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FAMILY PRESERVATION JOURNAL

A Publication of the *Family Preservation Institute*

Winter 1996

ARTICLES

Improving Family Functioning Through Family Preservation Services: Results of the Los Angeles Experiment, *by William Meezan and Jacquelyn McCroskey*

Idiographic Self-Monitoring Instruments to Empower Client Participation and Evaluate Outcome in Intensive Family Preservation Services, *by Barbara Peo Early*

Evaluating Family Preservation in Nevada: A University-State Agency Collaboration, *by Christine Bitonti and Joy Salmon*

The Family Partners Credit Card: A Token Economy System Adapted for Intensive Family Preservation Services to Enable Families to Manage Difficult Behavior of Adolescents, *by Jude Nichols and Barbara Peo Early*

Toward the Development of Ethical Guidelines for Family Preservation, *by David A. Dosser Jr., Richard J. Shaffer, Michaux M. Shaffer, DeVault Clevenger, and Dustin K. Jefferies*

PLUS a review of current resources



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Provide five copies of the manuscripts. The title page only should list the author's name, affiliation, address, and telephone number. The author's name must not appear after the title page; only the title should appear on the

abstract and first page of the text. Include an abstract of about 100 words.

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Editorial

What's Good for Families?

In the midst of the debates in Washington, D.C. over the budget, health care, welfare, and foreign affairs, a central question remains unanswered -- what is good for families? Part of the ongoing debate has included family preservation which has been both touted as the solution for society's ills and, simultaneously, as the cause. The reality, of course, is somewhere in between. Family preservation is a new and exciting approach for helping the most basic unit of our society, families, do their job. The principles which guide family preservation grow out of professional helping values and practice experience. Family preservation is a powerful approach to practice which puts the families we are trying to help at the center of the process, not as "symptom bearers" or "dysfunctional systems," but as full partners. While family preservationists enter a family with their eyes wide open to help solve problems, sometimes very serious ones, most of their energy goes to finding strengths and resources in the family in order to meet its needs. It works! And thousands of families who have been helped, along with researchers and other practitioners, sing its praises.

Family preservation is good for families but it's not enough and never can be. Both the proponents and detractors of family preservation must not forget the broader issues effecting families as we continue to search for the ideal professional helping response. Just as individuals live in a context, families survive, thrive or perish in neighborhoods, communities, states and nations. It has never been easy for families. The job of a family is complex and challenging. But these are even more perilous times as reflected in profound economic, cultural, religious, and technological changes. Major forces continue to work against families including poverty, violence, racism, sexism, and rampant consumerism.

Beginning in the early 70's some politicians chose to highlight and exploit differences in our society for personal gain. Polarization and confrontation have been exacerbated. We sue each other "at the drop of a hat" (figuratively if not literally). Negativism is a prime marketing strategy for politicians and products. Materialism sparked by an economic base which can only be maintained by ever increasing consumption may be one of the most notorious "isms" facing families. These themes are pervasive, powerful, and every present in our society. To successfully address them family preservationists must first recognize them as the powerful adversaries they are.

No one approach, method, or technology will single handedly obviate the impact of these negative forces on families. Working with families in their homes from a strengths approach will not eliminate the poverty, racism, and violence outside (or inside) their doors. It is this reality which makes ours such a "messy business": no quick fixes, no miracle cures, no magic bullets. While we must continue to strive to account for greater percentages of the variance of what ails families we must be humble, realistic and prepared to work on multiple levels.

Editorial

Several of the state plans for the Family Preservation and Support Act contain missions and visions which reflect an understanding that what is good for families must address these negative themes at a community as well as personal level. Doing so entails creating a society which affords every member an adequate level of income and a fair and equal opportunity to participate. Until then no model, technique or approach will be the answer to "what is good for families"?

Family preservation principles and values must be ingrained in the fabric of society before the full potential of family preservation can be realized. The parallel process must extend beyond work with the family to all levels of the community. Politicians must develop policies which are family centered - not vote centered; administrators must develop regulations which are family centered - not agency centered, and corporate leaders must be family centered - not profit centered.

What is good for families begins with treating the families as the expert on their needs but also with recreating communities to be inclusive not divisive, nurturing not punitive, and to value diversity. To achieve these goals we must impact the negative trends which undermine communities at the same time that we help individual families. We ask a lot of family preservation and those who practice it. While family preservation is not the only answer, it is one solid approach which makes a difference for families.

John Ronnau, Alvin L. Sallee

Dedication to Family Preservation Workers

A special kind of workers are in the
world today

To help us as families, to show us
the way

To love each other, to live together, to
teach us to respect, stand by and stay together
as families should

These workers are ordinary humans like
you and I, the things that make them different
is they possess these golden qualities
They extend themselves beyond the call
of duty

They fill us up with positive solutions
to keep our families moving

There is only one way they lead us, it's
back to the right track

Yes, Family Preservation workers help us,
make it back

Where there is or have been years of
patterned abuses and or dysfunctions they may
not have been witnesses to it, or don't know the
reason at all, but deep down, inside of a genuine
devoted worker is that golden quality that beckons
them to answer our calls

Family Preservation workers have their
own lives and families too, each case they
handle isn't just another job they get paid
to do.

But everytime they are able to work through
the knots and ties and keep another family
together I truly believe it makes their job more
worthwhile

Family Preservation workers (or any worker)
who Trust and Believe in the Lord Jesus
Christ and Pray is an extra bonus to a
family, for if they are of such standing
we truly know they want only your best
they are not our enemies

Keep up the good work, even when
you handle families that don't want to
be saved or reached

Remember those who you have already
saved and helped and those you all have
yet to meet.

God Bless Each and
Every one of you and your
families as well

Remember they that wait
upon the Lord shall renew
their strength (Isaiah 40:31)
and Never, Never, Never,
"Throw in the Towel"

Every family is worth saving.

Linda Frank
Houston, Texas
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*For more information regarding this poem,
please contact the Family Preservation Institute.*

Improving Family Functioning Through Family Preservation Services: Results of the Los Angeles Experiment

William Meezan and Jacquelyn McCroskey

This article describes a study of the outcomes of home-based family preservation services for abusive and neglectful families in Los Angeles County. It focuses on changes in family functioning during the 3 month service period and one year after case closing. Families known to the public child welfare agency were referred to the project based on caseworker judgement of the need for services rather than on the criteria of imminent risk of placement. Two hundred forty families were randomly assigned to either the service group receiving family preservation services from two non-profit agencies or to the comparison group receiving regular public agency services. Both caseworkers and families reported small but significant improvements in family functioning for the service group families, but not for the comparison group families. Study findings also suggest the aspects of family functioning most changed by services, the characteristics of families most affected by services, and variables which predicted service success.

Los Angeles is the largest county in the nation, home to about 6.6 million adults and 2.6 million children. Population growth, 85% of which is due to births, is predicted to continue into the next decade. The county has an increasingly diverse population mix, especially among its children: in 1990, 50% of those under 18 were Latino, 27% were White, 12% were African American, and 10% were Asian American. About one in every three Angelenos were born outside the United States, and most have come here since 1980. Almost 14% of all residents,

The article is based on material which will appear in J. McCroskey & W. Meezan (in press). *Family Preservation and Family Functioning*. Washington, DC: Child Welfare League of America. Both authors have contributed equally to the conceptualization design, implementation, analysis and reporting of this study.

The project was funded by a generous grant from the Stuart Foundations of San Francisco, California. The authors would like to express our appreciation to the foundation as well as our numerous research partners including Brian Cahill, Lyn Munro, Pat Reynolds, Carol Goss, Alex Morales, Judy Nelson, Sandy Sladen, Peter Digre, Delores Rodriguez, Barbara Ahmad and Evelyn Syvertsen.

and 32% of all school children, have limited ability to speak or understand English. A significant gap also exists between the average incomes of families with children in the lowest income group -- \$9,170 for the bottom quartile -- and families with children in higher income groups --\$81,430 for the top two quartiles (United Way, 1994).

