also now recognize that many families will require services, resources, and support to fulfill their essential responsibility of raising children.

Family preservation services, particularly the intensive programs, evolved out of the child welfare and mental health arenas. Funded through Title IV-A and Title IV-E of the Social Security Act; and Medicaid, these services have increased our optimism for the potential of success of many families, which in the past would have been ignored. Key program characteristics such as services tailored to the family's unique needs, a strengths focus and respect and attention to cultural resources are now being applied system-wide through the new Family Preservation and Support Act.

A major challenge of early intensive family preservation programs was to protect their distinguishing features. These features included caseloads of two to four families, a very limited time frame, clear goals, and extraordinary flexibility. In their efforts to maintain the integrity and their uniqueness, program designers and foundation funding sources required that family preservation be defined and delivered in ways that could be easily described, taught, and replicated (Massinga & Cargar, 1991). As is true in any paradigm shift, control was considered important to assure that basic program components were not lost. Concerns for the integrity of these family preservation models were heightened as they expanded from the private into the public sector.

During the 1980's, growing out of the White House Conference on the Family, concerns for the impact of policy upon families increased in many states. Family impact studies were completed not only in child welfare, but also in mental health, Aid to Dependent Children, in schools and even taxation and revenue policies. Just as focused efforts are made to protect the earth through the Environmental Protection Impact Statements, so impact studies identify how state and federal policies impact families (Johnson, 1979; Lloyd & Sallee, 1990).

Growing out of these efforts, we have worked to develop initiatives which, in broad terms, seek to support and preserve the family as a basic institution in our society. Over the years we have witnessed attempts, now being implemented with renewed vigor, to dismantle initiatives that have been part of an ever growing yet fragile welfare state. With alarm, at the same time we consider what it means to successfully launch family preservation and support programs in our communities and states, we see that not only are families in need under fire, but also the very initiatives designed to help them -- both are in need of our resolve.

These challenges reflect the practice arenas. We may work diligently to unify a family only to discover that the child has been killed by gang-land gun fire outside their front door. Or we

might find that the family is evicted and dispersed into cross-town shelters. Are we destined to be today's policy and program pioneers whose daily advances become tomorrow's antithesis? On a more hopeful note, there is much to be learned from these challenges. As change agents and advocates for families, we must be mindful of who the ultimate beneficiaries of our efforts must be.

Family preservation and support services should be key components of a "long term care, policy agenda" for families and children, and part of a United States family protection agenda that includes a family bill of rights. The Family Preservation and Support Act of 1993 with its increased funding levels offers opportunities to expand the application of family preservation to a full array of services (Lloyd & Sallee, 1994; GAO, 1995).

## The Present

### Definitional Challenges

While family preservation has grown dramatically employing millions of dollars in private and public funding and has helped thousands of families across this country, it is not without its detractors (Davis, 1991; Bernard, 1992; Gelles, 1993; Wells, 1994; Schuerman, Rzepnicki, Littell & Budde, 1992). As with any other innovation, it should not be portrayed as a cure-all for the nation's social problems. To be most effective, it is important that practitioners, program developers and policy makers implement family preservation and support services from a common conceptual and theoretical framework. Conflicting definitions make it difficult for practitioners to collaborate and for administrators to sell this important approach to funding agencies and policy makers.

The absence of a commonly accepted definition of family preservation and support is well documented (Maluccio, 1991; Bernard, 1992; Ronnau & Sallee, 1992; GAO, 1995). Unlike intensive family preservation services, family support programs are less likely to follow a particular service delivery model. Family support programs "are often not clearly delineated as services, maybe multidisciplinary and strategies may overlap" (GAO, 1995, p. 31). Family centered child welfare services are a wide variety of programs with different titles (Nelson, Landsman & Deutelbaum, 1990). Numerous labels have been applied to family preservation: family-based services, home based services, in-home services, family-centered, family-focused; while "family preservation and support services" are identified in the current Family Preservation and Support Act (Leverington & Bryce, 1991; Cole & Duva, 1990; Nelson, Landsman & Deutelbaum, 1990; Nelson & Landsman, 1992).

Sudia (1993) states that the family-based services term was coined in response to Bryce and Lloyd's report, "Family-centered home-based services" and that Peter Forsythe and Betsy Cole originated the term, "Family Preservation." "In many instances, these terms are regarded as



synonymous which leaves a whole range of other programs feeling excluded, consequently presenting a political liability in gaining financial support" (Sudia, 1993, p. 8).

Ronnau and Sallee (1993), utilizing a Delphi methodology, surveyed 115 family preservation and support experts across the country, resulting in the definition presented earlier as well as a set of principles and values. The study respondents were in key positions nationally to influence the family preservation and support movement. While there was approximately a 70% agreement on the definition, unanimity was lacking and critical questions were raised of conceptual clarity for potential funding agencies, legislators, practitioners and consumers. A much higher level of agreement was noted among the respondents on the values and principles which guide family preservation and support. These are:

1. The definition of "family" is varied and each family should be approached as a unique system;
2. People of all ages can best develop, with few exceptions, by remaining with their family or relying on them as important resources;
3. Families have the potential to change, and most troubled families want to do so;
4. The dignity and right to privacy of all family members should be respected;
5. Family members themselves are crucial partners in the helping process;
6. The family's ethnic, cultural, religious background, values and community ties are important resources to be used in the helping process;
7. Policies at the program, community, state, and national levels should be formulated to strengthen, empower and support families.

Arising from this definitional quagmire are four main issues as identified by Ronnau and Sallee (1993). One is the critical need for clear definitions of family and support even though many of the principles and values identified by Ronnau and Sallee are found in the Family Preservation and Support Act definition. Secondly, prevalence of funding from two major foundations has dramatically influenced family preservation through a tightly controlled approach. As an Edna McConnell Clark Foundation report stated, "But endorsing just one intervention alienated some service providers, isolated Homebuilders from the home-based community, and created divisiveness among advocates and practitioners (Notkin, 1994, p. 5)."

Third, political groups have rallied around the major models further hindering progress towards a common definition and unified effort. As Friedman (1992, p. 9) states, "the costs of ideological battles are counted in lost energy, loss of resources, loss of community in our field, and a loss of integrative, creative staff effort." The reality is that as with most significant developments in the social service arena, family preservation owes its prominence to a convergence of factors (Mannes, 1991; Maluccio, 1991; Sallee, 1991) and has benefitted from the leadership provided by many.

While these concerns are real, there is reason for optimism given the apparent commitment by our national policy makers to the principles and values which underlie family preservation. Agreement on service components is emerging as "family preservation and family support services emphasize safety; a focus on the family; and a service-delivery approach that is flexible, accessible, coordinated and culturally relevant" (GAO, 1995, p. 4).

"Family preservation services are typically designed to help families (including adoptive and extended families) at risk or in crisis. Services may be designed to (1) prevent foster care placement, (2) reunify families, (3) place children in other permanent living arrangements, such as adoption or legal guardianship, (4) provide follow up care to reunified families, (5) provide respite care for parents and other caregivers, and/or (6) improve parenting skills . . .

Family support services are primarily community-based preventive activities designed to promote the well-being of children and families. Services are designed to (1) increase the strength and stability of families (including adoptive, foster, and extended families), (2) increase parents' confidence and competence in their parenting abilities, (3) afford children a stable and supportive family environment, and (4) otherwise enhance child development . . ." (GAO, 1995).

Carol Williams, Associate Commissioner of the U.S. Children's Bureau, states that her vision for the Family Preservation and Support Act encourages states and agencies to 1) think big in systems change, 2) create a vision for children and families through values and a shift in spending patterns from crisis intervention to prevention efforts and 3) to focus on principles not models. The regulations allow states wide latitude in developing their plans as long as the following principles are incorporated:

1. children and all family members must be protected,
2. services must be family focused,
3. services must be community-based, and culturally and psychologically available,
4. a strengths perspective,
5. a continuum of services is developed, and
6. planning should be very inclusive of all groups (Williams, 1994).

While the definition of family preservation and support remains somewhat elusive, we have made major strides towards consensus. Perhaps some of the confusion evolves from the fact that family preservation and support originated in child welfare but is now successfully applied in many other settings. There will always be ambiguities inherent in the concept of family preservation and support. This is because family preservation connotes 1) a desired outcome, 2) the direction intervention will take 3) and the types of relationships which will be established, not a recipe imposed upon all families regardless of their needs and resources.



While there is wide-spread agreement on the values and principles behind the movement, we are well advised to look beyond our achievements to our critics, set-backs and current barriers. We might ask, if family preservation is the solution, what is the problem? Is the problem out-of-home placement? Family stress that goes unmitigated? The need for permanency planning? Children at risk of being raised without biological families or other sources? Is it one of these, or a combination? In fact, some of the most provocative feedback comes from critics of family preservation. Issues such as risk assessment, cost effectiveness and evaluation continue to be raised. Critics also observe a lack of carefully controlled research on family preservation service models and their differential outcomes.

### Lessons Learned from Research and Evaluation

We live in an age of accountability (Briar, 1974), therefore, scrutiny of service delivery systems is a reality of life. While critics and supporters agree that the movement is having a profound effect on the delivery of services to children, youth and families criticism, in large part, stems from a lack of identifiable research and program evaluation outcome results. In fact, family preservation has been subjected to more research and evaluation than any other field of children's services. An extensive review of the research literature may be found in a number of places (Schene, 1994; Tracy, 1995), including Marianne Berry's article in this volume.

Four major themes emerge as a consequence of the definitional ambiguity and related challenges in operationalizing and specifying terms and process of family preservation. First, how do you evaluate a movement? We certainly know more about how to evaluate programs and work with individual families, yet how do you evaluate a philosophy or an approach to practice? Gelles (1993) and Wells (1994), among others, have identified the apparent lack of grounded theory underlying family preservation practice. Gelles (1993) has noted that too many studies lack empirical support for their initial assumptions and few existing studies "meet even the most minimum standards of scientific evidence" (Gelles, 1993, p. 539). Clearly, a major strength of family preservation is its appeal as a philosophy, policy, and set of programs. Yet, without concurrent evidence to guide and inform practice and policy the momentum of the past decade may be lost. We need to combine grounded theory and develop research strategies so that practice driven theory and data may help guide program development and provide a cornerstone of the family preservation and support movement.

The second issue regarding research and evaluation of family preservation is the methodology itself. For a number of reasons most of the methodologies used in family preservation research, have failed to provide the rigor necessary to inform practitioners and policy makers. Current tools are unable to account for multiple variables, including the number of different systems which are typically involved in the change process. Program evaluation is difficult in the best of circumstances but is even more complicated because the "subjects" of family preservation research range from an individual family member to the entire community. Furthermore, a

program's history and developmental stage must be considered, just as we assess a family's developmental stage as we work with them.

This leads to the third research and evaluation issue, measuring and examining process rather than outcomes. Overwhelmingly, the evaluations conducted on family preservation programs to date have looked at specific outcomes. This includes avoiding the placement of the child outside of the home and recidivism rates. The lack of a clear definition of family preservation and how to operationalize "success," whether in terms of avoiding out-of-home placement or improving the family's functioning, have been cited as flaws in a number of national studies (Yuan, McDonald, Wheeler, Struckman-Johnson & Rivest, 1990; Gelles, 1993; Wells, 1994). When researchers have difficulty defining an outcome, it is understandable that we see results ranging from unqualified success to high levels of skepticism.

Developing family preservation programs have been evaluated using outcome standards. This clearly violates basic principles of program evaluation which requires the evaluation of process towards goals until a program fully matures and can stand on its own. We believe that this maturing process in most family preservation programs requires at least five years, considering the context in which most of them have begun and the new techniques and strategies required. When you add into this mix of variables community values and political factors, it's only fair that programs be up and running before they are subjected to rigorous evaluation.

To us, successful program evaluation entails identifying and reporting positive results that can be used to improve the manner in which we work with families and communities. A major study that failed in this regard is the often cited Illinois Family First Program (Shuerman et al., 1993). It evaluated approximately thirty private agencies, many in the early stages of development, implementing numerous and varied models, on the basis of only one major outcome, out-of-home placement. The popular press, as well as the critics, picked up on this sole criterion measure as evidence that family preservation did not work. This leads us to the major difficulty with family preservation research and evaluation.

Program evaluation requires both technical and social skills. Fair and accurate evaluation of emerging programs, during a paradigm shift in a highly charged political arena, requires process evaluation. Few children, their parents or family service workers can comfortably engage in a sophisticated political debate with policy makers from the county, state, or national levels. Given that family preservation is such a value-laden field of practice, the media and popular press are easily misled by research which overstates the success of a family preservation program or unfairly evaluates it during the early developmental phase.

We agree that the research and evaluation on family preservation is not definitive in terms of its effectiveness in preventing placements in the long term or permanently improving family functioning (Schene, 1994). However, based upon anecdotal literature and experience, we do believe family preservation has a profound impact on families and communities. The inability



to definitively describe success may be more clearly attributed to the lack of grounded theory, inappropriate research technology and evaluation methodology, than to flaws in the basic principles and philosophy behind this new approach.

### What Family Preservation Mirrors in Us

All too often we hear family preservation practitioners say that at an earlier stage of their career, they did not have the ability to prevent an out-of-home placement or to reunify a particular child and family. These "breakthroughs" say as much about us as practitioners and policy advocates, as it does about family capacities and necessary conditions of change. Perhaps the next stages of practice development will advance our understanding of the ways in which family preservation and support can be facilitated.

For example, if it is our responsibility to motivate families, then practitioners need diverse sets of strategies and interventions upon which to draw. Some will need to be crafted by foster parents who help as reunification aids others, by child protection workers serving as mediators and motivators in the initial stages of the helping process, and still others by families in partnership with each other to provide ongoing support, incentives and mentoring. In some cases, encouragement will come from foster care reviewers who may encourage families to follow through with case plans.

Many unanswered questions remain. For example, how might these motivational skills be used to engage other professions? How many practitioners from other professions today despair over their belief that families cannot change? How many bequeath this negative attitude to families and children who, in turn, give up? Can ask teachers to be part of a family preservation and support agenda? Can they, in turn, find ways to build helpful, empowering relationships rather than blaming parents for children's learning and school problems? Can teacher's be family capacity builders, too? Can we even go one step beyond and link service relocation in or near schools and promote schools in their role of family stabilization, preservation and support (Lawson, 1995)? Furthermore, what good is it if we are forced to do reunification and placement prevention work within an environment of hostility, resentment and blame toward the parent? Unless teachers, nurses, law enforcement and other key service providers are collectively invited to be family support and prevention activists, how can we build a more coherent community agenda for family support and preservation?

Instances in which there are as many as fourteen providers delivering services to various members of the family, unknown to one another, is a telling sign of today's service delivery challenges. These challenges signal the family preservation and support agenda to be cohesive across professions and disciplines; otherwise we will continue to respond to crisis which we could have prevented. The lack of family preservation and support initiatives and collaboration manifest as "a prevention gap."

## The Future

### Building a Family Investment Model

To close this prevention gap, we must provide holistic approaches to both families and practitioners. Many family preservation programs have been launched with existing child welfare, maternal and child health funds shifted into more strategic uses (Hooper-Briar & Lawson, 1994). Out-of-home care, foster care, and other budget lines are being redeployed to accelerate placement prevention programs. Rather than seeing family preservation and reunification services as "add on" programs and service enhancements, they may need to be reconceptualized as investment initiatives. We must demonstrate that there is a more effective way of expending funds and energy for both workers and families.

As family preservation and support are seen as investments, we will be obliged to invent even better predictive tools and establish data bases inclusive of multiple indicators of relapse and risks for system re-entry. These steps may help ensure that chronically fragile families will not be forced to re-enter the system in order to receive help.

It is estimated that 75 to 90% of our service dollars go to crisis intervention, such as child protection, rather than prevention and early intervention. Moreover, it is estimated that families themselves provide up to 90% of the counseling, teaching, norm enforcement and health care they need despite the absence of supports, resources and skills. Thus, the family investment plan is also a family support and prevention gap strategy. When families are without support they should not have to injure themselves and those they love in order to get attention or help.

There are many promising pilot programs in which families are served by child protection workers before a case is formally opened. For example, in Boise, Idaho, early evaluation data reflect an 87% diversion rate from open child protection caseloads.<sup>1</sup> Child protection workers in school based services are able to respond to referrals from teachers with resources from Title IV-A funds to help families whose neglectful behaviors might have kept them in the system for a long time. In preventing families from entering child protection services, family support centers in Missouri reflect an 80% diversion rate<sup>2</sup>. Such findings show promise for the

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Data presented in panel presentation by Mary Anne Saunders, Theresa Tanowry, and Mark Lusk at the National Conference on Expanding Partnerships for Vulnerable Children, Youth and Families, Alexandria, VA.

2

Personal communication with Lois Pierce, University of Missouri; Statistics from State of Missouri-Division of Social Services, Department of Research and Evaluation, February 1995.



development of more innovations so that child protection involves immediate family support and systems diversion initiatives.

### Resources: An Achilles Heel for Family Preservation

When families have the support they need, the referrals to child protection are often very low. When families enter the system and lack the resources to follow through on court ordered plans, the consequences may be dire for the child, family and system. It is estimated that between 50 and 90% of families lack the resources to follow through on court ordered case plans<sup>3</sup>. How can systems already steeped in family preservation programs continue to operate without the requisite resources for critical action steps? How many families have to scrounge in dumpsters in order to make ends meet? How many will continue to be stripped of AFDC when their children are removed and yet required to attend counseling, parenting classes and drug and alcohol treatment?

### The Role of Universities in Sharing the Family Support and Preservation Agenda

When there is a child death or other high profile case, what role does the university play in mobilizing more research and technological supports to predict behavior? How often do we elicit from the very institutions that are charged to solve the problems of the day the efforts that are required to create more helpful supports for practice? Should not family support and preservation be reflected in university mission statements and supported, especially, in public universities (Lawson & Hooper-Briar, 1994)?

It was the family support and community problem solving agendas which catapulted some of the helping professions from their community bases to universities (Sallee, Lloyd, Ronnau, Sandau-Beckler, Mannes & Chandler, 1993). So, too, did the professions associated with these movements become a focus for the university. Seeking to be more relevant and responsive to the needs of the day, universities began to bring to their campuses the social workers, nurses, teachers, and law enforcement practitioners who otherwise might have remained in settlement houses, lab schools, hospital based nursing training or neighborhood precincts. Despite the recent rise of partnerships between social work education and child welfare agencies, as well as schools of education and public schools, there is little concerted effort to build cross-disciplinary and professional missions to sustain the family preservation and support policy agenda. In fact, our very definitions of family centered practice and support vary. Depending on the school, it may mean family involvement or family therapy or that families are empowered to be their own

<sup>3</sup> National Foster Care Review Board Meeting, March 1994.

case managers and problem solvers and to build mutual aid models with one another (Sallee & Lloyd, 1991). We must build curriculum from core values and principles allowing for diversity in approaches (Jensen, Maluccio & Sallee, 1993).

### Toward Family Centric Policy Making and a First Call Agenda

Despite the plethora of family related policies and systems, our nation lags behind many others in family health. In the United States we have never created a national family policy. If a comprehensive framework were developed, it might promote a new century of family centric policy making<sup>4</sup>. This would compel all systems that touch the lives of families to promote and protect family functioning by having family needs and resource challenges explicitly addressed as a top national priority.

To further advance the agenda, at least among the professional community, families and children would have first call on resources. The conditions that led to the child and family movement during the progressive era are every bit as challenging now, albeit different. To build upon the movement, we must organize families as well as other stake-holding professions and service sectors. Family preservation and support cannot belong to child welfare practitioners alone but must become the organizing framework for a social movement that is, at its core, an advocacy and a "first call" agenda in every community and state. Universities, too, must play a pivotal role in this shared agenda (Terpstra, 1992; Jensen, Maluccio & Sallee, 1993).

### Conclusion

As we examine the past two decades and look forward into the next millennium, we anticipate a steady progression and expansion for the family preservation and support agenda. We have identified benchmarks (see Appendix A) which reflect the possibilities in the different developmental stages of this agenda.

Family preservation and support clearly has a history of being practice driven with intense family-centered, home-based services and strong research and evaluation components. Family support has a legacy of strong consumer involvement and specific prevention programs. The present finds us with federal legislation and funding tentatively in place. This funding provides a catalyst to this major paradigm shift in the provision of services and care for families and communities. The future challenges us to learn to collaborate and move from a categorical

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The idea of Family Centric Policy is being developed for a forthcoming book on the International Year of the Family; *International Family Policy*, Sage, co-authored by Hal A. Lawson, Katharine Hooper-Briar, Chuck Hennon, and Allen Jones.



problem oriented service system to designing integrated family focused programs which incorporate family preservation and support principles. The opportunity is here to tear down the walls which separate programs from the community, state and federal levels and move to one playing field. Striving to blend funding, provide training in a common set of values and principles, and practicing from a strengths perspective are challenges which will face us for many years.