As in most other urban areas, the education, health and social service delivery systems in Los Angeles have faced dramatic challenges over the last two decades. Public child welfare has been one of the systems most affected by the ongoing economic recession in the state, which has caused significant increases in family poverty and in demand for services. The Los Angeles County Department of Children and Family Service (DCFS) is one of the largest public child welfare agencies in the country. Referrals to the emergency response program have almost doubled over the last decade -- there were 74,992 referrals in 1984 and 134,248 referrals by 1992 (United Way, 1994). By November of 1993, DCFS was serving 72,486 open cases (Department of Children and Family Services, 1994).

Although California initiated a series of family preservation demonstration projects in 1984, it was not until 1992 that Los Angeles County implemented its Neighborhood Family Preservation Plan, and began funding community-based networks to provide a broad range of family preservation and family support services in communities throughout the county. No such networks existed in 1989 when this study began; only a few nonprofit agencies provided family preservation services funded primarily by special grants and charitable contributions. This study was thus designed to answer many of the questions about family preservation raised in Los Angeles at that time, and to provide direction for the potential expansion of these services in Los Angeles county and in other urban areas around the county.

The study was conducted between 1989 and 1994 under the auspices of a practice-research partnership among two non-profit voluntary agencies [Children's Bureau of Southern California (CBSC) and Hathaway Children's Services (HCS)], the Los Angeles County Department of Family and Children's Services (DCFS), The Stuart Foundations, and the University of Southern California School of Social Work. This article focuses on four of the major questions addressed by the study:¹

1. Is there a change in the functioning of abusive/neglectful families over time, and can such changes be attributed to the programs of the two agencies under study?

¹Other study questions were about: utilization of the Family Assessment Form (FAF) as both a practice and a research instrument, comparison of cases referred by community sources (e.g. schools, medical clinics) with those referred by the public agency, the impact of changes on individual children, and the relationship between parental personality characteristics and service success. Results of these analyses will appear in McCroskey, J. & Meezan, W., *Family Preservation and Family Functioning*, forthcoming from Child Welfare League of America.

2. What factors are associated with positive outcomes for families and children participating in the experimental programs?
3. Do ratings of family functioning differ when information is collected by practitioners in contrast to research interviewers?
4. To what extent is participation in the experimental programs associated with decreased need for other child welfare services, including out-of-home placement?

When this study began it was considered an anomaly by many in the field who thought that family preservation services should be shorter and more intensive (see, for example, Edna McConnell Clark Foundation, 1985; Haapala et al., 1990, 1991; Kinney et al., 1977), referral criteria should be limited to those at imminent risk of placement (Cole & Duva, 1990; Nelson, 1989, 1991; Tracy, 1991), and outcomes should be calculated exclusively in terms of placement prevention and cost avoidance (Nelson, 1991). The partners in this study all believed otherwise, and were willing to go against the then current tide by providing a less intensive service, for a broader range of families, with different standards for measuring program success. These were not new ideas (see, for example, Bryce & Lloyd, 1981; Hutchinson et al., 1983; Maybanks & Bryce, 1979), but they were out of favor nationally when this study took shape.

Principles Guiding the Evaluation

When this study began in 1989, the evaluation of family-based services was still a relatively new enterprise, and some were beginning to voice concern about the conceptualization, focus, rigor, and implementation of the studies which preceded it. This questioning, as well as the philosophical preferences of the partners, led to the design of a study that we hoped would move the field forward in terms of understanding the impacts of family preservation services. The study was thus guided by a number of principles.

First, the study was based on the conviction that a better understanding of the impact of family preservation services on the functioning of families and children is an essential precondition for determining whether family-based services are worthwhile. While recognizing the importance to policy makers of placement avoidance, all of the research partners agreed that this single focus contributed to a simplistic notion that the occurrence of placement was a "service failure," and this ran counter to considerable professional knowledge about the benefits of placement for some children at some points in their lives (see, for example, Barth & Berry, 1994). This study was therefore designed to focus primarily on the impact of services on the functioning of the family as a group and as individuals.

Prior to this study, most of the research on service outcomes in family preservation had focused on placement prevention, both because it seemed to be a clear and quantifiable indicator of success and because it had readily understandable policy and cost implications. Although

results of early studies without control groups seemed to indicate that significant placement avoidance occurred through the programs (see, for instance, Fraser et al., 1991; Haapala & Kinney, 1979, 1988; Kinney et al., 1977), the next generation of studies, using more rigorous experimental designs, left significant doubts about their efficacy in preventing placement (Feldman, 1990; McDonald & Associates, 1990; Rossi, 1992a, b; Schuerman et al., 1993). Yet many of these same studies that also included measures of family functioning demonstrated some modest positive change in this area as a result of services (Feldman, 1990; Fraser et al., 1991; McDonald & Associates, 1992; Nelson et al., 1988; Wells & Whittington, 1993).²

It was thus believed that the program outcomes used in this study should be defined broadly and not be limited to placement prevention. Beyond the research findings available at the time of the study, a number of important considerations influenced this position, including concern that the welfare of children not be narrowly equated with placement avoidance (Frankel, 1987; McGowan, 1988; Wald, 1988) and the need for a better understanding of potential program impacts on children (Wald, 1988) and families (McCroskey & Nelson, 1989).

Second, the research partners believed that in order for the field to successfully negotiate the shift from placement prevention to family functioning as a primary outcome variable for family preservation programs, the development, identification, and use of appropriate practice-relevant measurement instruments was essential. This study relied heavily (though not exclusively) on a practice-based instrument developed by practitioners at CBSC to assess family functioning (McCroskey & Nelson, 1989; McCroskey et al., 1991; McCroskey & Meezan, in press).

The Family Assessment Form (FAF) is based on an ecological approach to practice, is sensitive to both family strengths and weaknesses, including risks for child abuse and neglect, and was seen by practitioners in this study as useful in their daily practice. We believed that continuing efforts to build this and other such practice-relevant instruments was needed to enable the field to sensitively evaluate many different family preservation and family support program approaches, and that the current difficulties in measuring changes in family, parent and child functioning was not a sufficient reason for ignoring first-order questions about the impact of family preservation services on the primary service recipients -- families and their children.³

Third, acknowledging that reality may be a social construction (Guba & Lincoln, 1990), and that people view realities differently depending on their situations, the evaluators decided to collect study data from multiple perspectives. Psychotherapists have long held that "there is little reason to expect that outcome ratings from different vantage points should agree with one another. Instead, they represent distinctive perspectives that are not reducible to one another"

²For a thorough review of the research on family-based services, see Pecora et al., 1992.

³For a summary of assessment practices and instruments used to date in family-based services research, see Pecora et al., 1995.

(Gurman & Kniskern, 1978: 832). Indeed, there is good reason to question ratings from almost any single perspective. The patient's or family's perception may be subject to "distortion" from being too close to the situation; the counselor's views from outside the family system can be similarly subject to his or her own preconceptions or distortions (Lambert et al., 1986).

In 1987, Achenbach et al. conducted a meta-analysis of 119 studies using multiple informants to rate child behavior and emotional problems. Their analysis showed significant variation among the reports of different kinds of informants. The authors suggest that, rather than "casting doubt on one or both informants," such findings point to the existence of multiple truths: "Low correlations between informants may indicate that target variables differ from one situation to another, rather than that the informant's reports are invalid or unreliable" (Achenbach et al., 1987: 213). Their meta-analysis also documented considerably higher consistency among informants with similar roles than among informants with different roles. Thus, parents and other family members rated similarly, and professional mental health workers and teachers rated similarly. Overall ratings of professionals tended to be more similar to each other than to those of family members.

Pelton (1982: 83) has suggested several reasons why perspectives of child welfare clients may differ from those of their workers including: "... the coercive context of this helping relationship, the suspicions that initiate the relationship, the implicit threat to the parents that their children may be removed from them, and the emotional nature of the issue."

Thus, the notion that the lens through which we see the world determines, in large measure, what we see does not come as a surprise to experienced practitioners. However, most child welfare research has not routinely incorporated the views of multiple informants, relying either on caseworkers to "objectively" observe and record client progress or on clients to report their own experiences. Thus, this study included ratings from five different perspectives -- parents, case-carrying voluntary agency workers, experienced non-case-carrying DCFS workers, teachers, and observers -- in an effort to give a voice to all of those participating the complexities of family change.

Fourth, a criticism often heard at the time this study was initiated was that there were too few controlled experiments with adequate sample sizes that incorporated a follow-up period. Many reports of program "success" were based on research using small samples, simple testimonials, or uncontrolled descriptive designs. The partners in this study therefore believed that the use of as rigorous a design as possible was essential. It was decided to use a randomized group design with a year-long follow-up period, and to choose a sample size large enough to convince policy makers and practitioners of the validity of the results. The study partners rejected "imminent risk" as a criterion for sample selection for both conceptual and practical reasons: conceptually, the services were seen as a way to enhance family functioning, not primarily as a way to reduce placement; and practically, it was not possible to operationalize imminent risk in the context of practice in Los Angeles. In addition, the partners were interested in discovering

which factors were associated with enhanced family functioning, allowing the agencies to refine their programs and to designate appropriate target populations. Limiting cases to those at imminent risk would have narrowed the range of cases available, and thus would have decreased the possibility of discovering which families were most likely to benefit as a result of services.

The complex research strategy employed in this study thus foresaw many of the concerns that have been expressed subsequent to its implementation (Rossi, 1991; Besharov & Baehler, 1992; Cole & Duva, 1990). The study strategy seems even more important now than it did when this work began, since experts continue to raise questions regarding the rigor of the methodologies used in the previous generation of studies (Rossi, 1992a, b) and the contradictory findings of many of the studies to date (Pecora et al., 1992).

Fifth, the partners believed that designs for family preservation services should vary depending on community and family needs, resources available, and program orientations and goals. The agencies evaluated did not provide a Homebuilders-type crisis intervention service. Rather, they had designed the time period, intensity, and caseload parameters of the services to reflect their experiences with community and family needs.

The agencies provided less intensive but longer term services than crisis-oriented programs, serving families for about three months with one to three visits per week. HCS used teams of clinical therapists and community workers, and CBSC used two-person teams made up of bachelor's- or master's-level workers. While the teams usually worked together for case assessment, they often worked individually with families after the assessment period. Caseloads averaged about ten to 12 cases at any point in time. Although staff members could be reached in emergencies on a 24-hour basis, round-the-clock availability was not stressed because the programs were not conceived as a crisis service, but rather as a family-stabilizing and support service. The services evaluated here could therefore be classified as "family centered services" rather than as "intensive family centered services" (Child Welfare League of America, 1989; Pecora et al., 1995).

The agencies believed that many different kinds of families could benefit from services, and that earlier rather than later intervention was preferable. Before the evaluation, they served about 50% public agency-referred cases and about 50% community-referred cases. For the purposes of the evaluation, they agreed to reserve about 70% of their services for DCFS referrals. Given their commitment to serving a wide variety of families, however, they requested that DCFS refer a full range of cases.

Finally, the partners agreed that another important aspect of the service was the belief that the relationship between families and workers is the key to the success of any service model. Thus, ratings of the satisfaction of both families and workers, proxy measures of the quality of the relationship, were included in the study. Unfortunately, because of the limited number of workers involved in the study, it was not possible to fully investigate all of the factors related

to worker satisfaction. Client satisfaction, however, may indicate not only the family's reaction to service, but also the extent to which client and worker were able to establish an effective working relationship.

Study Methods⁴

Design

The study used a modified experimental design with a one year follow-up, randomly assigning DCFS-referred families to the service group or to a comparison group receiving "regular" DCFS services. The drawbacks of this design, common to many social service experiments, are: (1) the absolute effectiveness of the service cannot be ascertained because they are not compared to a "no service" condition; (2) the impact of the treatment is underestimated, since comparisons are to a "regularly"-served rather than to an unserved group; and (3) the research questions are focused on comparative rather than absolute effectiveness (Seitz, 1987).

Sample

DCFS workers were asked to consider referring any family that might benefit from family preservation service, that had at least one minor child living at home, and that lived in the geographic catchment areas served by the two agencies (South Central Los Angeles for CBSC and the Northern San Fernando Valley for HCS). Families were eliminated from consideration for the study only if they refused service or were totally incapable of understanding or participating in case planning (e.g., active psychosis, extreme substance abuse). The total sample was 240 families; the service group (n=111) was made up of 53 families served by CBSC and 58 families served by HCS, while the comparison group included 129 families from both geographic catchment areas.

Although a total of 374 cases were referred to the project by DCFS workers, the final sample included only 240 families, a loss of about one in every three referrals. There were several reasons for this: 73 of the families had could not be located during the two weeks allowed between DCFS referral and the beginning of service; 11 families refused service; 35 refused to participate in the research; 11 had no children at home (or were inappropriate for the service); and four did not participate for other reasons. In addition, as expected, there was attrition in the sample over time as families moved or dropped out of the study (Time 2 n=194 and Time 3 n=152). Such sample attrition is especially a problem when data is gathered from different sources using different methods, as was done in this study. Complete data elicited from one source, but missing from another, will eliminate the subject from an analysis, thus reducing

⁴For a discussion of the issues involved in implementing this study, see Pecora, et al., 1995, Chapter

statistical power. Families received a \$25 voucher (they could choose whether it was for a local grocery or department store) for each of the three research interviews.

Instrumentation

The Family Assessment Form (FAF), originally developed by practitioners at CBSC, was used to collect a great deal of the study's information on family functioning. The FAF was completed by workers at the participating agencies at the beginning and at the termination of services (T1 and T2) using a nine-point scale with five anchor points ranging from "above average" to "situation endangers children's health, safety and well-being." For the purposes of the study, the researchers also converted the FAF into a research interview, lasting between two and three hours, which was designed to collect the parent's own perceptions of their family's functioning at all three points in time.

The two principle characteristics of the FAF that distinguish it from other instruments currently being used in the field are its ecological orientation and its practice base (McCroskey & Nelson, 1989; McCroskey et al., 1991; Pecora et al., 1995). The researchers also used study data to examine the psychometric properties of the FAF using factor analytic techniques, which suggested six primary areas that define family functioning for the purposes of this study: the family's financial conditions (e.g., financial management and financial stress); its living conditions (e.g. safety of the home); the supports available to caregivers (e.g. availability of friend support and child care); parent-child interactions (e.g. use of consistent discipline, maintaining appropriate authority roles); developmental stimulation for children (e.g. providing learning experiences); and interactions between adult caregivers (e.g. conflict between caregivers).⁵

Four standardized instruments, with known, adequate psychometric properties were used in the family interviews to collect data on individual children and caregivers. The primary caregiver (usually the mother), completed the Brief Symptom Inventory (BSI), a measure of parent mental health status, at the end of each of the three interviews. In order to collect data on individual children, researchers designated one child --elementary school age or younger, if possible -- as a "study"child. When the study child was over the age of six, caregivers were asked to respond to the Child Behavior Checklist (CBCL) (Achenbach & Edelbrock, 1984) at each of the three points in time. When the study child was younger than six, interviewers completed the Home Observation for Measurement of the Environment (HOME) (Caldwell & Bradley, 1984) at all three interviews. Caregivers were also asked to report on their satisfaction with service at T2 and T3; they responded to questions about help received in each area measured by the FAF,

⁵For a full description of the FAF, see McCroskey and Meezan (in press); Meezan and McCroskey (in preparation) or contact the researchers at USC School of Social Work, Montgomery Ross Fisher Bldg, Los Angeles, CA 90089-0411

their satisfaction with this aspect of service, and completed the Client Satisfaction Questionnaire (Larsen et al., 1979).

Other data collected by the study included: teacher reports on elementary schoolchildren at T1 and T3 (Achenbach & Edelbrock, 1986); data from the DCFS management information system for the entire 15-month project period; review of DCFS case files at the close of the project period (conducted by retired DCFS caseworkers); and interviews with case-carrying workers at the two agencies (Tracy et al., 1992).

Study Findings

The Families

On average, the adult caregivers in the families were about 33 years old, the oldest child was about 10 years old, and their households had 5.3 members (1.8 adults and 3.5 children). About 40% of the families had one adult and 60% had two adults (28% both parents, 20% one parent and a relative, 7% a parent and a step-parent, and 5% a parent and an unrelated adult). About 40% of those reporting had never been married, 30% were married, and 30% were separated, divorced or widowed.