Thanks to the contributions of family preservation pioneers, the current system has many strengths to build upon. As we design an array of services and move from a deficit model to a strength perspective, the families with whom we work can come to the table as partners to preserve the family as society's most treasured institution.

## Appendix A

As we look back over the past two decades and ahead to the next, we predict a steady progression and expansion for family preservation and support agenda. Here are some benchmarks to look for along the way.

### BENCHMARKS: FROM FIRST TO SECOND GENERATION FAMILY PRESERVATION POLICY, PRACTICE AND RESEARCH

#### First Generation Benchmarks

- Pilots of intensive social services with demonstrable results in keeping children and families together through placement prevention
- Statewide policies supporting family preservation and program expansion across each state
- Philosophy of Family Preservation introduced in several kinds of state legislation and in at least 50% of the states
- Family preservation practices required of all subcontracting service providers with state and local government child welfare agencies
- Family centered and family preservation principles used throughout child welfare, in child protective services, foster care and reunification support and adoption
- Diverse implementation strategies and divisiveness over models of "best practices"
- Family Preservation philosophy able to withstand child deaths, to become a sustainable agenda at State and local levels
- Program expansion without theoretical bases
- Federal policy developed and philosophy captured in several pieces of federal legislation
- Poor research and research that has contradictory results
- Lack of clarity in definitions

#### Second Generation Benchmarks

- Family Support and Preservation services become entitlements
- Laws are drafted that treat every abuse attack as a sign that service systems got there too late
- Reduction in punishment syndromes toward families from teachers, child welfare workers, police; families are asked what services and supports they need, what the necessary conditions are for their being more successful. Such data drive legislative bodies
- Universities adopt a family preservation and support agenda as one of their missions in surrounding communities and regions
- Family supports and services are delivered by families to one and another through assistance networks



- Incentive based services are supported to encourage families to get requisite skills and resources for their own preservation and support agendas
- Family preservation and support are addressed through employers and workplace policies as well as income generating and full employment agendas
- All services such as police, schools, health, social services, workplaces and schools adopt a family preservation agenda
- Lack of resources due to poverty is no longer a basis for the removal of children from their families
- All families have access to "wrap-around services and supports" to ensure ongoing mainstreaming and inclusionary practices in other service systems that might otherwise want the family member in more intrusive settings
- Resource strategies are added to service and support initiatives
- Sound theory will inform future development and research
- Research designs will improve, including more valid and reliable indicators and better sampling
- Program descriptors are clarified and criteria are made more precise to enhance replicability; for example, there will be clear guidelines for choosing families to participate in family preservation services; there will be clear guidelines for providers of services concerning implementation and service with interventions
- Developmental research strategies increasingly guide inventive practice and programs
- Definitions of the concept of effectiveness are broadened beyond placement avoidance to variables such as family changes that occur due to services

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## An Examination of Treatment Fidelity in an Intensive Family Preservation Program

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### Abstract

Most models of intensive family preservation services are based on providing flexible services to reduce risk and keep families together. This study examined 40 cases served by a public agency Family Preservation Unit in 1992-1993, in order to assess the provision of hard, soft and enabling services in the program and whether their provision matched the program model. The relationships of these services to program outcomes, in terms of child removal, new reports of abuse or neglect, and family gains in resources and strengths, are also assessed.

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Intensive family preservation services are provided to families at imminent risk of child placement, in the hopes of (1) strengthening the family environment, (2) reducing the risk of continued mistreatment, and (3) eliminating the need for child placement. Evaluations of family preservation services must therefore assess not only the effectiveness of the program in preventing placement, but also the impact of the program on family gains and the reduction in risk to the child.

Because the sources of risk can vary by family, the solutions for each family will also vary, and family preservation services are designed to afford the flexibility of focus and resources necessary for devising and implementing an appropriate plan for the strengthening of each individual family. Intensive family preservation services provide services to the entire family for around three or four months, and workers are available to the family around the clock to do whatever it takes to strengthen the family, reduce the risk of mistreatment, and prevent the otherwise imminent out-of-home placement of children.

While intensive family preservation services are intended to be flexible and matched to the risks presented by the individual family, program evaluations have been criticized for focusing exclusively on child placement as the indicator of program success, or for using other global indicators of family satisfaction and well-being that are not related to the gains programs intend to produce (Jones, 1991; Pecora, Fraser, and Haapala, 1991).

This study sought to add to the evaluation literature on family preservation by examining an intensive family preservation program in Fort Worth, Texas. The objectives of the research were to describe the service components of the program and to assess the association of services provided to concrete and specific gains made by families. To accomplish this, family preservation workers kept detailed logs of the type and duration of services offered to each family and specific assessments of family risk factors at intake and again at closing. While not a large scale controlled evaluation of intensive family preservation services, this study sought to provide more detailed information than is usually found describing service provision and amelioration of family risk factors.

### Intensive Family Preservation Services

Family preservation programs provide a range of flexible services to strengthen the family and the family environment. This rather expansive and vague goal, accompanied by a time-limited period of treatment, necessitates an ecological focus of treatment, one that incorporates and strengthens the family's social network and its skills to operate within that system. Because of the time-limited nature of treatment, goals must be limited to realistic gains in the safety of the child and strengthening of family functioning to the extent possible in a short period of time (Kinney, Haapala, Booth, & Leavitt, 1990). Utilizing social supports and building family skills

and resources during treatment assumes that these supports, resources and skills can and will continue to bolster family functioning after formal family preservation services have ended.

Ecological family preservation programs assess family stressors and resources and help to bolster and increase the family's resources to the point that the stressors which are associated with risk of placement can be ameliorated. Because intensive family preservation programs are flexibly structured to provide a range of services to improve family functioning and reduce risk, solutions are intended to spring from a detailed assessment of these risks, and be individualized to the family's needs.

The service components provided by intensive family preservation services have been categorized as hard and soft services, but they actually comprise a continuum of services ranging from the softer services, such as counseling and family assessment, to enabling services devoted to building social supports (both informal and formal), to the harder services of household maintenance help and provision of furniture, car repairs, a telephone or other basic needs (Fraser, Pecora, & Haapala, 1991). Thus, the enabling services bridging the gap between hard and soft services facilitate access to both the harder and softer services, and appear to be an essential feature of intensive family preservation services.

**Soft Services.** Family preservation caseworkers work to engage the family and instill hope early in the intervention (Kinney, Haapala, and Booth, 1992). Workers provide emotional understanding and support by listening to families and helping families to define the problem and set their own goals for treatment. Most family preservation programs do not, given the short duration of services, emphasize the truly soft services of psychological individual or family counseling. Rather, Whittaker and colleagues (1986) focus on the teaching of specific life skills. This form of soft services is especially applicable in short-term interventions where the less tangible emotional support from agency workers is available only for a finite period, usually two to three months. The skill-building that occurs will continue to support and reinforce positive family interaction in the long run, after formal services have ended.

Treatment based on an ecological model focuses on modeling of life skills, such as parenting skills, and teaching and practicing with family members the positive and constructive communication and negotiation skills that will contribute to a more positive and less abusive family environment. Workers assess parenting and communication skills, help parents and children identify non-punitive methods of interacting, and model and practice positive interaction. These skills not only apply to parent and child interaction, but also help families to more productively interact with landlords, doctors, teachers, social workers, neighbors, relatives, and other members who contribute to the support or stress in the family's social environment. Such a training or teaching model is also practiced in supervisory and peer relationships in the family preservation model.



**Enabling Services.** Since many insular mothers may indeed be stressed more than helped by interchanges with relatives and friends (Tracy, 1990; Van Meter, Haynes, & Kropp, 1987; Wahler & Dumas, 1984), enabling the social support of families in a more formal (than informal) sense may be needed by multi-stressed families. Such formal social support could include assistance from the housing bureau, food stamps, day care centers and schools, weekly support groups, hospitals, continuing education, etc. Enabling work with families focuses on helping families negotiate access to the supportive services offered by agencies and institutions.

**Hard Services.** The ecological family preservation model recognizes the role of concrete resources in the support of families. Provision of concrete resources is important for three reasons. First, families who improve in their communication skills and increase the self-esteem of their members will continue to be stressed by their physical environment if they cannot provide for the basic needs of their children, such as housing, food, and medical care. Approaching solutions from a systems perspective recognizes the importance of these physical and environmental resources to family well-being. Therefore, assistance and the provision of concrete resources can reduce stress pile-up.

Second, Kinney and colleagues (1992) at Homebuilders (tm) have established that the provision of concrete resources helps to establish rapport between the caseworker and the family, by showing the family an understanding of their concrete needs, and applying a direct and real solution. Intensive family preservation caseworkers often help families to fix broken windows, shop for food, request added furniture, access car repairs, etc. These hard services improve the impoverished circumstances of families and the physical environment, and also provide an opportunity to model these repair, shopping, or negotiation skills so that families can learn to do them on their own.

Third, research on child placement decisions indicates that child welfare caseworkers are influenced by the physical environment and economic impoverishment of the family when deciding whether to place children in foster care (Lindsey, 1991; Pelton, 1990; Stehno, 1982). Any program which hopes to decrease the likelihood of child removal, both while in treatment and following case closure, must work to improve the physical aspects of the household and the economic stability of the family.

### Evaluations of Service Components in Family Preservation Programs

A variety of intensive family preservation programs have been evaluated, and most report their placement prevention rate as the primary criterion of success. Only a few evaluations have addressed other effects on the reduction of risks, such as child behavior or family functioning (Berry, 1992; Fraser, Pecora, & Haapala, 1991; Kinney, et al, 1989). Few studies have evaluated service provision in intensive family preservation services in detail. Two published

studies to date (Berry, 1992; Fraser, Pecora, & Haapala, 1991) have examined the contribution of hard and soft services to case outcomes, namely placement prevention, risk reduction and treatment goal attainment. Fraser and colleagues, including Robert Lewis (1991) conducted a detailed evaluation of the Homebuilders program with 453 families, and found that only one concrete service, the provision of transportation, was used by more than half of families served, while 31 clinical, or soft services, were as commonly provided, centering around development of the treatment relationship, improving parenting effectiveness, modifying problem behaviors, teaching an understanding of child development, building self-esteem, and consulting with other services. Lewis postulated that the variation in provision of services to families indicated a sensitivity in treatment provision to the needs of individual families.

Lewis (1991) describes how concrete services serve two primary functions: to improve the conditions facing families and to assist in building relationships with families. In this second function, concrete services assist in the engagement of families in softer services, by demonstrating the caseworker's understanding of the concrete circumstances facing families and their basic needs for safety, financial and material resources, and human comforts. In the Homebuilders evaluation, Lewis (1991) found that one concrete service, "giving financial assistance" was associated with goal attainment of "establishing trust between therapists and families" (pg. 230).

Berry's (1992) study of a family preservation program in Northern California serving 367 families found that the most common services provided included case planning, assessment, parent education, supplemental parenting, and teaching of family care. In this California study, the type of service provided did make a difference in treatment success. Families that remained intact had received significantly larger amounts of time in supplemental parenting, teaching of family care, and help with medical assistance. Families who experienced subsequent placement had received somewhat smaller amounts of respite care, help in securing food, and parent education. Berry also found that services had been matched to family need, in that the amount of time a worker spent in the home was related to the environmental needs of the family (severity of environmental danger and uncleanness). Workers spent more time in homes that needed greater improvement.

In Berry's (1992) study, families who remained intact after leaving the program had made significant gains in the physical condition of the household, the cleanliness and order of the household, and parents' general child care skills. Families who experienced a child placement had deteriorated during family preservation services in the cleanliness of the home and the physical condition of the household.



## The Program

The program which is the subject of this research offers intensive family preservation services within the public child protective services agency in Fort Worth, Texas. The program began in June of 1987, and was modified from a case management approach to a more intensive and home-based model in April of 1990. The program is staffed by seven bachelor's and master's level social workers and one unit supervisor. There is also a volunteer coordinator who oversees the use of volunteers. Volunteers provide child care during support group meetings, one-on-one mentoring of individual children and families, and some acquisition of hard resources and services. Family preservation workers are to spend at least 20 hours per month in the home with each family. Each caseworker serves up to 7 families at a time, and each case is to be open for four months or less. Approximately 100 families are served each year.

Referrals come to the program from the regular child protective services caseworkers, based on the following acceptance criteria: families must be willing to accept services and intervention; if a sexual abuse case, the perpetrator must be out of the home; mental retardation must not be too severe to prevent use of services; and runaway behavior must not be the presenting problem. The program accepts substance abusing families who are willing to enter treatment, mentally ill parents who are stabilized by medication, and parents who are not severely mentally retarded. The primary family issues treated by the program include: parent-child interaction, communication and conflict-resolution deficits, money management or financial problems, chemical or alcohol misuse, parenting skills needs, family-of-origin conflicts, lack of general resources, mental problems, mental health issues (including depression), and child behavior problems.

## Service Provision

A key component of the program is the use of weekly education and support groups for parents (primarily mothers) concerning nurturance and social support. There are currently three basic groups: "Learning About Myself," a 15-week group for neglectful mothers, focused on self-esteem, empowerment, and relationships, as well as budgeting, nutrition, and health; "Nurturing," a 23-week group focused on parent/child interaction and positive parenting; and "Rightful Options and Resources," a women's group centering on women's issues around violence and assertiveness. The groups are attended by approximately 7 to 22 adults, with a usual attendance of 10 to 15. All parents are asked to attend the "Nurturing" group, and all mothers referred for neglect are also asked to attend the "Learning About Myself" group.

Each group meeting lasts for about 2.5 hours, and is led or co-led by family preservation caseworkers. These hours are counted as part of the required 20 hours per month spent with the worker in the home. The program has developed a curriculum for each group, using manuals

developed by Bavolek and Bavolek (1988) and Karsk and Thomas (1987). Groups often meet in the evening, and transportation, child care, and a snack are provided by the agency to help encourage attendance. Homework assignments are an integral part of the group content. Sometimes, homemakers are contracted to attend the group with the parent and then to assist the parent with any homework assignments in the home. These groups thus serve two purposes: educational skill-building and establishment and nurturance of social linkages between families.

In addition to these educational and supportive groups, family preservation workers also provide other typical home-based services. They provide services in the home according to whatever the family needs to reduce the risk of maltreatment. This may include housecleaning, transportation, counseling, and information around budgeting, health care, nutrition, or household maintenance. This also includes helping the family in maintaining or developing a supportive social network (including friends, relatives, schools, day care, churches, and public agencies), which will continue to assist the family after the short-term agency services are terminated.

## Method

### Procedure and Design

The evaluation utilized a one-group pre-test post-test design. Families whose cases were opened by the Family Preservation Unit over a six month period were assessed by caseworkers on a variety of measures at intake and at case closing. This design included neither a control group who received no services nor a comparison group who received other DPRS services. This lack of a control or comparison group was partly compensated for by the use of multiple outcome measures (placement, continued abuse, and developmental and environmental outcomes).

**Sample.** The sample consisted of all cases opened between May 1, 1992 and October 31, 1992. These cases closed between June, 1992 and April, 1993. This six-month period of case openings provided a sample of 40 families with 97 children. Cases were followed-up for placement outcomes in May, 1993 to allow time for placements to occur.

**Measures.** Each case provided the following information: outcome information, client characteristics, and service characteristics. Most information used the family as the unit of analysis, but some measures were assessed for each child in the family (placement risk and some outcomes). Any person who lived in the household and considered themselves a member of the family was included in the definition of family (boyfriends, grandparents, etc.).

Data came from three sources: caseworker assessment, the computerized state information systems and surveys of families. Family preservation unit and referring caseworkers were



trained prior to the beginning of the study in the content and coding of assessment measures used in the study. Many of the assessment tools were already in place as a part of the assessment process. Weekly staff meetings allowed for discussion of measurement or coding issues that arose during the study. In order to assess the validity and reliability of caseworker reports, the research coordinator went out on occasional home visits, and attended unit meetings.

**Case outcomes.** Outcome information included the following: (1) whether any child was placed in out-of-home care while or after receiving services, (2) whether children remaining in the home were reported to child protective services for mistreatment while or after receiving services, (3) whether the case was reopened for services by another DPRS unit for up to six months following closure by the Family Preservation Unit and (4) whether the family's level of risk regarding the physical and emotional environment was reduced. Outcomes 1, 2, and 3 were obtained from monthly computerized state records.

Shelter care lasting less than 48 hours followed by a return home did not qualify as a removal. Placements with relatives did qualify as removals, if outside of the current home, but were noted as relative placements (ranked as less restrictive and more family-like than non-relative out-of-home placements). Each report of child mistreatment was noted as to date of the report, the nature of the mistreatment, and which children in the family were the subject of the report. Dates of, and reasons for, case reopenings were also obtained from computerized state records.

The family's level of risk was measured at intake and case closing using the Child Welfare League of America's Family Risk Scales (Magura, Moses, & Jones, 1987). This is an inventory of 26 items assessed for each caretaker and child in the household, at both intake and case closing. These items provide summary scores of parent-centered, child-centered, and economic risk. The parent-centered risk score is made up of twelve items, including adult relationships, parent's mental health, knowledge of child care, substance abuse, motivation, cooperation, preparation for parenthood, supervision of older children, parenting of older children, physical punishment, verbal discipline, and emotional care of younger children. The child-centered risk score is made up of eight items, including parent's attitude to placement, emotional care of older children, child's mental health, school adjustment, delinquent behavior, home-related behavior, child's cooperation, and child's preparation for parenthood. The economic risk score is made up of four items, including habitability of residence, suitability of living conditions, financial problems, and caretaker's ability to meet the physical needs of the child. The Family Risk Scales were normed on a sample of 1158 families served by preventive programs in New York over a two month period in 1983. Factor analyses on the summary scales found alphas of .88, .83, and .78, for parent-centered, child-centered, and economic risk, respectively. These Family Risk Scales thus provide reliable summary scores of risk as well as information on individual risk items for analysis.

**Client characteristics.** The following were measured at intake: nature of family's presenting problems, placement risk for each child, and demographic characteristics of family members. *Placement risk* was a dichotomous variable delineating the imminence of risk of placement (if the child were to receive no further services) for each child in the family. This rating was derived from the referring caseworker, based on the investigation report conducted in the home, at staffings conducted prior to the Family Preservation Unit acceptance of the case. *Demographics* included family composition and constellation, monthly income, prior child removals, criminal history, and presence and severity of substance abuse. *Family resources* were assessed at intake and at case closing, to measure whether they had increased during services. These included material resources such as food, a phone, AFDC, and housing, and other resources such as employment and the ability to read and write.

**Service characteristics.** Basic service characteristics included number of days the case was open and number of hours served. Monthly *Contact Sheets* were utilized by caseworkers to track service time with the family, documenting the amount and site of service time provided. This provides a specific count of hours spent in the home versus those spent in the office and other places. Enumeration of hard, soft, and enabling services was provided by a *Checklist of Services Provided* (such as household care, teaching of family care, transportation, health care, etc.), completed by the caseworker at case closing.

## Results

### Case Outcomes

**Child removal.** Of the 40 cases served by the Tarrant County Family Preservation Unit during this period, 36 (90%) were still intact at case closing and 36 (90%) were intact three months later. Of the 97 children served, four were placed, for a 96% placement prevention rate for children. Of the four families who were not still intact at case closing, three had voluntarily placed their children with relatives. The one child who was involuntarily placed was a failure-to-thrive infant who subsequently died. The remaining two (older) children in that family were not removed.

Only 53% of cases were closed outright due to satisfactory progress. Another 22% were transferred to other services; most to Catholic Social Services, a private agency offering a home-based program that could continue to support and monitor the family. Two cases were transferred to another in-house (non-family preservation) unit. None of these cases referred for continuing services had a subsequent substantiated report of abuse or neglect, nor were any reopened for services.



There were 34 families judged to be at imminent risk of placement in this sample, and all four placements occurred in imminent risk families. The non-placement rate among those families judged to be at imminent risk, therefore, was 88% at closing and at three months following case closure. There were a total of 61 children judged to be at imminent risk of placement, and the four children who were subsequently removed (7%) had all been at imminent risk.