In general, the demographic diversity of the study families reflected the diversity of the geographic communities served. The total sample (n=240) of families included about 48% Latinos, 27% African-American, 22% White, and 3% families from other ethnic backgrounds. About 20% of those reporting had greater than a high school education, 20% were high school graduates, 30% had not completed high school, 25% had only an elementary school education, and 5% had no schooling at all. About 33% of the families had incomes under \$750 per month; 52% had incomes between \$750 and \$1499 per month and 15% had incomes over \$1500 per month. About half of the families received some kind of financial support from the government, usually AFDC.

According to the experienced DCFS workers who read the case files, these were not "easy" families to work with. They had significant numbers of personal problems, including substance abuse (50% of case records noted significant substance abuse problems), health problems (20% of children and 14% of caregivers), and mental health problems (18% of children and 17% of caregivers). They also faced environmental and contextual problems, including problems in school (28%), domestic violence (24%), incarceration of a family member (25%), desertion by a parent (37%), and housing problems (23%). Many caregivers had experienced violence and abuse themselves; about one-third reported having been severely victimized and a significant number reported that they had acted violently themselves.

The families in this study represented the full range of cases that might be appropriate for in-home services. Some had just been referred, and were receiving emergency response services from DCFS. About one-third of the study families had been known to the department prior to this report, and about 17% had a child placed in out-of-home care prior to this report. The sample included children who had experienced many different kinds of maltreatment, including some who were referred with multiple allegations (43% physical abuse, 41% neglect, 18% sexual abuse, 4% emotional abuse).

Analyses using chi-square and t-test statistics showed that there were few differences between the service and comparison groups -- clearly random assignment procedures produced comparability between groups. Other than demographic variation which can be attributed to serving different geographic communities, the service groups at the two agencies were also basically equivalent. Analysis also showed that the demographic characteristics of the sample were not affected by sample attrition over the course of the study in any critical way.

The Services Provided and Families' Responses

Although statistical analysis revealed that there were differences between the service models used at the two agencies, the families reported receiving similar amounts of help and had similar perceptions about the outcomes of service. Parental reports of service receipt were remarkably similar to the reports of the workers. Generally, HCS provided a shorter and more intensive service than did CBSC. The average CBSC family was seen for 19 weeks while the average HCS family was seen for 10 weeks. CBSC workers saw the families less frequently and for shorter periods of time each week than did workers at HCS. On average, CBSC workers saw families less than once a week (0.7) for about 70 minutes, while HCS workers saw families more than once a week (1.1) for about two hours. CBSC workers also reported making more collateral contacts per cases than HCS workers, perhaps due to the difference in the availability of other resources in the catchment areas served.

Despite these differences in service models, however, there were no significant differences in agency reports of case closing or goal achievement for families. Families in both services reported receiving considerably more help than families in the comparison group, and they said that they were more likely to receive this help from workers than from others in their extended support systems. The help that families in both programs reported receiving was largely focused on the two areas targeted by the programs -- child-rearing skills and family interactions.

Overall, statistical tests confirmed that families in the service group were much more satisfied with services than comparison group families. Service group families expressed significantly greater overall satisfaction with services, thought they had received significantly more help, and were significantly more likely to rate the services they had received as helpful than were comparison group families. For service cases, family report of help received in a specific area of family functioning was significantly correlated with caseworker report of improvement in that

area. Family report of help received in a specific area of family functioning was also correlated with self-report of improvement in that area for service cases but not for comparison cases.

Not all families in the service group completed the full-course of service. About one-sixth of the service cases had fewer than 10 in-person visits, fewer than 9 weeks of service, unplanned closings, and failure to achieve case goals. Whether this represents inability of service workers to engage families, unwillingness of families to engage in service, inappropriate referrals to the service program, or something else, is not known.

Although some of these families received only "limited services," the researchers retained them in the sample, even though their inclusion would diminish the chance of finding significant differences between the service and comparison groups. The study took this conservative approach, reasoning that this would provide a fairer estimate of overall service effectiveness.

Such cases can also teach us a great deal about the meaning of "service failure." For example, although these families received some help from workers, family reports suggest that they received more help from other sources, especially in relation to concrete needs. Perhaps these families were activated by a smaller amount of service, or were more resourceful in finding the concrete help they needed. However, since even this "limited service" group fared better overall than the comparison group, it may be that some exposure to home-based services is better than none.

Changes in Family Functioning

Families in both the service and comparison groups reported to interviewers that they did not have significant problems with family functioning in any of the six overall areas of family functioning as measured by the FAF at case opening. During research interviews, caregivers in both groups tended to rate themselves and their families as being "generally adequate" or having only "minor problems" in functioning. Change scores, using paired comparison t-tests, showed that neither the service nor the comparison families reported any significant changes in their functioning between case opening and case closing ($n=194$).

However, a year later, service group families reported improvement in two areas of family functioning -- living conditions ($p=.004$) and financial conditions ($p=.09$)⁶ -- while comparison group families reported no improvements in any area of family functioning. Thus, the caregivers' reports to the research interviewer indicate that changes occurred in the more

⁶These statistics are based on two-tailed probability tests. Since the hypotheses in this study was that the service group would fare significantly better than the comparison group, the probability levels reported in the paper are conservative and underestimate the degree of difference between the two groups.

concrete areas of their families' lives, and that they occurred only during the year *after* the service was completed.

CBSC and HCS caseworkers used the FAF as a practice instrument to assess family functioning at case opening and case closing, allowing them to judge change over the course of service. Overall, workers rated very few families as having severe problems in any of the six areas. The reasons for this are not clear. It may be that families with numerous severe problems had children removed immediately or that DCFS did not refer such families to these home-based programs. Or, it may be that workers were reluctant to rate the families they served as having severe problems, either because they did not want to label them negatively or they did not want to perceive the families as being beyond their ability to help or their agency's capacity to serve.

In contrast to the reports of the families themselves, however, workers at both agencies rated the families as having "moderate problems" in all six areas of family functioning at Time 1. By the close of service, analysis using paired-comparison t-tests revealed that the workers saw statistically significant improvements in four areas of family functioning -- interactions between caregiver and child ($p < .001$), supports available to caregiver ($p < .001$), developmental stimulation available to children ($p < .001$) and living conditions of the families ($p = .003$). In addition, the data indicate that improvements in three areas -- caregiver-child interactions, developmental stimulation, and support to caregivers -- were clinically significant, indicating substantial progress that improved the family's practical ability to care for their children. That is, at least 15% of the families in the service group moved from either the "severe" category to the "moderate" category, or from the "moderate" category to the "no problem/strength" category in these three areas during the course of service.

Findings using other standardized tests also showed that service families tended to improve in areas of related to individual children while comparison families did not. For example, parents of school aged children in the service group reported more improvements in their children's behavior between the opening and closing of service than did parents in the comparison group. Based on interviewer observation at case opening and case closing, parents of preschoolers in the service group improved their parenting skills more than parents of preschoolers in the comparison group in a number of areas measured by the HOME inventory.

Factors Related to Changes in Family Functioning

A series of stepwise regression analyses were also performed, using both family-reported and caseworker-reported data, to identify the variables that could best predict improvement in each of the six areas of family functioning in the service group. While it is beyond the scope of this paper to present these data fully, some general patterns gleaned from these analyses shed further light on family change due to the intervention.

Interestingly, factors associated with the service models of the two agencies were not primary predictors of change, from either the families' or workers' perspectives. Further, DCFS allegations against the family at the time of referral did not seem to predict change in any area of family functioning. However, in both the worker- and caregiver-reported data, help in concrete areas was predictive of change in interpersonal relations. Targeting problems also seemed to predict change -- the areas the *workers* were most likely to rate as improved were the ones in which the *caregivers* reported receiving help.