**Reports of mistreatment.** Two-thirds of the families served ( $n=27$ ) had no further abuse or neglect reports while receiving FPU services. One-third of the forty cases served ( $n=13$ ) had an additional abuse or neglect report filed while the case was served by the Family Preservation Unit. There were 26 individual abuse reports filed in these thirteen cases, since some reports concerned more than one child in a family. Half of these reports were for physical abuse; another 35% were for neglectful supervision; the remainder were for sexual abuse (8%), emotional abuse (4%) or other mistreatment (4%). It is important to note that in at least seven cases, reports were unsubstantiated.

Twenty-nine families (72%) had no further reports of abuse or neglect after case closure. There were abuse or neglect reports filed on eleven families (28%) subsequent to receiving services. Four of these concerned physical abuse, five concerned neglect, and one, sexual abuse (one did not specify the type of abuse). Five of these reports were substantiated. The five children with subsequent substantiated reports of abuse (and the two children whose cases were subsequently reopened) had each been judged to be at imminent risk of placement when served by the Family Preservation Unit. Caseworkers appeared to apply the imminent risk determination judiciously in this evaluation.

**Case reopening.** Of the eleven abuse or neglect reports filed after case closure, only two resulted in the case being reopened to a DPRS unit, both for neglect. These reopenings occurred 2.5 and 4.5 months after case closure. Among the 37 cases that had been closed for at least three months at the time of this report, therefore, 35 (or 95%) were neither reopened nor had a child removed.

### Characteristics of Children and Families Served

As is common among many evaluations of intensive family preservation services, few family or child characteristics were associated with program success or failure. This may be because the population served by these programs tends to be fairly homogeneous. The only family characteristic associated with a subsequent substantiated report of mistreatment or with case reopening was the problem of child neglect.

Over half of the families served had either one (35%) or two (20%) children, although some families had three (22%), four (13%) or five children (10%). No family had more than five

children (see Table 3). The children tended to be fairly young, with a mean age of 4 years, and ages ranging from 13 days to 14 years old. Approximately one-third of families (35%) were headed by a single caretaker. Almost all of the families (85%) had at least one child who was judged to be at imminent risk of placement when the case was opened by the Family Preservation Unit. Eight families (20%) had experienced a prior child removal.

The type of abuse was noted for each family, and more than one type of abuse or neglect could be noted for a family. Over half of all cases were opened for physical abuse (58%), followed in frequency by neglectful supervision (30%), physical neglect (25%) and medical neglect (15%). Relatively uncommon were cases opened for sexual abuse (8%), emotional abuse (5%), abandonment (5%), or refusal to accept parental responsibility (5%). Subsequent reports of mistreatment and/or case reopenings were significantly more likely for families who had received services for physical neglect and/or neglectful supervision.

In most families, the primary caretaker was female (85%). Using the ethnicity of the primary caretaker as a proxy for family ethnicity, over half of the families served were Anglo (57%), followed by African American (30%) and Hispanic (13%). There was only one family where the primary and secondary caretakers differed in ethnicity. Two of the three families who voluntarily placed their children with relatives were African American.

The mean age of both the primary and secondary caretaker was 25 years old, although the youngest primary caretaker was 13 years old. No caretaker was older than 38 years old, and 15% of each group were younger than 21. The parent's age was not related to case outcomes. Few primary caretakers had a criminal history (8%), but a greater proportion of secondary caretakers (31%) had such a history.

Caseworkers were asked to list any special conditions of the primary or secondary caretaker which impaired their ability to parent. Among primary caretakers, 13% were said to have a learning disability, 5% a physical disability, 3% a developmental disability, and 10% were said to have a substance abuse problem. Among secondary caretakers, caseworkers noted that 15% had a substance abuse problem, followed by physical disability (8%), developmental disability (8%) or acute illness (3%). Special conditions were not associated with poorer outcomes.

It is interesting to note that, while substance abuse was noted as an impairing condition for 10% of primary caretakers and 15% of secondary caretakers, caseworkers noted that 20% of primary caretakers and 31% of secondary caretakers (double the proportion of those who were impaired by substance abuse) were said to actually abuse substances. The primary substances listed were alcohol, cocaine and inhalants. Substance use or abuse, as noted by the caseworker, was not associated with poorer outcomes.



**Family resources and risk factors.** Caseworkers noted whether each family had a number of basic supports or resources at the initial assessment (see Table 1). The vast majority of families had a parent who could read, could write, and could speak and understand English. A large number had food in the home and housing. Over half of the families began treatment receiving Medicaid and/or food stamps, with fewer families receiving AFDC and/or SSI. Just over half of families had a phone and just fewer than half had a car.

Only one-third of families had a parent with employment. The mean monthly income at intake was \$732.50, for a mean annual income of \$8,790 (including AFDC and other cash sources). There were ten families, however, for whom an income amount was unknown. Monthly incomes at intake ranged from \$0 to \$3000.

Mean risk levels, as measured by caseworkers using the Family Risk Scales, were comparable to those found by Magura, Moses, and Jones (1987). The mean summary risk scores on parent-centered risk and child-centered risk were slightly lower than those for the normative sample of 1,158 families in New York, while the two groups were equivalent in economic risk (see Table 2). Cases referred for neglectful supervision were rated as having more severe levels of parent-centered risk at intake. Physical neglect cases were rated as having significantly more severe levels of parent-centered risk, child-centered risk, and economic risk at intake, and still had significantly higher levels of parent-centered risk at case closure, as well.

Looking at the proportions of families for whom any particular risk item was a problem (scoring more poorly than a "1," or "adequate"), more than two-thirds of families in this sample were judged to be at risk concerning knowledge of child care, financial problems, verbal discipline of children, emotional care of children over age 2, preparation for parenthood, adult relationships in the household, use of physical punishment, and parenting of older children. Risk was most severe regarding parents' knowledge of child care, emotional care of children over 2, parenting of older children, financial problems, use of physical punishment, and school adjustment.

Relatively few families were judged by caseworkers to be at risk concerning sexual abuse (13%), the parent's attitude to preventing placement, the habitability of the residence, the mental health of the child, or the parent's substance abuse.

Families were more likely to have subsequent substantiated abuse or neglect reports following case closure when they had entered family preservation services with more severe levels of economic risk. Severity of parent-centered or child-centered risk at intake was not associated with subsequent reabuse.

## Service Provision

**Type of service provided.** The most common services provided were soft services, namely case planning, assessment, teaching of parenting and family care, crisis intervention and counseling by the caseworker (see Table 3). Of these, counseling by the caseworker was associated with subsequent family stability. Forty percent of families received counseling from the caseworker, and none of the families who had subsequent substantiated reports of abuse or neglect had received counseling from their FPU caseworker.

Due to budget cuts halfway through the evaluation, provision of purchased services to families was severely curtailed, with cuts in funding for purchased services (except for protective day care) to 40 hours per month for the Family Preservation Unit. Due to these cuts, fewer than a quarter of families received some of the soft services, such as adult counseling, parenting classes, family counseling, child counseling, child development services, psychological assessments or attended the contracted groups for neglectful mothers or anger control classes.

Of the enabling services, referral was a fairly common service for families, followed by the "Learning About Myself" and "Nurturing" support groups. Half of all families attended the "Learning About Myself" educational and support groups and/or the "Nurturing" educational and support groups. Many families were provided purchased protective day care for their children. Many families received help in acquiring medical services, food, financial assistance, and housing. Relatively few parents attended the "Rightful Options and Resources" educational and support groups, or parenting classes. Few were helped with parent educational goals.

Of the hard services, transportation was very commonly provided to families, but help with household maintenance or resources were provided to only 10% of families. This is too low a proportion, given the number of families with severe levels of risk concerning the adequacy of the residence and material resources.

**Site and length of service provision.** The mean time spent in direct contact with a family was 52.5 hours, although contact time ranged from 7.5 hours to 129 hours. Cases were open an average of 123 days (or 17 weeks). Fewer than half of cases (39%) closed in the recommended four months or less, but 73% had closed by the end of five months.

Each family received an average of 14.7 hours in in-home service with the caseworker (see Table 4). This is much less than the required 20 hours per month in the home. Families spent another 11.8 hours on average in agency support groups such as "Learning About Myself" or "Nurturing." The client spent another 11.7 hours on average with the caseworker at other locations outside the office. These could include schools, hospitals, day care centers or households, grocery stores, etc. Almost four hours were spent by the caseworker per case on the phone, and 3.4 hours were in the car. Fewer than two hours on average were spent with the



clients in the office, and fewer than two direct service hours were spent on paperwork. A little over an hour, on average, was spent in collateral contacts, meaning time with other parties such as teachers or doctors, when the client was not present.

The intensity of service for a case was computed by averaging the number of minutes spent on a case per week. Service intensity ranged from 42 minutes to 363 minutes (6 hours) per week, with a mean of 3 hours per week. Service intensity was not related to the severity of risk levels in the family at intake or at case closure, and did not differ by the type of abuse or neglect present in the family.

Families with subsequent abuse or neglect reports had received significantly less service time overall (28.4 hours vs. 56.6 hours, on average), and fewer days of services (90 days vs. 127 days, on average). Families who had substantiated reports of abuse or neglect following FPU services had received significantly less time in support groups, in field contacts, and in office contacts. They also had received somewhat less time, on average, of services in the home.

The match of services to family risk. It appears that there was some matching of services to the initial risk factors present in the family. When families had severe levels of parent-centered risk at intake, they were significantly more likely to receive teaching of parenting skills and help with legal assistance. When families had greater severity of child-centered risk, they were also significantly more likely to receive teaching of parenting skills, and were significantly less likely to receive adult counseling or attend the Rightful Options and Resources support group. When economic risk was severe at intake, families were significantly more likely to receive help acquiring food, help with household maintenance, and transportation. In addition, families with severe levels of economic risk were somewhat more likely than others to receive help with financial assistance, or help with medical care.

The amount of total service time spent with a family was not correlated to the risk levels present in the family at intake. Regarding the site of service, the amount of time spent in the home was not related to levels of risk at intake. Caseworkers spent significantly less office time and significantly more collateral contact time with families with a higher level of parent-centered risk, and spent significantly more collateral contact time and more time in staffings when there were higher levels of child-centered risk. The number of days the case was open was not related to the family's severity of risk at intake.

### Client Gains During Treatment

At case closing, equivalent numbers of families could write and understand English, and there were no increases in the number of families with food or housing. There were statistically significant increases, however, in the number of families receiving Medicaid (from 58% to

83%), food stamps (from 58% to 80%), and AFDC (from 33% to 50%). Two more families had a phone and four more families had a car at the close of services. Five families had gained employment by the end of services. The mean monthly income increased by \$156.50 to \$889 a month, or \$10,668 a year, still under the poverty level for a family of three. Again, there were twelve families for whom a monthly income at closing was not given.

The mean scores on family risk items decreased from initial assessment to case closing on all items but two, which remained the same. Thus, on average, severity of family risk did decrease somewhat from intake to closing, as rated by the caseworker. A statistically significant decrease was seen in parent-centered risk, particularly concerning the parent's knowledge of child care, preparation for parenthood, and the emotional care of children over the age of two. There were no significant decreases in child-centered or economic risk, however. Subsequent reabuse was not associated with severity of risk levels at case closure.

Looking at the proportions of families for which risk factors were still judged to be a problem at closing (rated more poorly than "adequate"), there were decreases in most individual risk factors from case opening to closing, with a statistically significant decrease in the proportion of families for whom adult relationships were a problem. Despite the lack of statistical significance, there were large decreases (greater than 15%) in the proportion of families with problems with preparation for parenthood, parental cooperation, parent's mental health, emotional care of children over the age of 2, children's school adjustment, children's cooperation, and delinquent behavior. At case closing, however, there were still large proportions of families with poor parenting of older children (80%) and financial problems (77%). The fewest improvements were seen in the proportion of families judged to have inadequate social support, problems with parenting of older children, and poor emotional care of infants.

Risk levels at case closing were also not associated with the amount of time the worker had spent with the family, or with any particular service. Severity of risk at closing was also not related to how long the case had been open.

## Conclusions

### Limitations of the Research

Before discussing the findings of this evaluation and their implications, several cautions about the study design and data are in order. This program evaluation examined the cases opened by the Family Preservation Unit over a six-month period, from May 1 to October 31, 1993. This time period resulted in a sample size of 40 families, which is a relatively small sample for any statistical comparisons. The lack of statistically significant associations between client or



service characteristics and case outcomes, therefore, may be more a function of sample size than anything else.

Without a control or comparison group, this study was not able to assess whether children would actually have been placed with or without family preservation services. It is hoped that a control group will be added in subsequent evaluation efforts, but, because the program was relatively new in the agency and there was political concern about the fit between the Family Preservation Unit and conventional units, a control or comparison group at this time appeared infeasible and unwise. A control group was particularly infeasible due to the high-risk nature of the sample; denial of services to this population would be contrary to the state mandate to serve these families. Once this pilot study lays the groundwork for research efforts in the unit, access to comparison (conventional services) cases may become more available.

All information about families, from client characteristics to severity of family risk factors, was based on caseworker assessment of, or information about, the family. It may be that changes in family functioning from intake to closing (or the lack of change) was biased by other factors affecting the worker's perception of the family, rather than objective assessments of family risk or family characteristics. Use of the Family Risk Scales, in which each rating score is anchored by operational definitions of risk for that level, was intended to minimize the subjectivity of ratings, but the extent to which this occurred is unknown.

Only a three-month follow-up period has elapsed since closure of the majority of cases in this evaluation. It is probable that more children may be placed or more cases may be reopened as more time passes. Therefore, the placement prevention and case reopening prevention rates reported will probably decrease at six-month and twelve-month follow-up points.

## Conclusions

This evaluation found that 90% of families were still intact at three months following case closure (88% among imminent risk cases). This placement prevention rate is on the high end of the range of success rates reported by family preservation programs across the country. About one-fifth of cases, however, were referred upon case closure to Catholic Social Services for continuing services. None of the families referred for continuing services had a subsequent report of abuse or neglect and none were reopened for services. While this is a positive finding regarding case outcomes, the cost-effectiveness of intensive family preservation services when they result in subsequent referral to ongoing services has not been examined.

The characteristics of children and families served were fairly typical of a child protective services caseload, in that these were fairly young parents with fairly young children. Approximately one-third of families were headed by a single parent. The mean income for

these families was \$732.50 per month. Over half of all cases were opened for physical abuse, although large proportions were open for neglect.

The Family Preservation Unit was least effective in strengthening families who had the presenting problems of physical neglect or neglectful supervision. This has been found by other evaluations of family preservation services (Berry, 1992; Yuan & Struckman-Johnson, 1991), as well. A short-term model of services is probably best suited to acute crisis-level problems and not to chronic situations of severe neglect. Neglectful families typically come to the attention of child welfare services after a longer period of dysfunction and are also more difficult to engage in treatment. If family preservation caseworkers are not well-trained in engagement tactics and also do not provide the concrete assistance and social supports needed by these more impoverished and isolated families, intensive and short-term services will continue to be inadequate.

The primary services provided to families by the Family Preservation Unit caseworkers appear to concern the soft services of case planning, assessment, and the teaching of parenting and family care. The most common hard service is transportation. There did appear to be some matching of services to the severity and type of risk factors present at intake. Teaching of parenting skills was significantly more likely to be provided to families with higher levels of parent-centered and child-centered risk. The enabling services of help acquiring food, help with household maintenance, and transportation were more likely to be provided to families with higher levels of economic risk.

The amount of total service time or time in the home, however, was not related to the level of risk in a family at intake. The five families who had subsequent substantiated reports of abuse or neglect had not received counseling by the caseworker and had attended significantly fewer hours of support groups. This finding may indicate that caseworker counseling and support groups are very effective services. On the other hand, the provision of counseling by the caseworker may also or instead serve as an indicator of parental motivations or engagement of the family by the caseworker. This conclusion is corroborated by the finding that families with subsequent substantiated reports of mistreatment had received less direct service time, on average, and their cases had been open significantly fewer days.

After receiving services from the Family Preservation Unit, significantly larger numbers of families received financial assistance, in the form of AFDC, food stamps, and Medicaid. The mean monthly income of families had increased to \$889 or over \$10,000 a year. Risk factors decreased for many families, with a significant decrease in parent-centered risk and a substantial reduction in the number of families judged to have a problem with parenting practices. There were smaller decreases in the severity of economic risk and in the presence of environmental risk factors, such as financial problems, suitability of living conditions, habitability of residence and the parent's ability to meet the physical needs of the child.



## Recommendations

**Clarity of purpose.** Family Preservation programs need to make clear the distinction between appropriate and inappropriate cases for intensive family preservation services. Clear criteria for determining whether a family is at imminent risk of placement is most important. If a Family Preservation Unit is to stand apart from other ongoing services units in a child welfare agency, the other units need to understand the focus of the treatment model. Family Preservation programs which provide short-term and intensive service to families in acute crisis will not be effective with chronic neglect families nor as a monitoring service for less than crisis-level cases. Acceptance of inappropriate cases will degrade a program's adherence to an intensive model of treatment and the role of such a program within a larger agency.

**Clarity of method.** Many researchers and practitioners are lamenting the phenomenon whereas agencies are implementing the family preservation model due to the appeal of short-term treatment and highly publicized effectiveness, without adequate training of workers or agency directors in a coherent and integral model. As discussed earlier, this model builds on family-defined needs and goals to engage families early in treatment through all three types of services: hard, enabling and soft. Caseworkers, therefore, need additional training and assistance in engaging resistant clients through client-defined goals and other strategies. This training should include attention to the role of providing concrete assistance and services as a way to build trust with families within the Intensive Family Preservation model.

Slippage from adherence to the classical intensive family preservation services model is most evident in the low number of hours spent by caseworkers in the home (workers spend fewer than 15 hours per case, on average, in the home, although they are practicing a home-based model of services), and the low average number of total service hours per week with the family (an average of 12 hours per month). The family preservation model of services emphasizes spending the bulk of service hours in the home and with field contacts, such as school and medical personnel, to increase the provision of concrete and enabling services. The neglect of concrete resources and the inability to engage resistant clients indicates that this program is slipping toward a more general model of ongoing services, but with the added stress of a four-month time limit. Family Preservation caseworkers, therefore, need basic and ongoing training in the classical home-based and family-centered model of treatment, with some attention to how their particular program adds to or modifies that model.

Concrete resources are a necessity in short-term programs with high-risk families. These families need assistance with household maintenance and basic needs such as food and transportation. Attention to these needs is a critical element of intensive family preservation services, for two purposes that are empirically sound: assistance with concrete needs helps to engage families in the short period of time that cases are open, and child placement decisions,

made by investigators not familiar with the family, are heavily influenced by the environmental safety and appearance of the household.



Table 1  
Family Resources

	At Intake		At Closing	
	Number	Percent	Number	Percent
	(n=40)		(n=40)	
Parent can read	39	98	40	100
Parent can write	39	98	39	98
Parent speaks/understands English	39	98	39	98
Family has food in home	38	95	38	95
Family has housing	36	90	36	90
Family receives Medicaid	23	58	33	** 83
Family receives food stamps	23	58	32	** 80
Family has a phone	21	53	23	58
Family has a car	18	45	22	55
Family receives AFDC	13	33	20	* 50
Parent is employed	13	33	18	45
Family receives SSI	6	15	5	13

Mean monthly family income  
(all sources)

\$ 732.50

\$ 889.00

\* Increase from intake to closing is significant at .05 level (one-tailed test).  
 \*\* Increase from intake to closing is significant at .01 level (one-tailed test).

Table 2  
Family Risk Scores

	Mean Risk Scores		Percent with Problem	
	Number	Percent	Number	Percent
	(n=40)	(n=39)	(n=40)	(n=39)
<b>Summary Factors</b>				
Parent-centered risk (b)	1.9	** 1.6		
Child-centered risk ©	1.4	1.3		
Economic risk (b)	1.7	1.6		
<b>Household and Family Risk Items</b>				
Financial problems (a)	2.2	1.9	83	77
Adult relationships (a)	1.9	1.7	73	** 53
Family's social support (a)	1.8	1.7	62	59
Suitability of living conditions (b)	1.6	1.6	45	37
Habitability of residence (b)	1.3	1.2	20	14
<b>Primary Caretaker Risk Items</b>				
Knowledge of child care (a)	2.5	** 2.1	88	73
Preparation for parenthood (a)	2.1	* 1.9	75	56
Parent's motivation (b)	2.0	1.7	55	49
Parental cooperation (a)	1.7	1.5	58	41
Parent's physical health (b)	1.5	1.3	35	24
Parent's mental health (b)	1.5	1.3	49	30
Parent's substance abuse (b)	1.4	1.3	24	16
Attitude to preventing	1.1	1.2	13	6
<b>Oldest Child Risk Items</b>				
Emotional care if child 2 or	2.3	* 1.7	79	63
Parenting of age 10 and up (a)	2.3	1.5	67	80

\* Pre-to-post difference is significant at .05 level (one-tailed test).  
 \*\* Pre-to-post difference is significant at .01 level (one-tailed test).

(a) Item is measured on a 4-point scale. Lower number indicates lower risk.  
 (b) Item is measured on a 5-point scale. Lower number indicates lower risk.  
 © Item is measured on a 6-point scale. Lower number indicates lower risk.



Table 2 — continued  
Family Risk Scores

	Mean Risk Scores		Percent with Problem	
	Number	Percent	Number	Percent
	(n=40)	(n=39)	(n=40)	(n=39)
<b>Oldest Child Risk Items (continued)</b>				
Physical punishment (b)	2.2	1.7	71	60
School adjustment ©	2.2	1.6	57	22
Verbal discipline (a)	2.1	1.8	81	64
Child cooperative (a)	1.8	1.6	50	30
Physical health (b)	1.7	1.6	35	24
Physical needs met (a)	1.6	1.4	41	34
Supervision under age 10 (a)	1.6	1.4	38	27
Emotional care if child	1.5	1.5	40	47
Sexual abuse (b)	1.4	1.3	13	14
Behavior at home (b)	1.4	1.2	28	22
Delinquent behavior (b)	1.4	1.1	27	6
Mental health (b)	1.3	1.2	22	16

Mean scores are presented for the purpose of pre-to-post comparisons on factors and individual items, but are not appropriate for comparisons between factors or items.

\* Pre-to-post difference is significant at .05 level (one-tailed test).

\*\* Pre-to-post difference is significant at .01 level (one-tailed test).

(a) Item is measured on a 4-point scale. Lower number indicates lower risk.

(b) Item is measured on a 5-point scale. Lower number indicates lower risk.

© Item is measured on a 6-point scale. Lower number indicates lower risk.

Table 3  
Service Provision

	Total Sample		Experienced Subsequent Abuse	
	Number	Percent	No	Yes
		(n=40)	(n=35)	(n=5)
			%	%
<b>Soft Services</b>				
Case planning	33	83	86	60
Assessment	32	80	83	60
Teaching parenting and family care	29	73	71	80
Crisis intervention	22	55	51	80
Counseling by caseworker	16	40	46	* 0
Contracted adult counseling	9	23	100	0
Contracted family counseling	5	13	14	0
Contracted child counseling	4	10	9	20
Contracted child development services	4	10	9	20
Contracted psychological services	3	8	9	0
Contracted filial therapy	1	3	3	0
<b>Enabling Services</b>				
Referral	27	68	63	100
Learning About Myself support group	20	50	54	20
Nurturing group	20	50	51	40
Help acquiring medical	19	48	49	40
Protective day care	17	43	40	60
Help acquiring food	16	40	40	40

\* Difference is significant at .05 level.



Table 3 — continued  
Service Provision

	Total Sample		Experienced Subsequent Abuse	
	Number	Percent	No	Yes
	(n=40)		(n=35)	(n=5)
			%	%
<b>Enabling Services (continued)</b>				
Help acquiring financial assistance	13	33	34	20
Help finding housing	8	20	20	20
Rightful Options and Resources group	6	15	14	20
Contracted parenting classes	6	15	17	0
Parent education	5	13	14	0
Neglectful mothers group	3	8	9	0
Anger control class	2	5	100	0
Help acquiring legal assistance	2	5	6	0
<b>Hard Services</b>				
Transportation	32	80	83	60
Household maintenance	4	10	9	20
Other	6	15	14	20

\* Difference is significant at .05 level.

Table 4  
Service Time Spent by Family Preservation Caseworker

	Total Sample	Reabused	
		No	Yes
	(n=40)	(n=35)	(n=5)
<b>Mean Number of Hours Spent:</b>			
In home	14.7	15.3	11.2
In group	11.8	13.1	* 4.2
In field	11.7	12.8	* 4.9
On phone	3.9	4.0	2.8
In car	3.4	3.5	2.7
In office	1.9	2.1	** 0.2
Paperwork	1.9	2.0	1.2
Collateral contacts	1.2	1.2	1.2
In staffing	0.3	0.3	0.1
Other	2.0	2.3	0.0
<b>Total Time Per Case</b>			
	52.5 hrs.	56.6 hrs.	* 28.4 hrs.
<b>Mean Number of Days Case Open</b>			
	123.0 days	127.0 days	* 90.0 days
<b>Intensity</b>			
	2.9 hrs./wk.	3.0 hrs./wk.	2.0 hrs./wk.

\* Difference is significant at .10 level.

\*\* Difference is significant at .05 level.



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## Intensive family reunification services: A conceptual framework and case example

by

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## Abstract

Recent federal mandates require child welfare agencies to make reasonable efforts to reunify families after out-of-home placement. Consistent with those mandates, agencies are increasingly employing techniques from family preservation services intended initially to prevent out-of-home placement. The purpose of this article is to articulate a conceptual framework and practice guidelines for family reunification services and to describe an experimental reunification program based on a family preservation model. A case example illustrates the way in which the services affected one family that participated in the experiment.

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Reunification of foster children with their biological parents is a preferred outcome in child welfare (Barth & Berry, 1987; Kadushin & Martin, 1988; Kammerman & Kahn, 1990; Stein & Gambrill, 1985). Rarely, however, have child welfare workers developed specific programs to promote family reunification (Kaplan, 1986; Pine, Krieger, & Maluccio, 1990). Even though reunification serves as one of many compelling foster care goals, it often receives short shrift. Consequently, some children remain in foster care longer than necessary (Horejsi, 1979; Maluccio, Fein, & Olmstead, 1986).

Family reunification and preservation programs were promoted by the enactment of Public Law 96-272 (United States Statutes at Large, 1981). Family preservation programs were implemented to strengthen families having children at risk of out-of-home placement. Although the findings are mixed (see, for example, Schuerman, Rzepnicki, Littell, & Chak, 1993), evaluations of these placement prevention programs suggest that many children can be safely diverted from placement and, with proper family treatment, remain in their homes (Auclair & Schwartz, 1986; Feldman, 1991; Forsythe, 1992; Fraser, Pecora, & Haapala, 1991; Henggeler, Melton, & Smith, 1992; Jones, Neuman, & Shyne, 1976; Kammerman & Kahn, 1990; Nelson, 1985; Nelson & Landsman, 1992; Szykula & Fleischman, 1985). Family preservation programs appear to prevent or delay out-of-home placement for approximately 50% of children at risk (Wells & Beigel, 1991).

Over the past decade, a series of promising family preservation programs was implemented in the State of Utah. These programs were designed to provide brief, intensive, in-home, family-focused services to families with children at risk of out-of-home placement (Callister, Mitchell, & Tolley, 1986; Fraser et al., 1991; Lantz, 1985). Because of the apparent success of these prevention programs, and that of other such programs throughout the country, an innovative program was initiated to determine whether brief family services using a similar intervention model could be employed to reunify families after a child had been placed in out-of-home care. This federally-funded project began in July, 1989, and was evaluated over an 18-month period. Compared to routine foster care casework, the reunification service was effective.

Children in the "treatment" group ( $n=57$ ) were (a) returned to their homes with greater frequency and (b) remained in their homes for longer periods of time than children in the "control" group ( $n=53$ ). By the end of the 90-day treatment period, 92.9% of the treatment children had returned to their homes compared to 28.3% of the control children ( $\chi^2 = 48.68$   $df = 1$ ,  $p < .001$ ). At the end of a twelve month follow-up period, 75.4% of the treatment children were in their homes compared to 49% of the control children ( $\chi^2 = 8.18$   $df = 1$ ,  $p < .004$ ). There was wide variation in the amount of time the children spent in their homes. Some were reunified at the beginning of the 90-day period, and a few were not reunified at all. Likewise, a few returned home but subsequently were placed in out-of-home care. The treatment children were in their homes an average of 72.7% of the 90 days during which they received reunification services. In contrast, the control children were in their homes 16.4% of that time ( $t = 10.05$ ,  $p < .001$ ). During the second of two six-month follow-up periods, treatment children were home 83.2% of the time while control children were home only 45.4% of the time ( $t = 4.67$ ,  $p < .001$ ).

(For a detailed description of the research methodology and results, see Walton, 1991; Walton, Fraser, Lewis, Pecora, & Walton, 1993).

The two-fold purpose of this article is to present the conceptual framework and rationale for the treatment model for this successful experiment and to describe the reunification services qualitatively using the case study method. The focus of this article is a single case, but it is important to view that case in the context of the larger project. Hence, a part of the larger study is included. To appreciate the scope of the project, however, the reader is referred to the original sources (i.e., Walton, 1991; Walton, Fraser, Lewis, Pecora, & Walton, 1993).

## Conceptual Framework

The conceptual frameworks for family preservation services and for family reunification services are different. Crisis theory is key to the rationale for preventing out-of-home placements because interventions usually take place at a time when the risk of placement is high. By contrast, reunification takes place after crises have passed and a measure of stability has been achieved—which gives service delivery personnel flexibility in planning and implementing reunification services. Fewer time constraints and a greater variety of options are available. The planning and implementation of reunification services derive from beliefs and assumptions that are rooted in several well-known theories.

## Maslowian Theory

Conceptually, families may be thought of as having nested needs or needs within the context of a larger hierarchy of needs. Maslow (1973) theorized that human behavior is motivated by needs and that "... needs arrange themselves in hierarchies of prepotency on a scale ranging from physiological on the bottom to self-actualization on the top; that is to say, the appearance of one need usually rests on the prior satisfaction of another, more prepotent need" (Maslow, 1973, p. 153). Maslow's theory provides an important framework within which to view family reunification.

Families most frequently in need of reunification services are "multiproblem" families with basic food and shelter needs plus what might be called "higher order" needs. Consistent with Maslow's (1973) theory, Rabin, Rosenbaum, and Sens (1982) argued that basic needs must be met before the family can be helped emotionally or behaviorally. Dumas and Wahler (1983) found that families embedded in a variety of problems associated with every-day life could not respond to psychotherapeutic treatment. In the same vein, Gilbert, Christensen, and Margolin (1984) reported that the needs of families with multiple problems are so basic that it may be difficult for family members to give interpersonal support. Because transportation is a basic



issue for families with multiple problems, it is not surprising that Bryce (1982) observed that the majority of children at greatest risk of maltreatment, delinquency, and other problems are not reached by in-office approaches. Mueller and Leviton (1986), arguing for in-home services, concluded that the effectiveness of family treatment corresponds with the degree to which a family's priorities match the priorities of the organization or agency. The priorities of the clinic may simply not be appropriate for families with multiple problems because many basic needs are ignored within the clinic setting (Kaplan, 1986).

If families seem resistant, unmotivated, or hopeless, it may be that basic needs are, in Maslow's (1954) terms, prepotent or unfulfilled. For many families, reunification services must address prepotent needs through the provision of concrete services (e.g., food, transportation, or cash assistance). Concrete services are integral rather than ancillary to family reunification, and Maslowian Theory undergirds this element of the service model.

### Family Systems Theory

Systems theory, as presented by the biologist Bertalanffy (1968) and applied to social interaction by Anderson and Carter (1984), is a paradigm for organizing and assessing a family's environment. It, too, is useful in thinking about family reunification. Whether regarded as a metatheory, a framework, or a model, systems theory provides a way in which to view any dynamic, recurring process of events. Thus, it helps us to understand people, both individually and collectively, in terms of concepts such as structure, boundary, equilibrium, entropy, interaction, dependence of parts, conflict, and input and output of resources (Rodway, 1986). Systems theory fits the "person-in-situation" concept identified as the base from which the social work profession has developed, and the primary task for the therapist is "to focus on the whole system of the family, which is both the sum of its parts and their goal-directed organization" (Rodway, 1986, p. 527). Systems theory, as applied to family reunification services, is a process of identifying the systems in which a family is involved and designing solution-oriented interventions to fit those dynamics. Basic to an assessment in family reunification is the identification of strengths within the family system. It is through the family system that a reunification service should work to build resources and skills using various approaches to family intervention: (a) structural family therapy (Minuchin, 1974), (b) strategic family therapy (Madanes, 1981), (c) problem-centered therapies (Epstein & Bishop, 1981), and (d) family-centered social work practice (Hartman & Laird, 1983).

### Social Ecological Theory

Just as a child's problems are nested within the family system, a family's problems are nested within a larger environment including such systems as schools, neighborhoods, churches, and

places of employment. This "system of systems" is referred to as "social ecology"--a composite of interdependent social systems organized at family, school, community, and institutional levels (Heying, 1985). Ecological theory (often referred to as eco-systems theory) may be thought of as a hybrid of systems theory. Through it, theorists endeavor to explain the ways in which the various systems accommodate each other within the context of the larger environment (Bronfenbrenner, 1979).

Bronfenbrenner (1979), the primary apologist for eco-systems theory, wove an ecological framework around the concepts of parental role, life stressors, and social supports. He argued that child-rearing practices are a function of the interplay between a person and his or her environment. Bronfenbrenner observed,

... whether parents can perform effectively in their child-rearing roles with the family depends on role demands, stresses, and supports emanating from other settings. . . . Parents' evaluations of their own capacity to function, as well as their view of their child, are related to such external factors as flexibility of job schedules, adequacy of child care arrangements, the presence of friends and neighbors who can help out in large and small emergencies, the quality of health and social services, and neighborhood safety. The availability of supportive settings is, in turn, a function of their existence and frequency in a given culture or subculture. This frequently can be enhanced by the adoption of public policies and practices that create additional settings and societal roles conducive to family life (p. 7).

The creation, activation, and use of supportive strategies within the context of social systems is central to reunification. With a network of supportive resources, the family is more likely to be responsive to the worker and to acquire new skills that facilitate improved family functioning. Like Maslowian theory, ecological theory underpins the strategic use of concrete services at the beginning of the reunification effort. Successful reunification depends on successful coordination of a variety of systems-level strategies that, depending upon the unique needs of a child and her/his family, may include school, extended family, church, health care professionals, neighborhood groups, and a variety of supportive organizations.

### Social Learning Theory: Skill-Focused Approach

Social learning theory emphasizes the role of skills in explaining family processes and child behavior (Bandura, 1973). According to social learning theorists, one's behavior is in large part a consequence of the reinforcement, or lack of reinforcement, that follows events in life. Through direct instruction, modeling, and contingency management (Kinney, Haapala, & Booth, 1991), the caseworker teaches a variety of skills such as communication, anger management,



problem-solving, self-control, conflict resolution, and parenting. The caseworker models the skills, and learning is reinforced with role-playing, feedback, and homework assignments. Contracts are made for specific behavior changes with corresponding rewards. Parents are coached in contracting with their children for specific behavior changes and corresponding rewards (Henggeler et al, 1992; Kinney, Haapala, & Booth, 1991).

### Client-Centered Theory

Successful intervention with families requires empathy, warmth, and genuineness on the part of the therapist or caseworker. These "core conditions" are basic to Rogers' (1982) humanistic view of intervention called "client-centered theory." The term "client" as opposed to "patient" also suggests the active, voluntary, and responsible participation of the client (Rowe, 1986). From this perspective, the client is empowered as the driving force behind the treatment. The client's agenda becomes primary, and the client owns the problems. The caseworker's role is that of an enabler whose listening skills are critical in helping to release an already existing capacity for self-actualization (Rowe, 1986).

Lewis (1991) found that clinical techniques such as empathic listening and supportive responses were associated with goal attainment in delivering family preservation services. However, he found that trust-building interventions aimed at improving the family's situation and capabilities were more effective than interventions focused on the therapeutic relationship alone. In a qualitative analysis, Fraser and Haapala (1987) connected the provision of concrete services to client-therapist relationships by theorizing that the combination increases trust and client rapport. This connection may be significant in light of the findings of Jones, Neuman, and Shyne (1976) that trust is a significant service component.

### Reunification Guidelines

Just as client-centered therapy by itself was not sufficient for preserving families, no theory alone is likely to be sufficient. The combination of theoretical perspectives provides a set of service guidelines for successful family reunification. These service guidelines are listed as follows:

- 1) The child's safety is always of paramount concern in reunification.
- 2) Families have hierarchical needs, and basic needs must be addressed in the initial stages of reunification.
- 3) Children are best treated within the context of the family system. Problems and strengths should be defined from a family rather than a child perspective.

- 4) The family is best treated within the context of its larger environment or social ecology which must be activated to provide support if reunification is to be successful.
- 5) Families can be taught skills to solve problems that may have led to separation and that can promote reunification.
- 6) Reunification requires a caring, trust-building client/caseworker relationship to engage parents and children and to promote social learning.

### A Family-Based Reunification: Case Example

These guidelines must be manifest in a family-based program designed for the purpose of enabling families separated through out-of-home placement to be reunified. To that end, a model for intervention was developed based on the Homebuilders™ model for family preservation (Kinney, Dittmar, & Firth, 1990; Kinney, Haapala, & Booth, 1991; Kinney, Haapala, Booth, & Leavitt, 1990). Although the basic philosophy for intervention was patterned after the Homebuilders™ model, there were some important differences. The length of service was expanded to 90 days because it was hypothesized that reunification would take longer than the prevention of placement--a major focus of the Homebuilders™ model. Also, because families were not in crisis, it was hypothesized that the intensity of the service could be reduced somewhat. Consequently, the caseloads were 6 families per worker. However, the total amount of direct contact time with each family was about the same as that provided in Homebuilders-like programs (Lewis, Walton, & Fraser, in press).

The experimental intervention was skills oriented and family-centered. It included the following elements:

- 1) Caseloads were limited to six families.
- 2) Services were brief, limited to 90 days.
- 3) Workers tried to return children to their homes at the beginning of treatment, so as to be able to work with families in their natural home settings.
- 4) Psycho-educational and behaviorally-oriented interventions were utilized by the caseworkers. These included assisting family members in managing personal problems; teaching skills such as communications, problem-solving, assertiveness, and parenting/child management; building social supports; and accessing a network of resources.
- 5) The caseworker served as both "primary therapist" and foster care caseworker for assigned cases. The caseworker arranged for or provided concrete services and the coordination of other resources.
- 6) Services were more intensive than routine foster care. Caseworkers met with families at least three times per week.



- 7) Caseworkers were available 24 hours a day, seven days a week.
- 8) Services were focused on the family rather than on the child.
- 9) A special fund was available for concrete services (i.e. housing, transportation, cash assistance, food, medical care, etc.). A maximum of \$500 could be spent per family.

### Caseworkers

Seven caseworkers volunteered to provide the reunification services. Six of the seven held the Master of Social Work degree, and the seventh held a Bachelors degree in Child Development. Prior experience varied. One caseworker had more than 20 years of experience in child welfare while another had only two years of experience. All the caseworkers were male.

Prior to the experiment, two days of start-up training were provided for the caseworkers. Training included an overview of the Homebuilders™ model and skill-building techniques for promoting communication, effective parenting, attachment, and social bonding. The training was conducted by family preservation staff, the project coordinator, and a foster care supervisor.<sup>5</sup>

Throughout the project, caseworkers received training on the Homebuilders™ model. They also received training in strategic family therapy. Once a month workers and their supervisors met with the project coordinator. Meeting agenda included (a) staffing difficult cases, (b) instruction in data collection procedures, and (c) discussion regarding referrals for the project to ensure the random assignment process was consistently and fully implemented.

### Services Provided

Fifty-seven of 110 consenting families were randomly assigned to the experimental reunification service and were transferred from routine foster care to the experimental reunification program<sup>6</sup>. Prior to the child returning home, the caseworker became involved with the parents and the child. Together they developed a reunification plan. During this time, the caseworker involved other systems related to the child and her/his family (e.g., the juvenile court, guardian *ad litem*,

<sup>5</sup>Even though the model for intervention was essentially a Homebuilders™ model, the training was not provided by a member of the Homebuilders™ program.

<sup>6</sup>A variety of families participated in the project. For a detailed report on the demographic features of the families, see Walton, Fraser, Lewis, Pecora, and Walton, 1993.

therapists, and school authorities). While notifying the court, the worker tried to activate a process for returning custody and guardianship of the child to the parents.