The data also indicate that there were differences between families who changed during the service and those who changed in the year after services were completed. Unfortunately, information about outcomes a year after service completion was available only from the families' perspective. According to the caregivers, those who most needed help in a given area of family functioning at Time 1 tended to improve in that area by the close of service. Based on their reports, however, it appears that improvements in interpersonal areas of functioning (as opposed to concrete areas) were not sustained at follow-up.

Analysis of change during the follow-up period also seems to indicate that those in the service group who changed after the completion of service, or sustained change after services were terminated, rated themselves or were rated by their workers as somewhat less troubled at case opening. The data indicate that these families had fewer environmental stressors, less troublesome histories, fewer psychological symptoms, and more positive personal characteristics. It should be noted, however, that those caregivers who improved by follow-up were not necessarily the caseworkers' favorite clients -- they were not the most cooperative or adaptable clients and they could also use their strengths to oppose the caseworker judgements.

Out-of-Home Placement

The study relied on official placements reported in the DCFS management information system, a source which has a number of limitations (Pecora et al. 1995). Like many other recent controlled studies of family preservation programs (Feldman, 1990; Scheurman et al., 1994; McDonald & Associates, 1990), this study found no significant difference in placement rates or types for children in the service and comparison groups.

Prior to the start of the project, over one-third of the service group families and about one-quarter of the comparison group families had at least one child placed outside of the home. Twenty-six percent of the service group children (88 of 335 children) and 14% of the comparison children (58 of 424 children) had been placed prior to the beginning of this project. Thus, the service group was disadvantaged in terms of their prior involvement with DCFS. They had more children in care before the project period and more children who were in care when the project began.

During the 15 month project period, there were no statistically significant differences between the groups in the number of new placements. Few families from either group had children who entered care; 12 service families had 19 children who entered care while 12 comparison families had 34 children who entered care. Of those who did enter care, most entered foster homes and entered, on average, in the fourth month of the project period.

Children who were in out-of-home care during the project period (either entering prior to or during the project period) were equally likely to return home. On average, children in the service group were likely to return home later in the project period than children from comparison group families; service group children who returned home from care did so, on average, during the sixth month of placement while comparison group children returned home during the third month of placement. Of children who did leave care during the project period, 90% of those in the service group remained at home for the duration of the project period, while fewer than half of the children in the comparison group remained at home for the rest of the project period. While the numbers are quite small, these data suggest the need for more research on the on the long-term placement trajectories of children whose families have received family preservation services, including placement length and re-entry patterns.

A stepwise logistic regression analysis, designed to identify the variables that could best predict placement, identified some different predictor variables for the service and comparison groups, suggesting that placement decisions may be made differently for families receiving home-based services than for those receiving traditional child protective services. These data should be viewed tentatively, given the limited number of cases and the assumptions of the statistical technique, but they suggest interesting directions for future study.

Overall, the data tentatively suggest that, for the service group, factors beyond the worker's control were more likely to account for a child being placed. When a family member was incarcerated (which was more likely for African-American families and clearly related to substance abuse), the family had been unsuccessful with DCFS in the past, and the caregiver was judged by the caseworker to be aggressive, the possibility of child placement was much higher. For comparison families, lack of services during the service period, coupled with previous involvement with DCFS, aggressive behavior, emotional instability of caregivers, and serious problems in family functioning seemed to account for child placements. These findings tend to affirm the feelings of most practitioners that, for some families -- those where placement is not immediately needed to assure the safety of children -- placement decisions are contingent on a complex interplay of familial characteristics, history and service availability.

Conclusions

Taken together, the data showed small but significant improvements in family functioning, according to both families and workers, for the service group but not for the comparison group.

From the families' perspectives, those in the service group improved only after the close of service, when they reported modest changes in concrete areas of family functioning. Comparison families reported no significant changes in any areas of family functioning during or after service.

The workers reported a very different picture. From their perspective, families started the programs with moderate problems in all areas of functioning, and they improved during the course of service in four areas, many of which had to do with interpersonal functioning. Even at Time 2, however, they still rated functioning in all areas as more problematic than the families did.

How should these differences be interpreted? On the one hand, it seems unlikely that these parents -- under the supervision of DCFS -- had no problems. But it does seem likely that parents would be reluctant or unable to admit having problems during the service period (especially to a research interviewer) when the stakes were so high and admission of problems might lead to the removal of their children. Further, if they perceived no problems at the beginning of service, how could significant improvement take place? Even a year after service, it was easier for parents to see concrete improvements in the environment, or changes in their children, than to see changes in family interactions and relationships. Workers, on the other hand, reported less environmental change and greater change in family interactions. In the workers' view, these families had parenting problems that they could help with. Such understandable differences in perspective help to elucidate differences between the ratings of families and their workers. Families under DCFS supervision "cannot" see improvement; caseworkers "must" see improvement when they have invested themselves in families.

Nonetheless, according to the data provided by the workers regarding family functioning and according the parents regarding child behavior, considering these families as untreatable, as some have suggested (MacDonald, 1994), is not warranted. The families seen by these two agencies appear to have strengths as well as problems, and were not those for whom there was little hope of maintaining child safety or family bonds.

The fact that service characteristics did not predict outcome, despite the differences in the service model between the two agencies, adds to the knowledge base about family preservation services. Rather than the service model, it appears that the relationship between worker and caregiver, and the implementation of the philosophy behind family-based services, is what is critical to achieving success with families. And based on the regression models, it appears that family-based services can benefit families facing allegations of either abuse or neglect.

The research supports the idea that unless the immediate, concrete needs of families are met, positive changes in interpersonal relationships are unlikely to occur. Further, the data also support the targeting of services to specific area of family need. It thus points out the need for

thorough assessments, clarity of focus in intervention, and the necessity of joint planning between the worker and the family.

The findings of the study also lead to ideas about modifications in family preservation services which might be necessary to make them more effective. The fact that those with greater strengths did better over time with the provision of the service, and that improvements in areas of interpersonal relationships were not sustained over time, lead us to question the viability of one-shot services for many of the families entangled in the child welfare system. Perhaps some families need longer or more intensive services, or "booster shots" of service to sustain improvements.

Implications

The findings of this study reaffirm, in our view the importance of family preservation services as one part of the service continuum. Such services cannot take the place of out-of-home care or adoption for children whose safety and well-being are at risk. They cannot take the place of long-term counseling or substance abuse treatment for parents who need them in order to offer their children a safe and nurturing home. Nor will family support services offset all need for family preservation, although such services are much needed in almost every community. One kind of service will not fit all needs.

The results of this study come at a critical juncture: on one hand, critics have raised serious questions about whether family preservation services expose some children to additional harm and, on the other hand, many professionals believe that preserving families may be the best long-term hope for some children. We believe that both are right. Not every family can or should be preserved, and children should be removed when families cannot assure their safety. It is possible, however, to preserve families and to maintain children safely at home more often than current practice allows. Despite many efforts, today's child welfare system remains skewed -- both fiscally and operationally -- toward removing children. Family preservation programs offer an additional option that can help bring the system into better balance, but they can only grow if current policy intentions on the part of government are reversed (Meezan & Giovannoni, 1995) and better family assessment strategies are developed. We must remember that risk assessment is not the same as assessing family functioning -- it tells us only whether the child is likely to be safe, not whether the family has the potential to protect the child or to determine what supports and services might help families realize their potential.

The results of this evaluation also suggest guidelines which could enhance further development of both practice and research on family-based services. First, *desired program outcomes should be defined to include both effectiveness for clients as well as cost efficiency for the service system.* Both kinds of questions -- "does it work?" and "at what cost?" are important. While this study is a first step, we need to know more about how these services help, who they

help, and how much they help. The public policy debate about whether such improvements are worth the expenditure will be much more informed when we more fully understand what the benefits of these services really are for children, families and communities.

Second, *meaningful practice-relevant instruments should be used to assess family functioning.* It is only through the use of such instruments that their reliability can be assured and validity established. Since there are very few such instruments in existence now, development, testing and refinement of new instruments will be needed to ensure that program effects can be detected. This is not just a research enterprise or just a practice enterprise -- partnerships between practitioners and researchers will be essential to combine the expertise of both.