During the 90-day treatment period, the workers spent, on average, 2.5 hours a week with each family, for an average of 29.1 total face-to-face hours over the 90-day period. An additional 8.3 hours were spent providing telephone support, and 9.1 hours were spent accessing ancillary resources and doing paper work--making a total of 46.5 hours per case on average. A variety of services were provided including risk management (protective supervision), problem-solving, skills training, and the accessing of an assortment of resources including concrete services. (For a detailed report of the variety and differential use of clinical and concrete services, see Lewis, Walton, & Fraser, in press.) Toward the end of the 90 days, the treatment workers reduced the intensity of the services and attempted to reinforce the skills and techniques taught. In preparing for termination, an attempt was made to help the families anticipate future needs, and the families were advised that the worker would be available for short-term follow-up interventions if needed. At the end of the treatment period some form of less intensive follow-up services were in place for all the families. These included social services, private counseling, juvenile court supervision, parenting training, drug or alcohol treatment, and inpatient psychiatric care.

Throughout the course of treatment, workers continually evaluated the desirability of leaving the child in the home. By spending more time in homes than protective services workers, treatment workers were in a unique position to recommend removal of the child at any time. Just prior to the end of the 90-day treatment period, the worker staffed the case with the supervisor and a clinical team to determine if the case ought to be closed.

A wide array of family situations and problems was addressed in the project. It is beyond the scope of this study to provide a qualitative report reflecting that variety of problems. Through a case study method, however, the situation with one family who received the experimental service was studied in detail.

### Case Study Method

The case study method is a process for analyzing a single unit. The case study is often seen as a small step toward grand generalization; however, a sample of one weakly represents the larger group. In fact, a commitment to generalize or create theory through a single case study may be damaging (Stake, 1994). Case studies that rely upon qualitative methods are desirable when researchers seek firsthand knowledge of real-life situations and processes within naturalistic settings and endeavor to gain an understanding of the subjective meanings those processes have for the subjects being observed (Jarrett, 1992).



Case studies may be intrinsic or instrumental. The intrinsic case study design draws the researcher into the phenomenological world of a unique case. Emphasis is placed on understanding what is important about the case within its own world. The instrumental case study design draws the researcher toward illustrating how the concerns of researchers and theorists are manifest in a case (Stake, 1994). These two designs were combined in the qualitative analysis of the current study. The following example, though in the spirit of case studies not generalizable, reflects the process of the intensive intervention. The case was selected purposively because it is rich in details that illustrate the way in which the integrative theories were applied.

### Case Example: John and His Family

John (name changed to maintain anonymity) was 13 at the time he and his family received reunification services. John's biological father was in prison and had no contact with the family. John's relationship with his step-father was strained, and the step-father had been physically abusive. John, in turn, became abusive of his three younger siblings, which led to the involvement of Child Protective Services.

Initially, John was removed from the home and placed with a relative; but the relative abused him, and John was transferred to foster care. When the study began, John had been in foster care for six months.

The caseworker first became involved by meeting with the parents and John separately. John was large for his age and, in many ways, took on the appearance of a bully. As the caseworker began engaging John in a relationship, however, John revealed his emotional fragility. Since early elementary school, he suffered the painful rejection of peers and the criticism of teachers, who saw him as disruptive. He did not seem to belong anywhere, and he did not like himself. In foster care, he felt abandoned by his family and was eager to return home.

Although John's mother and step-father expressed love for him, they were apprehensive about his return. They were afraid they might not be able to control his violent outbursts. Moreover, the mother felt overwhelmed with the responsibility of three other children. She frequently found herself mediating conflicts between her husband and her children. She was exhausted from hearing about her children's problems (e.g., she dreaded getting calls from the school). She avoided facing family problems in a variety of ways and ignored some of her children's basic needs. Yet, at the same time, she had strengths. She had good nurturing skills and wanted John to come home.

After the mutual desires for reunification were established, the caseworker discussed with the parents their goals regarding their family in general. Then he invited the family to identify goals

specifically related to John. With specific goals and concerns identified, the caseworker spent time with the parents and John separately to negotiate plans for each goal. Even before John was returned to the home, the caseworker began teaching specific skills that would help the parents achieve these goals, one of which was learning to deal with John's angry outbursts.

After returning John to his mother and step-father, the caseworker met with the entire family together--three times per week during the first month of service, then twice a week during the second month, and once a week during the third month. It did not take long to establish the fact that all members of the family shared similar values and goals for the family. After facilitating that consensus-building activity, the caseworker helped the family identify mutually-acceptable rules that would reflect the family values and goals. The rules addressed the reason for initial intervention by children's services such as not injuring another person and respecting each other's rights and personal property. The next step in the intervention was to help the family determine appropriate rewards for obeying the rules and consequences for disobeying the rules.

The caseworker became the family's coach. He helped the parents implement the rules with natural and logical consequences. He taught family members to express their feelings assertively instead of aggressively. He taught the family how to show affection for each other. He helped John develop social skills. He also worked with John to help him in resolving the loss of his biological father. These efforts seemed to help increase John's self-confidence and the family's cohesion. At first, John's step-father was somewhat removed from services, but as the interventions became a natural and normal part of family life, he became more actively involved, and, after a few weeks, John became more involved with and attached to his step-father.

In addition to the caseworker's intervention with the family as a whole, he included John in a group of teens who were being reunified with their families after foster care. They jointly participated in a number of social activities. This social experience was refreshing and empowering for John because the group of teens shared common problems, and all had similar experiences with peer rejection. The caseworker helped them jointly to deal with those problems by facilitating their support of each other and by teaching them social skills.

The reunification process was not without set-backs. At one point John threatened his brother with a knife (as he had done prior to placement). In response, the family as a whole (with the coaching of the caseworker) sanctioned John by limiting his use of a knife for a period of time. It was determined that if John wanted to use a knife, he would have to explain his intended use for the knife and then "rent" it from his parents.

At the end of the 90-day treatment period, the family felt encouraged but termination was difficult because John had become attached to the caseworker. The caseworker gradually disengaged by helping the family obtain additional resources. Family therapy and individual therapy for John were continued through the community mental health center. Custody was



returned to the parents. At the end of the six-month follow-up period, the family was still together, and John's behavior was viewed by family members as appropriate. No additional reports of abuse were reported.

### John's Family in the Context of the Child Welfare System

The case study of John and his family demonstrates some of the processes and techniques used to promote successful reunification. The worker addressed individual, family, and systemic factors which often make reunification difficult (e.g., the role of the court and the foster family or the foster care system in general). A multi-tiered intervention is required, for barriers to reunification often lie within the child welfare system. As Hartman (1990) observed, "Family reunification and re-connection are really attempts to undo the often iatrogenic damage that has been done to families and children by a system that has been unable to follow the principles of permanency planning" (p. 12).

Further, the ecological framework upon which the model is built presumes the cooperative involvement of a variety of players and the networking of a variety of resources. The spotlight for this case study is on the role of the preservation caseworker and the caseworker/family relationship, and that role/relationship is key to a successful intervention in this model. However, it is clear also that there is much more to reunification than the involvement of a skilled therapist.

Finally, the study is not intended to be generalizable. The case was chosen as an example of the experimental intervention at its best. It is a simplified version of a success story which was shared for the purpose of (a) illustrating the way in which the model is intended to work and (b) providing hope for dedicated caseworkers who are continually looking for a new idea which might help families stay together.

### Theory Application

In analyzing the case example within the conceptual framework, social learning theory is easily identified. The caseworker spent much of his time teaching behavioral skills and reinforcing them in a variety of ways.

The client-centered approach of the caseworker was also evident. The intensive involvement of the caseworker with an emphasis on the client/caseworker relationship resulted in the family's report that the caseworker really cared about them, and that caring and intensive involvement was perceived as a primary factor in the change process. Moreover, it was the family's agenda that was addressed, and the emphasis on strengthening and empowering the family so that they

were not overwhelmed by their problems made it possible for the family to take responsibility for its own progress.

The relevance of family systems theory was evident from the way in which the caseworker refused to separate John's situation from the family's situation. The problem was defined as a case of family reunification--not juvenile delinquency.

Ecological systems theory was central to John's return home. It was clear that John was struggling to find a fit for himself in society--not just his family. The caseworker's intervention focused on John's school situation and his relationship to his peers. Through a group work approach, he helped John establish a new network of supportive peers.

Maslow's hierarchy of needs theory was less evident in this case example. John's family, though struggling, had fiscal resources, and the caseworker provided little in the way of concrete services. The issue of concrete needs most clearly defined the difference between John's family and the "typical" family in the study. With many families, particularly those referred for neglect, concrete needs were evident. John's caseworker helped other families with some very basic needs. For example, he helped one family paint the inside of their house. He put locks on doors and locks on cupboards in an effort to protect small children. He provided transportation for children to school and to therapy. He helped another family obtain needed furniture and yet another find an apartment (providing the first month's rent and the deposit). For still another family he purchased basic food items. But for John's family this was not necessary.

### Discussion

The application of social and behavioral sciences theories to the design of child welfare services is not commonplace. Services often arise in a theoretical vacuum, and theory is applied in retrospect to explain services that appear to work or that somehow find a place in the mosaic of child welfare programs.

This case study diverges from this tradition in part. In designing guidelines for a reunification service, five theories were integrated: Maslowian hierarchy of needs, systems theory, ecological theory, social learning theory, and client-centered theory. These theories serve as referent points for developing a service model that includes emphasis on building collaborative relationships with family members, the provision of concrete services to meet the physical and safety needs of children and their parents, and the use of in-home instruction in family decision-making, parenting, and other skills for family problem-solving.

Because this project focused on helping families who had already failed in the context of family preservation, it was anticipated that a number of parents would be reluctant to try again to solve



their problems. Moreover, it was assumed that many of the children would be jaded about treatment and hostile to workers. For the most part, these assumptions were incorrect. Parents and children were eager to reunify as long as they had the support and assistance of a worker.

With careful protective supervision and in-home training, service appears to have been successful. As shown in the anecdotal accounts of "John," brief, family-centered intervention can (a) bridge service gaps, (b) provide for concrete needs, and © train family members in new skills.

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## Intensive Family Preservation Services: Do They Have Any Impact on Family Functioning?

by

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### Abstract

This article presents a review of the intensive family preservation evaluation literature, the pre-post test methodology employed to evaluate three models in one state and the findings which have informed policymakers and program designers as the service expands. After intensive family preservation services, significant changes were found in parent-centered risk, parental disposition, and child-centered and child performance. No changes were found in economic risk and household adequacy.

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Intensive Family Preservation Services (IFPS) have been growing rapidly for over the past decade and have achieved remarkable popularity in the last five years. In 1988 there were only four recognized state associations for family-based services; by 1993, these numbers increased to 27 (Allen & Zalenski, 1993). The impetus for IFPS came with the establishment of the National Resource Center on Family Based Services at the University of Iowa in 1981. It contributed to the approaches of IFPS in a number of ways including the generation of large research projects (Nelson at Iowa, and Pecora, Fraser, and Haapala at Utah), the organization of a national conference, and the establishment of the National Association for Family-Based Services. This latter group has held seven annual conferences, the most recent being in Boston, in December, 1994. Although various IFPS programs across the nation differ among themselves, they share a number of common characteristics which are part of the current definition of IFPS. In general terms, IFPS refer to specialized modalities of serving families, which have evolved from the broader categories of "Home-Based Services" that served families in their homes and communities, and "Family-Based Services" which focused on the whole family, rather than the individual (Pecora, Haapala, & Fraser, 1991). Specific characteristics of IFPS include the following: clinical and concrete services are delivered in the home of the client families; therapist is available to clients 24 hours a day; duration of intervention is short, usually ranging from 4 weeks to six months; and therapists have smaller caseloads (Pecora et al, 1991).

In an era of fiscal constraints and accountability, questions have been increasingly raised regarding the effectiveness of IFPS. Do they reduce foster care and other placements and keep families together? Do they have any impact on the functioning of families? From the beginning, IFPS have been involved in evaluating their own programs (Wells & Biegel, 1992; Kinney et al, 1990). Most of these early evaluations focused on prevention of placement as the outcome of IFPS, and some studies have revealed positive results to that effect. Referring to one of the models in IFPS, the Homebuilders, Kinney et al (1990, p. 15) wrote: "Begun in 1974, by the end of 1990, Homebuilders had seen 5,314 cases. Three months after termination, 95% had avoided placement in state-funded foster care, group care, or psychiatric institutions. Twelve month follow-up data available after September 1982 showed that placement had been averted in 88% of the cases". Other studies have shown mixed results. Feldman (1991), for example, evaluated the impact of IFPS in five New Jersey locations, and concluded that IFPS families had fewer children placed, and they entered placement more slowly than control group children from the time of intervention to one year after termination. However, he noticed that the effects of treatment dissipated after nine months, and comparison figures at 12 months were not significant. In posttests, IFPS families scored significantly higher than control group families only on two of the 18 scales used to assess family functioning. Differential outcomes in child placement rates between IFPS and control families were not significantly related to family characteristics but to factors like the minority status of the families, previous referral to crisis intervention units, poor parenting, and presence of emotional problems in the child.

Analyzing recent studies conducted in New Jersey, California, and Minneapolis, Wells & Biegel (1992) concluded that IFPS did in fact prevent or delay the imminent placement of about half of the children who were truly at risk of placement. However, they also concluded that the effects of intensive family preservation were not long lasting; and that families were still vulnerable after service termination.

A related study was presented by Nelson (1990) who looked at family characteristics, service characteristics and case outcomes in 159 families who received family based services. She found that, at the termination of IFPS, 71% of the families previously referred for delinquency and 80% of the families previously referred for status offenses remained intact. Significant factors related to preventing placement included the participation (attendance at sessions) by the child at risk, and the primary caretakers' involvement in setting treatment goals. Outcomes were influenced also by factors like the workers' confidence in treating parent/child and marital conflicts, and by family structure, namely, two-parent or male-headed households had better outcomes.

The early studies to assess the outcomes of the IFPS had significant limitations such as lack of control groups, making it difficult to attribute outcomes to treatment efforts. Wells & Biegel, (1992), summarized these limitations in these words: data collection procedures were inconsistent, or were not articulated, and reliability of measures was not addressed; the "flow" of subjects through studies was described poorly; evidence of change rested on single-variable analyses; and effects of statistical regression were not taken into effect. These authors also commented that subsequent research, using quasi-experimental designs, and examining multiple outcomes and client-treatment correlates of success, demonstrated that factors associated with success in intensive family preservation services differed for different types of families.

Issues related to instrumentation of success of IFPS were raised by several authors. Many professionals began to question prevention of placement as the sole criterion of the success of IFPS and consequently other measurements were included in the evaluations, such as overall family functioning. Jones (1991) also discussed sensitivity to change in evaluating IFPS, specifically as to whether instruments might be so finely calibrated that they show very small change to be greater than it is, or so broadly calibrated that significant change hardly shows. For example, the Family Risk Scales (Magura, Moses & Jones, 1987) have a ceiling of "adequate". However, the "inadequate" side of the scale is more often underdeveloped. On items that have a floor of "adequate," families that do not reach it will not show any change. The same author, citing Gap (1966), discussed six dimensions of change: (1) occurrence, (2) direction, (3) magnitude, (4) rate, (5) duration, and (6) sequence. He argued that IFPS outcome studies must be concerned with at least the first three. The last three, which provide a picture of the dynamic quality of change, are rarely attempted in evaluation studies because of time, money and technology constraints. Further he argued that the nature of the changes that occur in families are more complex and dynamic than the existing measures (Jones, 1991).



Wells and Biegel also identified several future research agenda, including the following: assessment of the degree to which IFPS achieve therapeutic and policy goals; study of maintenance of gains made over time, which ultimately will answer questions as to what child, family, and community characteristics are associated with the maintenance of outcomes over time; evaluation of the impact of the ecological context on IFPS programs in order to understand which factors impede, and which facilitate, the faithful replication of services in various contexts; understanding of when are aftercare services needed to maintain gains made in treatment, and how do these impact the costs of IFPS; process evaluations which examine the underlying clinical assumptions of programs and treatment models; ethnographic studies to explore clients' experiences in IFPS programs; comprehensive evaluations of family functioning at service termination; assessment of the configuration of problems and personal characteristics that will define who can be best served by IFPS in order to extend IFPS to those who will benefit the most and to arrive at a balance between intensive and non-intensive services.

This article discusses research that addresses many of these concerns. The research as presented here is part of a longitudinal panel study designed to collect data for ten years. Current data represents the first year of this study. Currently we are beginning the fourth year of data collection. The focus of this study goes beyond the placement rates. It also addresses the issue of the functioning level of the families served. The primary questions to be answered are: 1) What is the rate of prevention of placement?, 2) What impact did IFPS have on family risk levels?, and 3) What impact did IFPS have on child well-being?

This study is presently being undertaken in the state of North Dakota in order to assess the efficacy of current IFPS efforts offered under the auspices of the North Dakota Department of Human Services. North Dakota currently has IFPS available for at risk families in nineteen counties of the 53 counties. While the program has been functioning for several years, there have been no attempts to evaluate these programs prior to this investigation. The Division of Children Services, North Dakota Department of Human Services, contracted with the Child Welfare Research Bureau at the Department of Social Work, University of North Dakota to evaluate the IFPS programs functioning in North Dakota.

## Methodology

The study evaluates the IFPS services being provided by five IFPS agencies in three communities. One agency used the Home Builders model of intensive family preservation. It is a highly concentrated, home-based service available for roughly a month to parents and their children on the verge of family dissolution. This flexible approach utilizes individual, professionally trained social workers to identify and address a limited number of crucial

problems for only two families at a time (more information can be found in Haapala and Booth (1991) and Frasher, Pecora, and Haapala (1990)). Families served by this model were seen 11 to 20 times a month. The clinical interventions utilize social learning theory as the basis for the intervention. Three agencies employed the Iowa model, a home-based model, with therapists seeing families for an average of 4.5 months (Nelson et. al., 1990). Families were seen seven to ten times a month, 57% of the time, three to six times a month, 23% of the time, and 11 to 20 times a month, 20% of the time. Treatment was primarily the use of family systems theory to focus on the entire family, the subsystems within it and its interactions with the family unit and with the community (Lloyd and Bryce, 1984). The fifth agency used two models of intervention: the Iowa model, as discussed above, and a court intervention model. The Court Intervention model uses a family therapist and a paraprofessional to work with the family using a two stage approach. In stage one there is mainly advocacy, parent education, community intervention, crisis management, and communication skills being focused on. In stage two, the family therapist follows up in the home to strengthen the work of the crisis intervention stage (Christofferson, 1991). Families were seen seven to ten times a month, 75% of the time, three to six times a month, 19% of the time, and 11 to 20 times a month, 6% of the time.

Using a one group pretest-posttest design, the study proposed to evaluate the extent to which intensive family based services in North Dakota affect positive family functioning and preservation. The population for this study is those families being served by intensive family based programs in the state of North Dakota. The study sample was selected from counties served by five IFPS services. All these families meet similar "intake" criteria for service. This criteria was loosely defined as "imminent - at risk of placement". The five IFPS sites were selected by Department of Human Service officials for their logistics (proximity) and representativeness (rural and urban). The sample for the present study consists of 87 families, the primary unit of observation, who received IFPS from five agencies who provided services in 12 counties of the state of North Dakota. The sponsored state agency invited the provider agencies who provide IFPS in North Dakota to participate in this study. Each IFPS worker was required to complete a comprehensive instrument, designed by the Child Welfare Research Bureau, for each of their families at the beginning and at termination of the services. The IFPS workers were provided training in scoring the evaluation instrument which included the Magura scales discussed below by the authors. Follow-up training is provided yearly. The authors were also available for clarification questions from IFPS workers when requested. The families were also informed that a follow-up will be needed to be completed six months after termination. Completed instruments were sent to the project director at the Bureau.

Prevention of placement was measured by tabulating placement data. In order to assess family risk and status of child well-being in the sample families two scales, additionally, family risk and child well-being scales were used. The *Family Risk Scale*, originally designed by Magura, Moses & Jones in 1987, is a 25-item scale that measures a child's risk of entering foster care. The items have four to six levels that range from adequacy to increasing degrees of inadequacy



on the dimension being measured. A factor analysis conducted by Magura and Moses established three terminal factors labeled parent-centered risk, child-centered risk, and economic risk. The alpha coefficients for these subscales were .88, .83, and .78 respectively indicating moderately high levels of internal consistency of scale. The IFPS worker recorded his/her assessment for each of the dimensions. The risk at the beginning and at the termination of IFPS was compared using a paired t-test.

**The Child Well-Being Scale:** The child well-being was measured by using the Magura Child Well-Being Scales (Magura and Moses, 1986). These scales measure a family's position on forty-four separate items completed by IFPS workers. The measurement levels for each of the forty-four scale items ranged from 1 to 6. While all scales had a low value of 1, upper values varied between 3, 4, 5, and 6. A value of 1 indicated absence of severity condition and a high value of 3 through 6, depending upon scale items, represented the existence of serious conditions. The scales were repeatedly used in the study at the beginning and at the termination of IFPS. These scales also have three factor dimensions accounting for 43% of the common variance of the individual scale scores. The three factors are household adequacy, parental disposition, and child performance. The factors have alpha coefficients of .88, .86, and .53 respectively. The overall reliability coefficient of the child well-being scale is .89 (Magura & Moses, 1986). Socio-economic and demographic data were also gathered from the sample respondents. Results are highlighted in the section below.

## Findings

### Demographic Characteristics of the Population Utilizing IFPS

A majority (63%) of the sample families came from small communities with populations under ten thousand (Refer to Table 1). Fifty-six percent of the primary caretakers and sixty two percent of the secondary caretakers were female. The average age of the primary caretaker was thirty-seven. Thirty-six percent of the sample families had only one caretaker. Forty-seven percent of the sample primary caretakers were married and living with their spouses. A large majority (78%) of primary caretakers were Caucasian. The Native American population represented seventeen percent of the primary caretakers. The average education level of the primary caretakers was twelve years of schooling. About three percent of the primary caretakers had over sixteen years of education. Over 52% of the primary caretakers were employed full-time, and 29% were unemployed.

There was a total of 255 children in the 87 sample families (Refer to Table 2). Sixty-eight percent of their children were listed as Caucasian and 25% Native American. A large majority (76%) of the children had an education between 0 and 8 years and most (87%) were biological

children of the primary caretaker. Twenty-two (10%) of the children in the sample had been previously placed in a temporary facility. All the children were identified as at risk. About one third of them were classified at high risk for placement.

There were 87 referrals received from the five referral sites. Forty-five percent were referred by the court system and 42% were referred by public social service agencies. The two primary referral reasons were adolescent conflict (24%) and status offenses (18%).

### Impact of IFPS Programs on the Functioning of Families Served

Table 3 gives the results of the t-test analysis of the family risk scale items. In general, results indicate a reduction in family risk at the termination of IFPS. The results are statistically significant ( $t=5.29, p=.000$ ). However, only two of the three factors of the risk scale that related to parent centered risk and child centered risk showed significant change. Specifically, differences in 6 of the 11 parent centered risk items of the scale registered statistically significant improvement. The items are parent's mental health, parent's knowledge of child care, parental motivation to solve problems, verbal discipline, supervision of teenage children, and use of physical punishment. Statistically significant improvement of child related risk was noted in five of the six items of the scale such as emotional care and stimulation of children under age two, child's mental health, home-related behavior, school adjustment, and delinquent behavior. The third factor of the risk scale, the economic risk, did not show any significant change as a result of the IFPS.

Table 4 gives the results of the t-test analysis of the Child Well-being Scale items. In general, results indicate an increase in child well-being at the termination of IFPS. The results are statistically significant for two of the three factors related to child well-being.

The 44 item Child Well-Being Scales (CWBS) found in the table had a score distribution of a low of 74, a high of 98 in the pretest, and a mean of 89 (s.d.=5). The posttest mean score was 91 (s.d.=7). For analysis purposes, CWBS scores were collapsed into three categories, namely 'inadequate' (scores less than 70), 'less than adequate' (70 to 89), and 'adequate' (90-100). No families received inadequate scores in the pretest. However, in the posttest, two percent of the cases received inadequate scores. On the other hand, there were far more families receiving adequate scores in the posttest compared to the pretest (58% versus 43%). The mean difference was statistically significant.

Parental Disposition (PD) is a fourteen item composite scale that measures the adequacy of mental health care, parental capacity for child care, parental recognition of problems, motivation to solve problems, affection for children, expectations of children, protection from abuse,



abusive physical discipline, and the threat of abuse. The PD scores had a distribution of 65 to 100 at pretest and 60 to 100 at posttest. The mean scores were 82 (s.d.=9) and 87 (s.d.=10) for pretest and posttest respectively. The difference was statistically significant.

The Child Performance (CP) subscale is a composite score of four items. The items include adequacy of education, academic performance, school attendance, and children's misconduct. The CP scores had a distribution of 59 to 100 at pretest, and 47 to 100 at posttest. The mean scores were 87 (s.d.=11) and 89 (s.d.=11) for pretest and posttest respectively. The difference was statistically significant.

The Household Adequacy scale is a factor dimension consisting of 10 items extracted from the original 44 items. This scale measures the adequacy of basic household needs such as food, clothing, housing, utilities, furnishings, sanitation, physical safety in home, and money management. The score distribution was 75 to 100 for pretest and 77 to 100 for posttest. The mean scores at pretest and posttest remained the same at 97 (s.d.=5), indicating no significant statistical differences. This finding theoretically is consistent with the lack of change in the economic risk of the client families.

The final paired t-test analyses involved testing the pre and posttest differences between each of the 44 pairs of items. Results indicate that only 12 of the 44 pairs of items were significantly different between pretest and posttest.

Apart from the above statistical information, the workers were asked to report about the overall success of IFPS. They reported that 86% of the families they worked with were successful somewhat or "definite" at meeting case objectives. In only five percent of the families was no change reported. Workers reported that families stayed together 74% of the time at case termination.

## Conclusions

The study indicates that after the intervention of IFPS services, significant changes were found in parent-centered risk and parental disposition, and child-centered risk and child performance. No changes were found in economic risk and household adequacy.

As a result of IFPS, parents' mental health, knowledge of child care, motivation to solve problems, supervision of teenage children, constructive verbal discipline, affection, child's mental health, school adjustment, and home-related behavior improved significantly. Use of physical punishment, sexual abuse, and delinquency significantly decreased.

The overall level of child well-being increased significantly. This improvement is related to positive changes in meeting the child's physical, psychological, and/or social needs. Although the t-tests yielded non-uniform results across the scales and subscales, it can be safely concluded that on an average family preservation services examined in this study had positive outcomes on family functioning. Results show that the overall child well-being status was higher at posttest. Changes were observed in the performance level of the children. These changes also indicate that the programs had positive impacts on parental disposition and child performance. This study has also identified with higher specificity the dimensions of family functioning that are amenable to positive outcomes by the currently provided services. There was no change in the household adequacy dimension which measures basic needs such as food, clothing, housing, utilities, furnishings, sanitation, physical safety in the home, and money management. This does not come as a total surprise given the fact that most families scored high on this scale in the pretest. However, further investigation into the impact of economic risk may be indicated.

The results of this research have program implications. The question to be asked is "Do we continue family preservation programs in the state of North Dakota?" Although there is not enough data to answer the question, there are some positive indicators. It appears, in general, that the interventions made by IFPS workers are having a positive impact on the functioning of the families served. At this juncture, it seems reasonable to recommend continued use of the IFPS model for intervention with families at risk of disintegration.

For further validation of this model, it is necessary for longitudinal data to verify its efficacy. This study, as presented, looks at the pre- and posttest results gathered during the first two years of the study. Data will continue to be gathered at yearly intervals for a period of ten years. Future analysis of the data include the interaction of demographic characteristics to family outcomes; the relationship between actual length of the intervention and family functioning; and the relationship between stress and family functioning.



Table 1  
Demographic Information of Caretakers

Demographics	Primary Caretaker n=87	%	Secondary Caretaker n=5	%
<b>Gender</b>				
Male	38	43.7	21	38.2
Female	49	56.3	34	61.8
<b>Age</b>				
20-29	8	9.6	7	14.0
30-39	52	62.7	32	64.0
40-49	17	20.5	8	16.0
50-59	5	6.0	3	6.0
60 and over	1	1.2	N/A	N/A
<b>Marital Status</b>				
Never married	5	5.7	1	1.8
Married-living with spouse	41	47.1	42	76.3
Living with significant other	3	3.5	3	5.5
Separated	10	11.5	4	7.3
Divorced	25	28.7	5	9.1
Widowed	3	3.5	N/A	N/A
<b>Ethnic background</b>				
Caucasian	68	78.2	44	80.0
Black	2	2.3	1	1.8
Hispanic	2	2.3	N/A	N/A
Native American	15	17.2	9	16.4
Asian/Pacific Islander	N/A	N/A	1	1.8
<b>Years of Education</b>				
0-8	4	5.4	1	2.2
9-12	46	62.2	24	52.2
13-16	22	29.7	21	45.6
Over 16	2	2.7	N/A	N/A
<b>Employment</b>				
Unemployed-not available to work more	18	21.0	6	11.1
Unemployed-available to work more	7	8.1	3	5.6
Seasonal work	3	3.5	2	3.7
Part time-available for more work	7	8.1	3	5.6
Part time-not available for more work	6	7.0	5	9.2
Full time	45	52.3	35	64.8

Table 2  
Demographic Information of Children in the Sample Families

Demographic	n=255	%
<b>Age</b>		
0-6	41	16.1
6-12	103	40.4
13-19	111	43.5
<b>Ethnic background</b>		
Caucasian	172	67.7
Black	8	3.1
Hispanic	7	2.8
Native American	64	25.2
Asian	1	.4
Other	2	.8
<b>Years of Education</b>		
0-8	185	75.5
9-12	58	23.7
13+	2	.8
<b>Relation of children to primary caretaker</b>		
Biological child	214	86.6
Adopted child	12	4.9
Stepchild	15	6.1
Grandchild	3	1.2
Ward	1	.4
Sibling	2	.8
<b>Previous placements</b>		
No previous placements	179	78.2
Emergency foster home - less than 3 months	22	9.6
Foster home - over 3 months	15	6.5
Group/residential/institution - over 3 months	9	3.9
Foster & group homes - over 3 months	4	1.8
<b>Risk of placement</b>		
Low risk	119	51.5
Moderate risk	32	13.8
High risk	75	32.5
In temporary placement	5	2.2



Table 2 -- continued  
Demographic Information of Children in the Sample Families

Demographic	n=255	%
<b>Origin of referral (n=87)</b>		
Court System	39	45.0
Public Social Service Agencies	37	42.0
<b>Reason for referral (n=87)</b>		
Adolescent conflict	21	24.0
Status offenses	16	18.0

Table 3  
Family Risk at the beginning and at the end of IFPS

Family Risk Scale Factors & Items	Pretest Mean	Posttest Mean	T- Value
<b>Family Risk (25 items)</b>	1.74	1.56	***5.29
<b>Parent-centered risk (11 items):</b>	1.90	1.65	***5.93
Adult relationships	2.23	2.05	1.31
Parent's mental health	2.11	1.89	*2.29
Parent's knowledge of child care	2.02	1.71	***3.47
Parent's substance abuse	1.41	1.38	0.18
Parental motivation to solve problems	2.02	1.78	*2.50
Verbal discipline	2.16	1.74	***4.35
Parental cooperation	1.38	1.35	0.53
Preparation for parenthood (adult)	1.83	1.33	1.46
Supervision under age 10	1.74	1.61	0.87
Supervision of teenage children	2.17	1.74	***4.55
Use of physical punishment	1.70	1.40	***3.60
<b>Child-centered risk (6 items):</b>	2.07	1.81	***4.21
Emotional care under age 2	1.90	1.66	**2.92
Attitude to placement	1.49	1.35	1.26
Child's mental health	2.11	1.89	*2.29
Home-related behavior	2.37	2.14	*2.03
School adjustment	2.53	2.25	*2.09
Delinquent behavior	2.04	1.56	***3.58
<b>Economic risk (4 items):</b>	1.19	1.20	0.62
Habitability of residence	1.10	1.10	0.00
Suitability of living conditions	1.06	1.08	-1.00
Financial problems	1.50	1.53	-.63
Physical needs of child	1.13	0.57	0.57

p = \* = < .05  
 \*\* = < .01  
 \*\*\* = < .00



Table 3 — continued  
Family Risk at the beginning and at the end of IFPS

Family Risk Scale Factors & Items	Pretest Mean	Posttest Mean	T- Value
Scales not assigned to factors (4 items):			
Family social support	1.83	1.71	1.31
Parent's physical health	1.27	1.27	0.00
Sexual abuse	1.38	1.10	*2.32
Child's physical health	1.29	1.23	1.27

$p =$  \* = < .05  
 \*\* = < .01  
 \*\*\* = < .00

Table 4  
Child Well-Being Scales

Child Well-Being Scale	Pretest Mean	Posttest Mean	T- Value
<b>Child well-being scale (44 items)</b>	<b>88.8</b>	<b>90.9</b>	<b>***-3.37</b>
<b>Parental disposition (14 items):</b>	<b>82.3</b>	<b>86.8</b>	<b>***-4.32</b>
Children's adequacy of mental health care	88.9	93.9	-1.95
Parental capacity for child care	88.6	88.8	-.10
Parental recognition of problems in the family	68.9	78.8	** -3.26
Parental motivation to solve problems	76.4	80.9	* -2.20
Parental cooperation with case planning	86.9	87.0	-.04
Parental acceptance of children	80.6	82.9	** -3.10
Parental approval of children	82.9	87.3	** -2.97
Parental expectations of children	81.1	97.6	***-3.39
Parental consistency of discipline	80.5	87.4	***-3.50
Teaching/stimulating children	85.7	87.0	-1.09
Protection from abuse	85.0	92.5	-1.79
Abusive physical discipline	87.9	65.1	* -2.40
Threat of abuse	89.8	94.7	** -2.73
Parental relationship with children through	77.6	85.2	***-3.52
<b>Child performance (4 items):</b>	<b>86.5</b>	<b>88.5</b>	<b>-1.73</b>
Adequacy of education	94.8	93.4	.86
Academic performance	86.2	86.1	.14
School attendance	91.6	92.2	-.45
Children's misconduct at home, school, and community	71.8	80.9	***-3.34
<b>Household adequacy (10 items):</b>	<b>97.0</b>	<b>97.0</b>	<b>N/A</b>
Nutrition/diet	93.6	95.3	-1.28
Clothing	98.9	98.9	.00
Personal hygiene	98.2	98.5	-.57
Household furnishings	97.6	98.8	-1.52

$p =$  \* = < .05  
 \*\* = < .01  
 \*\*\* = < .00



Table 4 – continued  
Child Well-Being Scales

Child Well-Being Scale	Pretest Mean	Posttest Mean	T-Value
<b>Household adequacy (10 items): (continued)</b>			
Overcrowding	96.9	96.4	.52
Household sanitation	97.6	97.6	-.09
Security of residence	99.0	98.7	.35
Money management	97.1	97.6	-.36
<b>Scales not assigned to factors (16 items):</b>			
Physical Health Care	98.6	98.7	-.12
Supervision of younger children	87.5	88.3	-.27
Supervision of teenage children	81.5	88.3	*-3.82
Arrangement for substitute child care	96.1	95.2	.67
Parental relations	67.3	71.5	-1.39
Continuity of parenting	90.8	92.1	-.77
Support for principal caretaker	90.5	91.4	-.27
Availability/Accessibility of services	91.9	90.9	.72
Deliberate deprivation of food/water	99.6	99.2	.57
Physical confinement or restriction	97.4	99.0	-1.24
Deliberate "locking-out"	99.2	98.0	.96
Sexual abuse	88.6	95.2	-1.61
Person committing sexual abuse	53.5	45.8	.40
Economic exploitation	98.7	99.0	-1.15
Coping behavior of children	69.0	72.3	-1.31
Children's disabling conditions (physical and emotional that could hamper with normal role functioning of children)	70.7	77.8	*2.22

p = \* = < .05  
 \*\* = < .01  
 \*\*\* = < .00

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Institutionalizing intensive family  
preservation services:  
A strategy for creating staffing  
standards based on projections of  
at-risk children from referral sources

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Abstract

In spite of new legislation and much public and professional interest, intensive family preservation service (IFPS) remains in a vulnerable position as compared to other child welfare services. This article details a method to project ideal IFPS caseloads as a function of children who are at-risk for placement by various referral sources. Using this approach, resource allocation for IFPS can be more nearly on equal ground with the traditional child welfare functions and help IFPS to assume its needed place as a core service in the child welfare continuum.



Kammerman and Kahn (1990), in their important critique of child welfare in the United States, concluded that in spite of all the pioneering efforts and validating research, intensive family preservation services (IFPS) exist largely as attractive project add-ons. Kammerman and Kahn made institutionalizing such services a primary recommendation for improvement of the child welfare field in the 90s:

Successful and important innovation needs to be institutionalized. Clearly, the idea of an intensive, family-focused, short-term, goal-oriented, clinical intervention has proven itself within the child and family service system... It is now appropriate to make it accessible, available as needed, offered as a standard part of the system response repertoire. (pp. 160-161)

Without such institutionalization, even very successful IFPS projects and services are highly vulnerable to elimination in the face of rising protective service or foster care caseloads or other administrative pressures. Over the past few years, some jurisdictions have reduced child welfare services to the bare minimum of investigating allegations of neglect or abuse and making out-of-home placements (Kammerman & Kahn, 1990). This has undoubtedly occurred because rising caseloads have not been matched by increases in funds for staff, and therefore, all available social work positions have been used to cover what administrators considered to be the most basic service functions. While administrators may justify such staffing decisions in terms of short-term economics, the long range outcome of reducing or eliminating preventive family-based services may well be even larger increases and greater public expense for maintaining children in substitute care. This is in addition to the more subtle costs to the children and families where unnecessary child removal and placement has occurred (D. W. Nelson, 1991).

Recent formal evaluations of IFPS have not provided unanimously positive results (see, for example, Rossi, 1991). However a number of studies suggest that when careful attention is given in the process of program design to targeting these services to families with children at immediate risk of placement out-of-home, many children can be diverted from placement and remain safely at home (Auclair & Schwartz, 1986; Feldman, 1991; Forsythe, 1992; Fraser, Pecora, & Haapala, 1991; Jones, Neuman, & Shyne, 1976; Kammerman & Kahn, 1990; Nelsen, 1985; K. E. Nelson, 1991; Nelson & Landsman, 1992; Szykula & Fleischman, 1985; also see Feldman, 1990 and Tracy, 1991, for discussion of the targeting issue). When implemented under these conditions, IFPS also appear to be cost effective for child welfare agencies (D. W. Nelson, 1991). In spite of these conclusions, these services remain in a vulnerable position in relation to other child welfare services, especially (and paradoxically) in the face of budget shortages and rising caseloads.

As a means to institutionalize and strengthen the position of preventive home-based services in child welfare, a stronger legal mandate for these services by federal and state governments has been advocated (Hardin, 1992). A number of states have passed legislation giving a statutory basis for family preservation services (Smith, 1991), and the recent passage of The Family Preservation Act by the U. S. Congress provides a federal mandate for such services. However, another strategy would also seem to be required in order to provide an adequate basis for establishing these services as universal components of child welfare systems. This second strategy is to define what constitutes appropriate and necessary levels for IFPS staffing for a given child welfare service population. Only in this way can IFPS begin to reach its full potential to contribute to the well-being of children and families within the child welfare service continuum.

Defining standards for service and staffing levels for IFPS may require a more complex analysis than for traditional child welfare services. For the latter, adequate staffing levels can be addressed directly by applying a caseload standard to the number of cases the office or program is required to handle. Protective investigation service is illustrative of such a program, where the numbers of referrals are almost entirely independent of staff activity, and readily define the caseload size. Efforts to screen for inappropriate referrals, to do public education and make more people aware of the service or understand its appropriate usage, etc., might make small differences in the overall numbers of investigations needing to be performed. However, the bulk of protective investigations come at the volition of parties totally outside of control of the staff of protective services programs. At best, only a limited proportion of referrals may be identified as not requiring a staff response. Therefore, the appropriate and necessary staffing level for protective investigation workers may be accurately calculated when the number of investigations to be performed within a time period is known and a caseload standard exists for number of investigations that a single worker can handle over a specific span of time. For example, using a caseload standard of 12 investigations a month, an office averaging 1000 child protective referrals a year should have about 7 investigation full-time equivalent (FTE) staff positions ( $1000/12 \text{ cases}/12 \text{ months} = 6.94$ ) for this function.

Likewise, the number of children carried in substitute care is a relatively accurate determiner of the number of foster care workers needed. Even if the number of children in care can be reduced, for example, by working intently with permanency planning, the number of children remaining in care dictates the number of staff needed to supervise and service their placements. Similar to protective investigation, if the usual number of children in care in a given jurisdiction is known and if a caseload standard for that service exists, needed staffing levels can be determined. For example, using a caseload standard of 12 cases per worker, an office averaging 100 foster children in its caseload should have 8.3 foster care worker FTEs.