Further, we need to measure the outcomes of these services for the functioning of communities. Measures of community functioning are almost non-existent. We need much more work in this area if we are to understand how these services can work best in different kinds of communities. And just as we need practice-relevant instruments, we must have community-relevant measures and community members must be involved in their development and application.

Third, *the field should incorporate multiple perspectives on the progress and outcomes of service into both research and practice.* This study demonstrates for family-based services what other therapeutic fields have documented for years -- clients and workers have different and equally valid views of the helping process. One is not right and the other wrong; each contributes information essential for improving services and outcomes.

Fourth, *we need to pay greater research attention to the relationship between the worker and the family.* If the relationship between the worker and the family is as important as practice wisdom tells us, and as this study seems to imply, the field of family-based services must invest in understanding the characteristics and dynamics of these relationships and how they impact the outcomes of services.

Fifth, *the multiple systems serving families and children must work much more closely to meet the needs of families and children.* Given the variation of backgrounds, allegations, and needs of the families in this study, it seems clear that the child welfare system cannot address all of the issues facing these families and their children. Without school, child care, health, drug, employment, housing community development and a multitude of other services, even the best family preservation services will be insufficient to help families help themselves.

Sixth, *programs must incorporate information on outcomes, not just on process, into their regular data collection.* Building systems to measure outcomes is not only in the best interest of agency administrators who need to assure funders that dollars are being well spent, but it is in the best interest of practitioners who need to know what works in order to improve service,

and in the best interests of families and communities who deserve the best possible services from expenditure of their tax and charitable contributions dollars.

Lastly, *researchers, administrators, practitioners, service recipients and funders must be partners in the challenging search for accurate and meaningful cost effective outcomes.* Without such partnerships, each of the stakeholders in the evaluation process will have only a partial and skewed view of the evaluation enterprise, and the enterprise will have only a limited chance of success. There must be a commitment on the part of all of the stakeholders to *experimenting* in order to improve services and change policy. Undertaking a program evaluation should mean that we want to learn about what works and what doesn't and for whom. It should also mean that we are willing to change, modify, or discontinue programs based on the results of the evaluation. Without this commitment it is senseless to undertake an evaluation, for program maintenance goals can conflict with the results of an evaluation (Pecora et al., 1995).

This evaluation was successful, to the degree it was, only because the funders and the agencies wanted to know what worked and the researchers were willing to listen to the needs of the agencies. The two agencies also shared some characteristics that were essential to the success of this practice-research partnership, including committed, skilled and experienced executive directors; accomplished program directors and staff members; coherent and flexible programs; belief in the capacities of the families and communities they served; and relatively secure financial bases.

The next few years promise to be a challenging period for family-based services. Family preservation has made it to the national agenda, but with that visibility comes heated debate and competition for limited resources. The outlines of the debate have been established, but its resolution is not clear. The results of this study offer directions for further exploration both in terms of program development and research. We are convinced that future efforts will help the field better understand and improve family-based services, and, through such efforts, that the entire continuum of child welfare services will be enhanced.

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Idiographic Self-Monitoring Instruments to Empower Client Participation and Evaluate Outcome in Intensive Family Preservation Services

Barbara Peo Early

Intensive Family Preservation Services seek to reflect the values of focusing on client strengths and viewing clients as colleagues. To promote those values, Intensive Family Preservation Programs should include a systematic form of client self monitoring in their packages of outcome measures. This paper presents a model of idiographic self-monitoring used in time series, single system research design developed for Family Partners, a family preservation program of the School for Contemporary Education in Annandale, Virginia. The evaluation model provides a means of empowering client families to utilize their strengths and promote their status as colleague in determining their own goals, participating in the change process, and measuring their own progress.

Criticism of Intensive Family Preservation Services (IFPS) has been fueled by claims in the popular press of harm to clients (Murphy, 1993). More scholarly objections have argued that the rate of placement alone is not an adequate outcome measure for such programs (Wells, K. & Biegel, D., 1992), and that broader measures such as family functioning should be used in conjunction with placement rates (Scannapieco, M., 1993). There is little controversy over the necessity for basing intervention on effectiveness determined through empirical data (Benbenishty, 1988). However, neither empirically derived placement outcome nor standardized measures of functioning specifically reflect two fundamental values in IFPS - focus on client strengths (Saleebey, D., 1992), and clients as colleagues (Kinney, J. Haapala, D, Booth, C., & Leavitt, S., 1991). To truly maintain those values, programs must rely more heavily on client strengths and abilities to play a larger role in their own change process.

Purpose

The purpose of this paper is to suggest that the ideal measure of outcome in Intensive Family Preservation Services is a broad package of instruments that includes systematic client self-monitoring. The paper will present a model of idiographic self-monitoring in time series, single system research design, developed for Family Partners, a family preservation program in Virginia. The evaluation model not only provides a means of practice evaluation, but also

empowers client families to utilize their strengths to determine their goals, enhance their participation in the change process, and measure their own progress.

Practice Evaluation in IFPS

The appeal to evaluate practice has been a theme in the social work profession from Richard Cabot's 1931 entreaty to, "measure, evaluate, estimate, appraise your results, in some form, in any terms that rest on something beyond faith, assertion, and 'illustrative cases,'" to the 1991 Conference, "Research and Practice: Bridging the Gap," (Cheetham, 1992; Mattaini, 1992), in which the need for an empirical base for practice was argued once again. Competent practice evaluation conforms to research principles (Thyer, 1989), including well proceduralized interventions; authentic systems rather than analogue samples; multiple measures from multiple sources; use of time series designs; and the production of knowledge of practical, meaningful importance rather than statistical significance alone. However, such idealized research is often impossible in many settings where intensive family preservation services are provided. Small programs have neither the resources for formal research nor the numbers of clients for group designs. If practice evaluation procedures in small IFP programs are to be successful, they must follow designs that are "worker friendly", that is, capable of being developed and carried out by overburdened line workers who can practice as "personal scientists" (Blythe, 1990, p. 148).

An ideal package of outcome measures in IFPS would reflect varied perspectives and rely on both standardized and idiographic measures to augment the simple tracking of placement outcome. Such a package should replace pre-post measurement designs with single system research designs of multiple measures in time series (Thyer & Thyer, 1992).

Multiple perspectives reflect the views of at least client, practitioner, and referrer. Standardized scales that measure practitioners' perspective on risk and family functioning further enhance determination of successful outcome. Follow-up satisfaction surveys bring the subjective perception of client and referrer to the process. However, none of the above instruments supports the value of clients as colleagues; nor does comparing a family's functioning against norms on standardized instruments respect the value of "starting where the client is" - rather it starts where someone else has determined that the client should be. An ideal package should take into serious consideration what the members of the client family think the problems are from their individual and cultural perspectives and to what extent the family thinks those problems are abating. Respect for the client family's view suggests a system that includes idiographic self-monitoring instruments in a single system research design. Unfortunately, social workers have not made extensive use of such systems of measurement.

Idiographic Self-Monitoring Instruments

Idiographic self-monitoring instruments are individualized measures of change in a client-chosen target as determined by client-chosen criteria. Created by worker and client to be unique to that client situation, they are intended to be intrusive by requiring members of the client family to be the monitors of change over time. Progress is monitored via a time series, single system research design (SSRD).

Idiographic self monitoring instruments include self-anchored scales (Bloom & Fischer, 1982), but may also be simple frequency counts. Unlike the similar Goal Attainment Scale (Kiresuk & Garwick, 1974; Compton & Galaway, 1989), these instruments are simpler, are monitored by the client and not the worker, and are used in a time series rather than a pre-test/post-test design.

Potential Resistance to Evaluation through Self Monitoring

The practice of using idiographic, self-monitoring, single system research designs is not yet commonplace. Despite the emphasis placed on practice evaluation in graduate programs of social work and the utility of SSRD for that purpose, LeCroy and Tolman (1991) found that social workers in the field did not use the more rigorous inferential ABA or ABAB designs, but relied on the more flexible and descriptive B only or AB designs. Although most respondents were highly favorable towards practice research integration, more than two thirds of those surveyed used no inferential designs in their last year of practice. The authors concluded that the majority of social workers do not use SSRD's because it is only the minority of social workers with a behavioral orientation who tend to use inferential designs, and because workers still do not have adequate training in practice evaluation either from academia or agency.