In contrast, the appropriate level of an agency IFPS caseload would appear to be dependent on several, more complicated, factors. Relying only on a simple caseload standard for IFPS tends



to make staffing levels a self-fulfilling prophecy. IFPS program staff have a considerable amount of control over the size of their caseloads, and tend to place emphasis on maintaining the integrity of the intervention by keeping caseloads low. IFPS programs may actively recruit cases or "screen in" families at lower levels of need or risk when referrals are low, and raise acceptance criteria, refuse to accept cases, or establish waiting lists when caseloads get high. Therefore, existing IFPS caseload numbers may have little relevance to service need, especially in an environment where the program is still in a developmental mode. The potential caseload level for a fully developed and staffed IFPS program would appear to be a function of the children at risk among each of the programs or parties that refer children for out-of-home placement, factored by IFPS acceptance criteria. In this kind of analysis, historical rates of children at risk and IFPS applicability for each program might be identified and applied to their total caseloads, in order to project the needed IFPS coverage for that source of referrals. The summation of the potential caseload from each individual service could serve as the overall case basis for projecting needed IFPS staff. To account for sources of referrals whose caseload figures are not readily available, these latter numbers might be projected as a proportion of at-risk cases where data are available. In summary, a base for projecting an ideal IFPS caseload for any jurisdiction should be a function of the accumulated totals, across all referring agencies or services, of the proportions of children in their caseload who are at-risk for out-of-home placement and appropriate for IFPS.

If portions of the IFPS referrals are received from parties outside of the domain of the IFPS agency and its caseload counting system, such as direct orders for services from a juvenile court, these referrals must also be factored into the ideal IFPS staffing projection. A simple method to estimate this segment of the IFPS caseload is to determine the proportion of the total caseload to arise from outside referrals, and then augment the total caseload projection by this percentage.

When the ideal IFPS caseload has been projected in this manner, then the number of IFPS staff necessary for the jurisdiction can be calculated. This is a simple matter of dividing the projected caseload by the agency IFPS caseload standard. In the remainder of this paper, a model application of these principles is described.

It should be noted that there are other practical implementation issues which may alter IFPS caseloads and required staffing levels, which this analysis does not specifically address, except that the model is adjustable for local policies and conditions. Some of these issues may be: the relative acceptance of IFPS by persons within the total agency structure or the presence of tensions and stresses between IFPS and other service functions; the clarity with which IFPS referral criteria have been defined and communicated by program instigators and the level of understanding and acceptance of these criteria by potential referral sources; and the effectiveness of mechanisms established for interrupting the child removal process to make the decision to refer cases for IFPS (K. E. Nelson, 1990; Pecora, 1990). Also, agreement does not exist with regard to caseload standards for IFPS. Caseload levels used by various IFPS

programs vary from as low as two cases at a time to ten or more, and targeted duration of services in various programs varies from as little as 30 days up to a period of six to nine months (K. E. Nelson, 1991; Pecora, 1991; also see Child Welfare League of America, 1989).

### A Model for IFPS Staffing

As an example of the staffing concepts suggested above, Figure 1 depicts a single integrated model (prepared in a spreadsheet environment). This particular model has been developed to project staff for an IFPS program housed within a public child welfare agency. A similar approach might also be useful to project the level of effort needed under a contract for IFPS services with outside providers.



Figure 1

## Intensive Family Preservation Services Staffing Levels Model

IFPS Caseload Standard:		24	Referrals Per Year		
IFPS Referral Sources	Proportion At Risk	Total Cases	Referral Criteria	Number of Cases At Risk	FTEs to Cover Cases At Risk
Within Agency Tracking System:					
Protective Investigation	0.078	968	Referrals Per Year	76	3.15
Protective Supervision	0.059	276	Cases Closed Per Year	16	0.68
Youth Services	0.006	380	Cases Closed Per Year	2	0.10
Foster Care (Reunification)	0.280	188	New Cases Per Year	53	2.19
Outside of Agency Tracking System:					
Proportion of Cases From Outside:			0.333	73	3.06
TOTALS				220	9.17

- Because of the rounding feature in the spreadsheet program used, figures displayed may not appear to calculate exactly.
- Shaded areas show data entry fields.

The right hand bottom line in Figure 1 supplies the projection for total IFPS staff needed. The shaded areas of the table show fields where data entry is required. The initial entry is the IFPS caseload standard. The simplest case is presented where a single standard is used for IFPS staff. The figure used in this case is 24 IFPS referrals a year. This number represents an average of two new cases a month per IFPS worker. This figure is the same as carrying an average caseload of 2 families with a 30 day time limit (the Homebuilders™ standard), or 4 cases with a 60 day term of service, or 6 cases for an average length of three months.

Four functions within the agency which refer cases for substitute care or IFPS are identified, namely, protective investigation, protective supervision, youth services, and foster care (for reunification). To be included in this segment of the model, all of these programs need to have caseload data available to IFPS program administrators. For each of these program areas, the proportions of their cases which are at risk for placement and amenable to IFPS are entered.

A caseload figure for each of the four program areas is also entered (yearly in this example). These caseload measures are defined in terms of the IFPS referral decision point for each service. In this example, child protective investigations come to IFPS from substantiated referrals. Protective supervision and youth services cases are referred at termination of these services. A portion of new foster cases are also identified as appropriate for IFPS as a reunification service strategy.

The final entry is a figure representing the proportion of cases from outside of the primary child welfare agency and its case tracking system. The entry is made to incorporate an IFPS service capability to respond to referrals for placement from sources which are outside the child welfare organization and tracking purview. For this example, the figure might take into account referrals from juvenile corrections, schools, mental health centers, self-referring families, etc. The entry of the figure .333 means that about one-third of the IFPS caseload is expected to come from these outside entities.

For the figures entered, a total of 220 families per year are projected to need services by IFPS per year. This caseload requires slightly over 9 full-time IFPS therapists for complete coverage. These figures are for direct service staff only and do not include supervisory and support staff. Supervisory and support staff projections should be able to be computed based upon general standards in existence in specific agencies when the number of direct service IFPS FTE positions is known.

This model for staffing allows for some flexibility in deciding the scope and targets of IFPS in a given jurisdiction. Figure 2 demonstrates how adjustments might be made which would result in a differing staffing projection, if, for example, some "down-sizing" in the program projection is desired. In this example, a decision is made to not provide IFPS to one of the potential in-house populations, the foster care reunification function. Additionally, agency leaders are



choosing to limit outside referrals to 20% of the total IFPS caseload. Under this delimitation, projections of the need for IFPS staff fall to about five direct service FTEs.

Figure 2  
Intensive Family Preservation Services Staffing Levels Model (Adjusted)

IFPS Caseload Standard: 24 Referrals Per Year					
IFPS Referral Sources	Proportion At Risk	Total Cases	Referral Criteria	Number of Cases At Risk	FTEs to Cover Cases At Risk
Within Agency Tracking System:					
Protective Investigation	0.078	968	Referrals Per Year	76	3.15
Protective Supervision	0.059	276	Cases Closed Per Year	16	0.68
Youth Services	0.006	380	Cases Closed Per Year	2	0.10
Foster Care (Reunification)	0.000	0	New Cases Per Year	0	0.00
Outside of Agency Tracking System:					
Proportion of Cases From Outside:			0.333	24	0.98
TOTALS				118	4.90

- Because of the rounding feature in the spreadsheet program used, figures displayed may not appear to calculate exactly.
- Shaded areas show data entry fields.

## An Application of this Model for Statewide Implementation of IFPS

The paper now reports the use of the model described above to define needed staffing levels for statewide implementation of IFPS, providing a rationale and method supporting institutionalization of these services at a level necessary to respond to all major populations known to contain children at high risk for substitute care placement. The agency is the Division of Family Services, which has responsibility for child welfare services for the Utah State Department of Human Services. The Division began to implement a brief home-based family preservation service in 1983 (Callister, Mitchell, & Tolley, 1986; Lantz, 1985) and has participated in a series of evaluations of these programs, e.g., the Family-based Intensive Treatment or FIT Project, and Utah Family Reunification Project (see Fraser, Pecora, & Haapala, 1991; Walton, Harlin, Fraser, Lewis, and Walton, 1993). In spite of the positive results reported in these evaluations, by 1991 the Division had not succeeded in achieving statewide implementation of IFPS. At this point in time, IFPS were available and well staffed, having solid local administrative support, in three of the four largest offices in the state. These three offices typically receive approximately 65% of the protective referrals and carry about 55% of the foster care caseload in the state. IFPS positions and funding had largely been obtained by these offices either from federal grants or by administrators reallocating staff and temporarily "shorting" existing services such as foster care. Over the past decade, some other offices had made limited attempts to use IFPS but these efforts had not found fruition in full-scale, enduring programs. While the organization for child welfare services in Utah is state-administered, local administrators have tended to have considerable flexibility in the delivery of non-mandated services. In the absence of a rationale and mandate for allocating staff for IFPS, and/or special funding for adding IFPS staff, and with heavy caseload pressures on existing staff, many administrators were unwilling to develop the service further.

In 1990 in connection with a broader effort within the Division to empower local office workers in program-related decisions, a family preservation services steering committee was organized. Made up largely of representative direct service IFPS staff and supervisors, this group began to explore ways to encourage more widespread implementation of IFPS, including ways to define best-practice levels of staffing for each office across the state. With or without a more specific statutory mandate, a rationale for defining needed levels of IFPS staff was thought to be able to provide a basis for either justifying added positions or for reallocation of existing child welfare staff, to support full statewide implementation of the program.

The analysis that follows evolved out of concerns of the steering committee. It is highly dependent on two types of information, (1) statistical information on child welfare services from across the state and from the offices where IFPS had been successfully implemented, and (2) practical field experience and judgments of persons on the IFPS steering committee. Following the process outlined earlier in this paper, an IFPS staffing standards model was developed to include (1) major sources of referral for IFPS, where data were available regarding caseload



counts and proportions of cases generating IFPS referrals, and (2) a factor for outside referrals. Major sources of IFPS cases from within the Division were identified from worker reports in the Home-Based Module of the USSDS management information system as child protective investigations (CPS), protective supervision, youth services, and foster care (for reunification service). Detailed figures for the initial model, providing projections for region offices, regions, and the entire state, are shown in Table 1. The following paragraphs describe the basis for estimating IFPS referral rates and other assumptions involved in the applying the model to each individual referral source.

Table 1  
Staffing Standards Model for Intensive Family Preservation Services

REFERRAL SOURCES:		CPS		Protective Supervision			Youth Services		
REGION			FTEs for CPS Cases At-Risk			FTEs for In-Home Cases At-Risk		FTEs for Youth Svc. Cases At-Risk	
OFFICE	Total Subst. Refris.	Cases At-Risk		Total Cases Closed	Cases At-Risk		Youths Served	Cases At-Risk	
% CASES AT-RISK:		7.8%			5.9%			0.6%	
Central									
CA	553	43.4	7.2	72	4.3	0.7			0.0
CB	6	0.5	0.1	2	0.1	0.0			0.0
CC	201	15.8	2.6	25	1.5	0.2	1126	6.8	1.1
CD	37	2.9	0.5	13	0.8	0.1	4	0.0	0.0
Subtotal	797	62.5	10.4	112	6.7	1.1	1,130	6.8	1.1
Eastern									
EA	20	1.6	0.3	12	0.7	0.1	2	0.0	0.0
EB	15	1.2	0.2	2	0.1	0.0	3	0.0	0.0
EC	7	0.5	0.1	5	0.3	0.0	1	0.0	0.0
ED	29	2.3	0.4	5	0.3	0.0	13	0.1	0.0
EE	15	1.2	0.2	18	1.1	0.2	15	0.1	0.0
EF	18	1.4	0.2	15	0.9	0.1	11	0.1	0.0
Subtotal	104	8.2	1.4	57	3.4	0.6	45	0.3	0.0
Northern									
NA	29	2.3	0.4	6	0.4	0.1	31	0.2	0.0
NB	104	8.2	1.4	16	1.0	0.2	29	0.2	0.0
NC	39	3.1	0.5	13	0.8	0.1	23	0.1	0.0
ND	132	10.4	1.7	23	1.4	0.2	74	0.4	0.1
Subtotal	304	23.8	4.0	58	3.5	0.6	157	0.9	0.2

\* Case counts are for services completed April 1 through June 30, 1991. Caseload standard is six new IFPS cases per three month period per FTE worker.

† Calculations were performed on electronic spreadsheet program, with extended numbers of decimals, and formatted (rounded) to one decimal for display purposes. Therefore, some columns will not appear to add exactly to the smallest decimal.

‡ Percent of cases at risk for the several referral populations is described in detail in the text.



Table 1 -- continued  
Staffing Standards Model for Intensive Family Preservation Services

REFERRAL SOURCES:		CPS		Protective Supervision			Youth Services		
REGION			FTEs for CPS Cases At-Risk	Total Cases Closed	Cases At-Risk	FTEs for In-Home Cases At-Risk	Youths Served	Cases At-Risk	FTEs for Youth Svc. Cases At-Risk
OFFICE	Total Subst. Refrals	Cases At-Risk							
% CASES AT-RISK <sup>c</sup>		7.8%			5.9%			0.6%	
Western									
WA	0	0.0	0.0	3	0.2	0.0			
WB	18	1.4	0.2	11	0.7	0.1	10	0.1	0.0
WC	3	0.2	0.0	5	0.3	0.0			
WD	2	0.2	0.0	0	0.0	0.0			
WE	4	0.3	0.1	3	0.2	0.0			
WF	1	0.1	0.0	0	0.0	0.0			
WG	0	0.0	0.0	1	0.1	0.0			
WH	1	0.1	0.0	0	0.0	0.0	1	0.0	0.0
WI	13	1.0	0.2	2	0.1	0.0	3	0.0	0.0
WJ	0	0.0	0.0	2	0.1	0.0			
WK	242	19.0	3.2	30	1.8	0.3	95	0.6	0.1
WL	6	0.5	0.1	4	0.2	0.0			
WM	33	2.6	0.4	8	0.5	0.1	76	0.5	0.1
Subtotal	323	25.3	4.2	69	4.1	0.7	185	1.1	0.2
Statewide Total	1,528	119.8	20.0	296	17.6	2.9	1,517	9.1	1.5

- \* Case counts are for services completed April 1 through June 30, 1991. Caseload standard is six new IFPS cases per three month period per FTE worker.
- b Calculations were performed on electronic spreadsheet program, with extended numbers of decimals, and formatted (rounded) to one decimal for display purposes. Therefore, some columns will not appear to add exactly to the smallest decimal.
- c Percent of cases at risk for the several referral populations is described in detail in the text.

Table 1 -- continued  
Staffing Standards Model for Intensive Family Preservation Services

REFERRAL SOURCES:		Foster Care (Runif.)		Other (Outside)		
REGION						
OFFICE	New Custody Cases	Cases At-Risk	FTEs for Reunif. Cases At-Risk	Cases At-Risk	FTEs for Outside Cases At-Risk	Esti. FTEs to Cover Total Cases At-Risk
% CASES AT-RISK <sup>c</sup>		28.0%				
Central						
CA	41	11.5	1.9	15.2	2.5	12.4
CB	1	0.3	0.0	0.2	0.0	0.2
CC	44	12.3	2.1	7.7	1.3	7.3
CD	3	0.8	0.1	1.2	0.2	1.0
Subtotal	89	24.9	4.2	24.3	4.1	20.9
Eastern						
EA	2	0.6	0.1	0.2	0.0	0.5
EB	0	0.0	0.0	0.1	0.0	0.2
EC	2	0.6	0.1	0.1	0.0	0.2
ED	17	4.8	0.8	0.3	0.0	1.3
EE	42	11.8	2.0	0.2	0.0	2.4
EF	7	2.0	0.3	0.2	0.0	0.8
Subtotal	70	19.6	3.3	1.2	0.2	5.4
Northern						
NA	3	0.8	0.1	0.3	0.0	0.7
NB	18	5.0	0.8	0.9	0.2	2.5
NC	12	3.4	0.6	0.4	0.1	1.3
ND	35	2.8	1.6	1.2	0.2	3.2
Subtotal	68	19.0	3.2	2.8	0.5	8.3

- \* Case counts are for services completed April 1 through June 30, 1991. Caseload standard is six new IFPS cases per three month period per FTE worker.
- b Calculations were performed on electronic spreadsheet program, with extended numbers of decimals, and formatted (rounded) to one decimal for display purposes. Therefore, some columns will not appear to add exactly to the smallest decimal.
- c Percent of cases at risk for the several referral populations is described in detail in the text.



Table 1 -- continued  
Staffing Standards Model for Intensive Family Preservation Services

REFERRAL SOURCES:	Foster Care (Runif.)			Other (Outside)		Esti. FTEs to Cover Total Cases At-Risk
	New Custody Cases	Cases At-Risk	FTEs for Reunif. Cases At-Risk	Cases At-Risk	FTEs for Outside Cases At-Risk	
REGION						
OFFICE						
% CASES AT-RISK <sup>c</sup> :	28.0%					
Western						
WA	0	0.0	0.0	0.0	0.0	0.0
WB	4	1.1	0.2	0.2	0.0	0.6
WC	2	0.6	0.1	0.1	0.0	0.2
WD	0	0.0	0.0	0.0	0.0	0.0
WE	5	1.4	0.2	0.0	0.0	0.3
WF	2	0.6	0.1	0.0	0.0	0.1
WG	0	0.0	0.0	0.0	0.0	0.0
WH	0	0.0	0.0	0.0	0.0	0.0
WI	2	0.6	0.1	0.1	0.0	0.3
WJ	0	0.0	0.0	0.0	0.0	0.0
WK	47	13.2	2.2	2.1	0.4	6.1
WL	1	0.3	0.0	0.1	0.0	0.2
WM	4	1.1	0.2	0.4	0.1	0.8
Subtotal	67	18.8	3.1	3.1	0.5	8.7
Statewide Total	294	82.3	13.7	31.4	5.2	43.4

- \* Case counts are for services completed April 1 through June 30, 1991. Caseload standard is six new IFPS cases per three month period per FTE worker.
- \* Calculations were performed on electronic spreadsheet program, with extended numbers of decimals, and formatted (rounded) to one decimal for display purposes. Therefore, some columns will not appear to add exactly to the smallest decimal.
- \* Percent of cases at risk for the several referral populations is described in detail in the text.

### Protective Investigation (CPS)

As defined in the Utah child welfare system, CPS involves assessing allegations of child abuse or neglect, and taking necessary actions to protect children in emergencies, within a 30 day period. The CPS at-risk rate of 7.8% of substantiated referrals was derived from the statewide placement custody rate (11.8%), excluding the Central Region, for children where abuse or neglect was substantiated for investigations terminated for the period April 1, 1991 through June 30, 1991, and reduced by a factor of .63 to account for those cases in which children had been abandoned or the threat was so severe that retention at home was not an option. Central Region cases were excluded from the analysis because a well-developed IFPS program was in place in that region. It was thought that the inclusion of Central Region cases might deflate the overall IFPS referral rate and produce a less than adequate picture of the level of staff needed. The .63 reduction figure was an estimate supplied by the panel of IFPS workers and supervisors, based on experience in screening protective cases for referral for family preservation and success rates with such referrals.

### Protective Supervision

Protective supervision provides oversight and low-to-moderate intensity casework services, to families with children at risk of abuse or neglect. Services may be either court-ordered or voluntary, depending on family motivation to accept services. Caseloads average about 20 families each. The protective supervision services at-risk rate of 5.9% was derived from the statewide rate of placement custody referral of protective supervision children at service closure for the period April 1, 1991 through June 30, 1991, excluding Central Region, and reduced by a factor of .63 to account for those cases in which family preservation was not an option. As above, the .63 figure was an estimate based on experience in screening protective cases for referral for family preservation and success rates with such cases. Central Region cases were again excluded from the analysis for the reasons given above.

### Youth Services

Youth Services are short-term crisis services to ungovernable and runaway youths and their families. The Youth Services at-risk rate of .6% was derived from the statewide rate of youth service referral for placement custody for the period April 1, 1991 through June 30, 1991, excluding Central Region, reduced by a factor of .28 to account for those cases in which family preservation was not an option. The .28 figure was an estimate based on experience in screening youth services for referral for family preservation and success rates with such cases.



### Foster Care (Reunification)

The Foster Care/Reunification Service rate of 28% is an estimate based on experience in screening cases for reunification services for the Reunification Project (see Walton et al., 1993). The figure represents those cases where the reunification of foster children with natural parents may be expeditiously achieved by intervening with an intensive family-based service. Cases deemed not appropriate included those where the child would be at serious risk if returned home, where the child was in a specialized treatment program of some duration, where the child had no parents, and where returning home was not a goal. The figure is conservative in that it assumes that no backlog of untreated long-term cases exists with the reunification service caseload derived from children newly referred into foster care.

### Other (Outside)

The Other (Outside) figure was projected from the combination of CPS, protective supervision, Youth Services, and reunification foster care figures. It was projected to increase FTE levels by one-third over these latter sources of referrals. Caseload figures for the outside referral sources were not available. The projection may be conservative based on current referrals served, and partially represents Central Region IFPS supervisors' intent to balance their program's response more toward inside-DFS clientele in contrast to outside referrals.

This level of staffing projects to the need for 43.4 direct service IFPS staff statewide. For the large offices that offer IFPS, the projections were slightly above but consistent with current staffing levels, providing some validation for the accuracy of the model.

### Simplified Family Preservation Services Staffing Formula

After defining the initial five referral source model, a simplified formula was also created using only CPS referrals as the base. This simplified formula generally approximates results obtained with the former model. This formula was designed to provide DFS administrators with a quick rule-of-thumb for projecting IFPS staffing needs by hand and for making communication with the general public and with legislators more understandable. The calculations for this simplified model are as follows:

$$4 \times 1528 = 6112, \text{ the number of substantiated CPS referrals projected to a full year's time}$$

$$6112/43.4 \text{ FTEs} = \text{the need for 1 IFPS FTE for every 140.8 substantiated CPS referrals, or}$$

$$140.8/42 \text{ (the rate of substantiation for referrals)} = \text{the need for 1 IFPS FTE for every 335.3 CPS referrals investigated yearly}$$

Another way to express these figures is that for every 1000 CPS referrals investigated yearly, there should be about three IFPS workers.

### Specific Staffing Implications

Information presented in Table 2 suggests particular areas of weakness in IFPS staffing across specific local offices, to be addressed when new funding and positions become available or by staff reassignment. In this table, actual IFPS FTEs are compared office-by-office against projections of numbers of staff needed using both the multi-sources and simplified models. The results of projections by the two models differ very little for most jurisdictions, with two exceptions: (1) Office CC, which services a large urban and inner city area, with high protective intake as compared to ongoing foster care cases, and has substantially higher projections on the simplified model; (2) Office EE, a rural office which has acquired a rather large Native American foster care caseload because of tribal court policies, and has a larger projection from the multi-source model.



Table 2

## Projected FTE Shortages for Family-Centered Services

REGION OFFICE	Total CPS Referrals <sup>a</sup>	Actual IFPS FTEs <sup>b</sup>	From Initial (Multi-Source) Standards Model		Using Simplified (CPS-Only) Standards Model		
			Projected FTEs Needed	FTE Shortage	Projected FTEs Needed	FTE Shortage	
Central							
CA	1087	9.9	12.4	2.5	13.0	3.1	
CB	5		0.2	0.2	0.1	0.1	
CC	956	6.1	7.3	1.2	11.4	5.3	
CD	79	1.1	1.0		0.9		
Subtotal	2,127	17.1	20.9	3.8	25.4	8.3	
Eastern							
EA	25	0.4	0.5	0.1	0.3		
EB	14		0.2	0.2	0.2	0.2	
EC	6	0.3	0.2		0.1		
ED	58		1.3	1.3	0.7	0.7	
EE	55	0.1	2.4	2.3	0.7	0.6	
EF	46	0.1	0.8	0.7	0.5	0.4	
Subtotal	204	0.9	5.4	4.5	2.4	1.5	
Northern							
NA	90		0.7	0.7	1.1	1.1	
NB	187		2.5	2.5	2.2	2.2	
NC	117	1.0	1.3	0.3	1.4	0.4	
ND	287	3.0	3.9	0.9	3.4	0.4	
Subtotal	681	4.0	8.3	4.3	8.1	4.1	

<sup>a</sup> Completed investigations April 1 to June 30, 1992.

<sup>b</sup> March 1992.

• Calculations were performed on electronic spreadsheet program, with extended numbers of decimals, and formatted (rounded) to one decimal for display purposes. Therefore, some columns will not appear to add exactly to the smallest decimal.

Table 2 -- continued

## Projected FTE Shortages for Family-Centered Services

REGION OFFICE	Total CPS Referrals <sup>a</sup>	Actual IFPS FTEs <sup>b</sup>	From Initial (Multi-Source) Standards Model		Using Simplified (CPS-Only) Standards Model	
			Projected FTEs Needed	FTE Shortage	Projected FTEs Needed	FTE Shortage
Western						
WA	10				0.1	0.1
WB	45		0.6	0.6	0.5	0.5
WC	8		0.2	0.2	0.1	0.1
WD	7			0.0	0.1	0.1
WE	12		0.3	0.3	0.1	0.1
WF	2		0.1	0.1		
WG	0			0.0		
WH	13			0.0	0.2	0.2
WI	20		0.3	0.3	0.2	0.2
WJ	0			0.0		
WK	414		6.1	6.1	4.9	4.9
WL	38	1.0	0.2	0.2	10.4	0.4
WM	108	1.0	0.8		1.3	0.3
Subtotal	677	1.0	8.7	7.7	8.1	7.1
Statewide						
Total	3689	23.0	43.4	20.4	44.0	21.0

<sup>a</sup> Completed investigations April 1 to June 30, 1992.

<sup>b</sup> March 1992.

• Calculations were performed on electronic spreadsheet program, with extended numbers of decimals, and formatted (rounded) to one decimal for display purposes. Therefore, some columns will not appear to add exactly to the smallest decimal.



Drawing conclusions from information supplied by both models, Table 3 presents a summary of projected need for additional IFPS staff. Projections for offices CA, CC, and ND add slightly to existing capabilities. A full unit of 5-6 staff is proposed for large urban office WK, with a 2-3 FTE unit established in moderate-sized sub-urban office NB. Other single FTEs are suggested for rural offices with a potential caseload size to justify a full-time position, or in the cases of the contiguous offices WI, WL, WC, and WD, a single FTE for the combined group. These additions should allow adequate staffing to provide IFPS to all the targeted at-risk populations across all areas of the state. This analytical approach provided the basis for the provision of funding of statewide IFPS implementation by the 1993 Utah State Legislature.

Table 3

## New IFPS Staff Needed By Location

Region and Offices	Added IFPS FTEs Needed
Central: CA/CC offices area	4-8 more FTEs total
Eastern: ED office EE office EF office	1 FTE 2 FTEs, with heavy emphasis on reunification 1 FTE
Northern: NA office NB office ND office	1 FTE 2-3 FTE unit 1 more FTE
Western: WB office WK office WI/WL/WC/WD offices area	1 FTE 5-6 FTE unit 1 FTE
TOTAL:	19-25 additional FTEs

## Conclusions

The availability of IFPS, as a full-fledged component of child welfare services in an agency, would appear to have important implications for the quality of services being provided. Without IFPS a public agency may well be unable to fulfill its mandate to use earnest and persistent efforts to prevent placement in foster care. Lack of IFPS resources may well result in higher foster care caseloads and costs, and unnecessary disruption of the lives of children and families through out-of-home placement. Ironically, one of the very situations that IFPS is designed to mitigate, e.g., increasing numbers of placements in foster care, may pressure some administrators to devote fewer staff resources to IFPS. In the absence of a firm criterion upon which to base staffing levels, IFPS remains vulnerable to reduction or elimination. These services may remain inadequately developed or never be initiated in the first place.

This paper has described a rationale for projecting required levels of IFPS staffing for an agency's child welfare service population. The use of these concepts may have important implications for the institutionalization of IFPS in child welfare agencies as a core service component. This model projects an ideal IFPS caseload as a function of the accumulated totals of the proportions of children across all referring agencies or services who are at-risk for placement and/or appropriate for IFPS. This approach provides a rational basis for agency administrators to seek necessary IFPS funding and positions, to restructure existing staff assignments to provide IFPS, or to protect an existing IFPS program if budgets tighten or overall child welfare caseloads rise. This approach may also begin to lay a foundation for achieving consensus on best-practice staffing of IFPS by national child welfare and IFPS standard setting bodies. Resource allocation for IFPS can be more nearly on equal ground with the traditional child welfare functions. All of this points the way for IFPS to assume its needed place as a core service in the child welfare continuum and to begin to realize its potential for revolutionizing the way that child welfare helps children and families.



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*Current  
Resources*



## Current Resources

*Kaplan, L., & Girard, J. L. (1994). Strengthening high-risk families: A handbook for practitioners. New York, NY: Lexington Books*

Reviewed by

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Lisa Kaplan & Judith Girard capture the essence of family preservation practice in this practical handbook. It is carefully authentic and buoyantly positive about families yet unabashedly direct in describing what must happen and what to avoid in serving them.

Its publication is timely, dealing directly with many issues raised by the federal Family Preservation and Support Act of 1993 (P.L. 103-66). As individual states respond to the planning mandates of the act, they would do well to become familiar with this solid base of information on the spirit and methods of family-centered practice.

True to the principles of family preservation, the authors approach the characteristics of high-risk families by describing five categories of their strengths, including resilience, wanting to keep their families together and to improve their lot, a healthy distrust of social service workers, and being natural experts on their own realities and needs.

The authors also describe how successful programs view and approach families. In "A Framework for Beginning Family Work," they establish the essential "differentness" of family



preservation practice -- full family focus, partnership with the family, a strengths perspective, and doable goals -- asserting that traditional social work training actually contradicts the philosophy of family preservation in some ways.

The section on "Treatment Strategies" is an exceptionally well-crafted and useful primer, isolating and succinctly describing the core of family preservation practice. In addition, they include important strategies and techniques which are often underestimated or overlooked, such as the potential of support groups as a significant component of family work.

The author's style may be carried too far, however, in regard to social learning theory and behavioral technologies. Together they are described in a single paragraph, while a systemic family counseling emphasis is threaded throughout the text. In consideration of the importance of skill-building to family empowerment and the number of therapists who come to family preservation untrained in basic skill-building, an increased emphasis seems justified.

Included as special topics are families with sexually abused children, HIV/AIDS, families who are homeless and families in transition to reunification. Child neglect, however, seems conspicuously absent from the list. The authors become most directive in their prescriptions for work with domestic violence and sexual abuse. Their treatment of both of these topics demonstrates professional depth in planning safety for highly vulnerable families. It is also encouraging to note that information and practice techniques relevant to cultural diversity merit an entire chapter as well as being woven throughout the text.

This book deals as forthrightly with the major issues in evaluation as in practice. It concludes that no other child welfare programs are held to standards of success as rigid as placement prevention in family preservation and asserts that success must be redefined, and evaluated within an ecological context.

For program designers the authors list obstacles and challenges to creating a service continuum based on the principles of family preservation. With sterling logic, they point out the irony that programs created to offer genuine flexibility to families may rigidly maintain caseload and time limits. "... as we note throughout this book, zealously holding to preconceived models nullifies the philosophical underpinnings of family preservation." Though many would concur with this observation, competition for resources, without safeguards, inevitably threatens the intensity of service which is necessary to address the needs of families at risk of placement.

The authors accurately presage the threats to the values and techniques of family preservation introduced by moving it into the mainstream "... the more mainstream a movement becomes, the more bureaucratic, compartmentalized, and professionalized it gets." They contrast it to the relatively new field of family therapy by noting that the family preservation movement "... still has no national leaders to champion its causes... there is an obvious paucity of books on family preservation... and (it) ... has not received much attention from academia."

At the same time, Kaplan and Girard join many in human services and government who have a grand vision for introducing the family preservation paradigm across disciplines. They mention juvenile justice, mental health, mental retardation, education and public health. Combining this vision with observations as to the need for leadership and resources suggests a dramatic role for education and training. However, the challenges of educating other professionals and meeting training needs are mentioned only briefly.

One could argue that the authors have attempted too much: historical retrospective, a design framework, treatment, evaluation and planning. This reviewer would argue that they have not. *Strengthening High Risk Families* is unmatched as a compilation of basic family preservation practice. It is useful, as well, in revealing how the rhetoric of infusion and integration sometimes moves beyond the realities of practice.

*Schuerman, J. R., Rzepnicki, T. L. & Littell, J. H. (1994). Putting families first: An experiment in family preservation. New York: Aldine de Gruyter.*

*Editor's Note: Given the level of discussion around this book, we've asked two colleagues to independently review it. Their response is as follows.*

#### Reviewed by

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The early optimism regarding family preservation services is increasingly being challenged by evaluative research that raises serious questions about their effectiveness in preventing out-of-home placement of "at risk" children. *Putting Families First* is the latest such study, conducted by a team of distinguished researchers from the Chapin Hall Center for Children at the University of Chicago. It consisted of an extensive and multi-faceted evaluation of the Illinois Family First initiative, a placement prevention program focusing on families officially reported for child abuse and neglect. The program was administered by the Illinois Department of



Children and Family Services, with services provided on a contractual basis by some 60 private agencies throughout the state.

The study design involved the following three phases: (1) collection of descriptive data on all Family First cases and programs; (2) an experiment testing program effectiveness, with cases randomly assigned to a Family First group or a control group receiving "regular" agency services; and (3) a longitudinal survey of parents in a representative sample of cases and programs, assessing the impact on child and family functioning. The findings indicated that family preservation services did not produce a significant effect on the risk of placement, subsequent maltreatment, child and family functioning, or case closings. In short, although the authors conclude that their message "is one of caution but not despair" (p. 229), the Family First program did not achieve its objectives, notably prevention of placement in out-of-home care.

What is one to make of these disappointing findings? To begin with, it is tempting to criticize the study on methodological grounds. Although the authors anticipate and reject such criticism, the study is flawed in a number of respects, as is typical of most program evaluations in the human services. For instance, the experimental variable (the nature of services) is inadequately defined and operationalized: within broad parameters, each agency defined what constitutes family preservation services. Also, the use of an experimental research design in the untidy world of practice may be questioned, as with previous experiments in such areas as juvenile delinquency, welfare dependency, and multi-problem families.

Despite these and other methodological limitations, Schuerman, Rzepnicki, and Littell make a substantial contribution by adding to the discourse on family preservation services and stimulating further debate regarding their nature, role, and effectiveness. They do so by providing an excellent critique of prior research; clearly delineating issues in the implementation and evaluation of family preservation programs; creatively adapting a variety of measures of child and family functioning; and thoughtfully considering directions for reform in child welfare, such as the importance of integrating the continuum of in-home and out-of-home services and merging placement prevention with family reunification (p. 247).

While direct service practitioners are likely to find the study of limited use in their work, administrators, policy-makers and researchers will find much of value. Above all, they will be challenged to reexamine their assumptions, clarify their ideas and expectations, and redirect their research and program development efforts toward more realistic goals. As an example, they will find an excellent discussion of the problem of targeting in family preservation --- that is, the often-used but largely inexact criterion of serving families with children "at imminent risk of placement".

In conclusion, *Putting Families First* provokes crucial questions: Should family preservation services be abandoned? Should evaluation of family preservation be abandoned? Should some other approach be adopted in the ever present quest for reforms (or panaceas) in the field of child and family welfare? In my view, proponents of family preservation services should

continue to hang in there --- but temper their enthusiasm about program effectiveness, while focusing on applying lessons learned from studies such as this one. Researchers too should hang in there --- but also temper their critique of family preservation services by displaying more tolerance for the complexities of the phenomenon under study and greater recognition of the limits of research methodology. Rigorous evaluation of "social experiments" --- or even more modest innovations in the human services --- remains a worthy but elusive goal.

Reviewed by

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*Putting Families First* describes the largest and most ambitious study of "family preservation" services to date, one which has been widely accepted as definitive. It not only outlines the research strategy and findings from this four year study of 6,522 families in 60 Families First programs in Illinois, but chronicles the political currents that swirl around the implementation and evaluation of family preservation programs.

The first part of the book lays out the context and concepts in recent child welfare history that have shaped family preservation and the development of the Illinois Families First program. After reviewing and critiquing the experimental research on placement prevention programs, the authors lay out their elaborate three tiered approach to the evaluation.

The second part of the book reports the descriptive data collected on all the families who received services with comparisons to the families participating in the second tier of the evaluation, a randomized experiment that included 1,564 families in 18 of the programs. Family problems and services were described by both the workers and a subsample of 278 families interviewed 7 to 13 months after referral (p. 78).

The detailed descriptions of the services provided demonstrate the range and variety of the programs in the study, as well as problems in implementing the design; for example, 60% of the families were served for longer than the intended 90 days (pp. 121, 138).

The remainder of the book describes and discusses complex analyses of outcomes, primarily comparing the 995 families randomly assigned to receive family preservation services to the 569 families who received regular services from the Illinois Department of Children and Family



Services (DCFS). The families are compared in terms of placement, subsequent maltreatment, case closing, and parents' views of changes in family problems and family functioning. Overall, the study detected few lasting effects in any of these areas that the researchers attribute to Families First.

*Putting Families First* is worth reading for its rich description of the process of implementing and evaluating family preservation programs in a politically volatile environment. There is much for both novice and veteran evaluators to glean from this study. The research design is multifaceted with careful explanations of the reasons behind the many choices involved in an evaluation of this scale. Research students will find a good model in this study and will appreciate the appendices that explain the sophisticated multivariate techniques employed.

For those seeking guidance in planning or evaluating family preservation services, the findings reported in this book have less to offer. As the authors themselves thoroughly discuss, the inability to target services to families at risk of imminent placement resulted in low placement rates in both experimental and control groups (pp. 150, 188). Since this means that placement was never at issue for 80% of the families in the experiment, it is not possible to learn what services or program characteristics might have been helpful in preventing placement.

Furthermore, the large and interrelated differences among sites, programs, and families create problems in assessing service effectiveness for subpopulations. For example, although the risk of placement in chronic neglect cases was much lower in the family preservation group than in the control group, since there were only 102 chronic neglect cases spread over the two groups in 18 programs they do not generate significant findings.

Indeed, the very scope of the study makes the results hard to interpret. Although the experiment was rigorously conducted, it is unclear what was being tested. It can be questioned whether "family preservation" was really being evaluated here, since the Illinois program was atypical in several important respects. For example, most of the workers did not see the value of brief intervention, so one of the hallmark characteristics of family preservation, time limited services, was not observed (p. 137). Neither was another hallmark, family participation in setting goals and defining service needs. Both tended to be defined by workers, only 40% of the families fully participated in the development of their service plan, and less than half of the families even agreed it (p. 117).

It is also unclear what "family preservation" was being compared to. In most sites, Families First clients clearly received more services, but in two sites the control group received services that were nearly as intensive (p. 110, 210). Since the data on the control group were collected in an entirely different way than in the experimental group, differences in data collection methods could also have distorted differences in the services.

Perhaps since only 20% of the families were candidates for preservation, what has really been tested in this study is the effectiveness of purchasing services from private providers with ill-

defined criteria and haphazard monitoring. In this case we might conclude that the extra money spent did not produce better outcomes for families than the usual assortment of services provided to families by DCFS. Given the lack of convincing evidence that any coherent version of family preservation services was tested, we cannot reasonably conclude from this study, as many have done, that they are ineffective.

*Behavioral Sciences Institute, HOMEBUILDERS Training Division. (1992). Skills for Family and Community Living. Federal Way, WA: Author.*

Reviewed by

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Skills For Family and Community Living is a 43 minute videotape that focuses on demonstrations of skills that assist families in potentially difficult situations. The video is designed as a teaching tool for professionals who work with families. A series of eight (8) vignettes of live action situations are presented and behavioral-cognitive skills are demonstrated. New skills are then introduced and supported in a reenactment of the same vignette. The tape allows for discussion and provides teaching strategies to further enhance the learning opportunity. The skills covered in the videotape include communication skills including "I" statements and listening, accepting "no" for an answer, attention and praise, impulse management, resisting peer pressure, anger management and teaching skills to children.

The strength of this video is the opportunity for professionals and family members to actually view difficult and realistic situations that families face. New skills are modeled and the tape is broken into segments that allow for discussion. The professional can select specific skills that the family seems to need or use the whole tape.



The only weakness is pointed out in the teaching guide that accompanies the tape, that not all clients might relate to these specific client groups. Suggestions for discussion with clients about this issue is, however, covered. For a professional audience, this tape may be too basic but, as a teaching tool to use with families it is excellent.

Using this tape as a teaching aide in family preservation courses, has proved worthwhile in integrating theory and practice. Discussing the underlying assumptions made in each vignette assists the student in developing a better understanding of a Behavioral-Cognitive approach to family preservation practice. Although educators may face the same issue as professionals regarding the basic level of the film, it does offer opportunities for them to relate pertinent and important skills to families and cultural groups with whom they are currently working.





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