Social workers have been resistant to systematic measurement systems in part because measurement interferes with their sense of practice as art (Frieband, Jayaratne, Talsma, & Tommasulo, 1993). Instead, they have simply assumed that they were effective with clients, while empirical documentation was absent (Blythe & Brian, 1985).

Social workers believe strongly that they should be practitioners rather than researchers. Gingerich (1990) attempted to settle this debate by making the distinction between practice research and practice evaluation. While research is aimed at knowledge development, evaluation determines whether the practitioner is being effective in work with the client as well as guides the practitioner in deciding if the intervention is effective. Gingerich proffered that direct practice should involve evaluation rather than research.

In addition to discomfort with systematic evaluation of practice, workers have resisted the concept of client self-monitoring, because they see it as too burdensome for clients. Yet, in spite

of anecdotal concern expressed among practitioners that clients dislike formalized study of their progress, Campbell (1990) found that clients accept the procedure of single subject evaluation procedures more readily than they do nonsystematic data gathering procedures.

Intrusive measures, such as self-monitoring, are also seen as contributing to measurement reactivity. When a subject is aware of being measured, particularly if he or she is involved in self-measurement, the validity of the outcome variable is compromised by the process. Client related reactivity is exacerbated by client self-monitoring as the client recognizes the occurrence of a behavior and systematically records that observation (Kopp, 1988). The phenomenon of reactivity makes it difficult to know how much of the change in the outcome variable is due to intervention and how much may be due to the measurement process itself (Bloom & Fischer, 1982).

Reframing Reactivity in Self-Monitoring: Clients as Colleagues in their Change Process

Bloom and Fischer (1982) maintain that while reactivity may compromise outcome, it also contributes to the intervention process. With a type of reactivity known as "measurement as change agent," the measurement process stimulates change in attitude or behavior, or the act of repeatedly practicing through measuring induces learning. Kopp (1988) says, "the belief that one can change may be enhanced through the worker empowering the client to self-record. The commitment to monitor is a commitment to act on a presenting issue, and implies a commitment to change" (p. 15).

Therapeutic reactive effects of self-monitoring have been well documented in behavioral treatment where the outcome is objective, observable, overt behavior (Gingerich, 1979; Kopp, 1988). More recently Applegate (1992) studied the influence of self-monitoring in psychodynamic treatment where the outcome variable was more subjective - the intensity of feelings such as anxiety, depression, and self esteem measured by a set of standardized scales. He hypothesized that particularly in psychodynamic intervention, where increased insight is the key to change, reactivity would be especially welcome. However, results suggested that those in the group that self monitored showed no greater improvement on the subjective measures than those in the non-self-report group. Significantly, though, the self-monitoring subjects did report that the monitoring process had a positive effect on their experience of the therapeutic process - noting in anecdotal comments that the process made them more aware of their feelings, more involved in the process, and contributed to their participation in organizing their process of treatment.

Although Applegate's (1992) findings do not appear to directly support earlier claims that the reactivity of self-monitoring positively affects outcome measures (Gingerich, 1979; Kopp, 1988), the measures chosen were standardized scales of general feeling responses rather than

reflections of the clients' presenting problems or of other client-chosen goals. Since the clients did find that the self-monitoring process increased their awareness and participation in treatment, had the variables measured been those that the clients actively chose to change, measurable changes in outcome might have resulted.

The phenomenon of reactivity in idiographic self-monitoring may be reframed from being detrimental to the validity of the measurement of outcome to being therapeutic by playing an integral part in the treatment process. In developing an idiographic measure with which a particular family may monitor its own progress in IFPS, a worker should acknowledge that this measure, unlike those of an observer, is indeed intrusive and thus prone to client related reactivity. So "measurement as change agent" reactivity stimulates change through enhanced client commitment to the change process, through the repeated practice of the time series design, and through the client participation in the choice and definition of targets to measure. Thus, worker and client can welcome reactivity and fold it into the intervention process.

If part of the change agent system is the measurement itself, and the client designs and carries out the measurement, the client then takes a collegial role with the practitioner. "Client as colleague" is also expressed in the concept of "stakeholder" (Frieband, et al, 1993; Guba & Lincoln, 1989) in the therapeutic process. In research, the major stakeholder is the researcher or the profession in general, interested in generating knowledge; in practice evaluation, the major stakeholder is the practitioner, interested in the efficacy of his or her therapeutic efforts; but in client self-monitoring, the major stakeholder is the client family, interested in facilitating its own change. Thus the purpose of the idiographic self-monitoring measurement system is not only to determine the effectiveness of the intervention, but also to utilize the client's strengths to affect his or her treatment through the self-measurement process. The client as stakeholder should be heavily involved in the intervention process from determining target behaviors to creating appropriate instruments, to monitoring progress.

The Family Partners Model of Self-Monitoring Practice Evaluation

Family Partners is a small family preservation program of the School for Contemporary Education, a private, non-profit special education school in Annandale, Virginia. The program provides intensive services to families with one or more children at risk of placement in foster care, residential treatment, psychiatric hospitalization, or juvenile detention.

In its first eighteen months of operation, Family Partners served 24 families of whom 18 were white, two African American, one Hispanic, one Asian, and two of mixed racial background. Most referrals (33%) were made through Special Education; while 21% came from the Department of Social Services; 17% from Mental Health; 13% from Juvenile Court; and the remaining 16% from other sources. The presenting problem for 20 of the families was coping

with difficult child behavior, for two it was coping with child's mental disorder, and for the last two was child physical abuse.

Family Partners includes idiographic self-monitoring instruments in its evaluation package for each client family. The process of developing these instruments is intended to be both "client friendly" and "worker friendly." That is, the process was designed neither to interfere with the intervention process nor to become such a burden on client or worker that they fail to systematically carry it out. The system is simple, directly related to client-identified problems and client-chosen goals, and easy to monitor. Unlike standardized scales that may have been developed through use with families with ethnic, racial, or cultural backgrounds different from those of the families referred, idiographic self monitoring instruments reflect the experience and needs of each family, defined in their own individual and cultural terms.

The process of developing idiographic self-monitoring instruments at Family Partners begins with family and worker determining specific, observable, and culturally relevant targets for family change. Targets flow from goals, and goals from problems. Client families come to the attention of IFPS programs because of a presenting problem - usually one related to risk of some form of child placement. The presenting problem - risk of placement - can be converted into the major goal of the IFP work - "prevention of placement."

Presenting problem and goal are usually recognized and determined by the institution that referred (child protective services, the schools, the courts, the mental health system). So, for a family to engage as colleagues in the process initiated by a system external to the family, it must translate the goal of preventing placement to target behaviors that the family owns. Targets may either be related or unrelated to the presenting problem and goal. For example, if a mother's substance abuse contributes to her neglecting her children, the target behavior of "avoiding substance use" relates to the overall goal of prevention of placement. If a mother was concerned that her home and yard were full of trash and in desperate need of cleaning, but the reason for referral was unrelated to the home environment, "keeping the home clean" might still be a target behavior that the worker and family would pursue in addition to those that did relate to the presenting problem.

The target behaviors chosen for measurement at Family Partners have three characteristics. First, they may be either overt or covert. "Yelling at the kids," "completing chores," and "following curfew" are examples of overt target behaviors, observable to others. Other targets involve covert behaviors, observable only to the client experiencing them. Feelings of "depression" or "anger," or attitudes such as "self esteem" are examples of covert target behaviors.

Second, target behaviors may be individual or they may be interactive, involving dyads or whole families. "Completing chores" or "following curfew" represent individual targets, while "using I messages," "giving clear directions," or "following directions" all involve interaction.

Finally, strengths-based, solution-focused target behaviors attempt to maintain a positive focus. Positive targets follow the "Dead Person's Rule" (Spiegler and Guevermont, 1993, p. 55) - that one should never expect a client to do what a dead person could do (i.e. "stop talking," "don't argue"). However, some problems, such as an uncomfortable emotion is best measured as a negative target to be decreased in intensity, rather than as a contrived positive such as "feel good". Much of the time, the client may "feel good." It is the times that he is depressed or she lets her anger get out of control that are problematic.

Target behaviors should not be confused with tasks or series of tasks. A task is accomplished at once, while target behaviors involve a process. A mother's applying for food stamps occurs only once and is clearly a task. If a family needs to find a new house, a series of tasks may need to take place. These sort of targets do not lend themselves to self-monitoring scales.

The scales are designed to measure clients' mastery of target behaviors over the course of intervention. Clients monitor targets that they wish to increase or decrease in their duration, severity, or frequency. How long do the child's tantrums last; how severe is the father's anger; how frequently does the adolescent attend school?

Although worker and client select target behaviors by beginning with problems, they develop and meet targets through the mobilization of strengths and abilities. Often families have been so focused on problems that they are unable to see solutions, or to recognize strengths they may have to find solutions. Berg's (1994) solution-focused approach offers several useful techniques to focus worker and client on strengths and solutions, rather than on deficits and problems.

A worker may ask the client the "miracle question" (Berg, 1994, p. 97) to envision what it would be like if a miracle happened overnight and the problem was solved. She would direct her client's thinking to what in his behavior would be different then, and how others would respond differently to him. Another fundamental tenet of Berg's method involves constant use of action questions: what can you do to make it better; what have you done in the past; what have you done since I last saw you? A third type of question involves positive, strengths perspective. What has gone well; or even - why isn't it worse? Both directly and more subtly, these kinds of questions move the client to strengths and solutions rather than deficits and problems and thereby help to reveal appropriate targets for change.

Once client and worker have identified strengths-based targets, they turn to developing the self-monitoring practice evaluation instruments. At Family Partners, workers and clients construct a self anchored or similar self-monitoring scale for each appropriate target (Gingerich, 1979). Some targets, such as school attendance or doing daily chores lend themselves to daily charts of the presence or absence of a target behavior (see Figure 2). The daily charts can later be translated into simple frequency counts by week.

Those targets whose level of duration or severity are better reflected in a self anchored scale. Self anchored scales are self-report instruments, devised by worker and client together, that measure the severity or duration of a client-defined target behavior (Fischer & Hudson, 1983). Each scale measures one target via a numerical range of equal intervals, usually 9 or fewer points. The target behavior should have only one dimension. For example, a client measures sadness on a scale from "very sad" to "not sad at all," rather than from "very sad" to "happy." All or some of the numerical points representing the client's subjective impressions of each target are "anchored" by way of concrete indicators of his or her thoughts, behaviors, or feelings. The indicators are assumed to co-vary with the target (Sheldon, 1983).

Nugent (1993) notes that self anchored scales have advantage over standardized scales, because the client provides the meaning to the construct that is measured, and anchors the points on the scale with descriptors that reflect his or her own meaning. Therefore, these instruments have a strong face validity compared to standardized scales. He attempted to fill a gap in the practice literature by studying the construct validity of a 200 point (-100 to +100) self anchored scale of self esteem against standardized scales of self esteem, depression, and demographic variables. Scores on the self anchored scales were correlated with those of the standardized scales. He found that the self anchored scale provided a valid measure of self esteem, based on convergent and discriminant validity.

Self anchored scales (see Figure 1) can be as simple as a "feeling thermometer" in which a subjective feeling target such as anger, anxiety, or depression is measured with a scaling question (Berg, 1994) - "On a scale of 1 to 10 with 1 being the most depressed that you could be and 10 being the least depressed, how are you feeling now?" A more complex example is the Subjective Units of Distress Scale (SUDS) (Wolpe, 1969), generally a 100 point range to measure how distressed one feels at the moment.

The Design

Ideally, the measurement of change in a target behavior may take place within an inferential ABA design. Such a design requires a baseline measure. In intensive home based programs, where a crisis may have precipitated the referral, a worker cannot wait to make a baseline measure of the outcome variable before beginning intervention. Therefore, she may construct a retrospective baseline, or the baseline may be only a single measure of where the client is at the beginning of intervention. This limitation precludes some statistical analysis of change, but reflects the reality of IFPS.

Following the baseline period (A), observations may be recorded by the client hourly, daily, or weekly to provide multiple measures in a time series during the treatment period (B). Family Partners has the advantage of a less intensive building phase that follows the intensive phase, so that the worker may take a follow-up measure after completion of the intensive phase. Thus

the follow-up constitutes the second A phase. Since the building phase involves additional treatment, the design is better characterized as ABCA, if follow-up measurement is again taken after completion of the building phase.

The Analysis

Data from self anchored scales is easily graphed and visually analyzed. When there is adequate baseline data, procedures such as the Shewart Chart can determine statistical significance of the change (Bloom, Fischer, & Orme, 1995). In the Shewart Chart, baseline and intervention observations are graphed, a mean for the baseline period is calculated, and two bands representing two standard deviations from the mean are drawn through the intervention area of the chart. When two successive intervention points fall outside the bands, statistically significant change is assumed.

Client Example

The Thomas family was referred to Family Partners, because Samantha, age 16, was at risk of return to psychiatric hospital unless changes in her family environment could help her maintain control of her behavior. Ms. Thomas defined as her own problem that she felt very uncomfortable when she attempted to set limits with Samantha and her sister. Intervention was aimed at increasing her comfort in limit setting, rather than in actually building the skill. So, rather than attempting to measure the mother's success in setting limits (which she could have chosen to do), the family worker devised a simple 10 point comfort scale in which the mother monitored her chosen target - "feeling of comfort in setting limits." The father constructed a similar scale to monitor his target of comfort in spending time with his daughters. These scales are examples of measuring a covert behavior, comfort, the severity or intensity of which the parents desired to increase. Although parents and worker could have chosen to measure "discomfort," that they wished to decrease.

It is important in helping clients to devise feeling thermometers not only to choose a point scale, but also to attempt to "anchor" the points (see Figure 1). For example, a five point anger scale might be anchored by "feeling in control, calm" at the zero end, and "feeling very angry, feel like hitting." The same parent working on learning to discipline appropriately might "anchor" the high end of the scale on that emerging skill with, "very appropriate, give warning, give consequence, ignore back talk," and the low end with, "not at all appropriate, no follow through." Anchors are entirely idiosyncratic and must have meaning only to the client.

Figure 1

1. Level of anger	0	1	2	3	4
no anger, feel in control, calm			Moderately angry, feel "hot," raise voice		very angry feel like hitting
2. Ability to discipline appropriately	0	1	2	3	4
very appropriate, give warning, give consequence, ignore back talk			moderately appropriate shout consequence, no warning, anger shows, can't ignore		not at all appropriate, no follow through

Figure 1. Two item scale measuring mother's ability to manage anger and apply appropriate discipline, measured each time child misbehaves.

In the Thomas family, the daughter, Samantha, sought to increase two overt target behaviors. She monitored progress on the targets of "attending school" and "taking medication" by simple daily frequency counts, recorded on a chart (see Figure 2). No anchors would be needed with a frequency count self-monitoring instrument.

Figure 2

Samantha's Targets: Week of (date) _____							
	Su	M	T	W	Th	F	S
1. Attends School	xxx						xxx
2. Takes Medication							

Figure 2. Example of chart to monitor an adolescent's progress on complying with target behaviors.

In addition to severity and frequency, self-monitoring scales may also measure duration of target behaviors. The mother might choose to monitor the duration of arguments with Samantha, keeping track of the time and length of arguments over a period of weeks.

Conclusion and Implications for Family Preservation Practice

Family Partners is too new to be able to make definitive conclusions about the impact of its use to date of self-monitoring scales. More data and further analysis will be necessary. Future study might attempt to test the hypothesis that reactivity plays a beneficial role in the treatment process, or that use of self monitoring enhances clients' sense of empowerment in the process of change.

This paper presents idiographic self-monitoring in a time series design as a means of intervention with and practice evaluation of an individual client. However, these instruments may also be used in program evaluation by aggregating the pre and post score data across clients and comparing means. Individual measures would have to use the same numerical scale (9 point, 100 point, etc), or data from differing pre and post scores may be converted into standard scores and aggregated.

Idiographic self-monitoring is a powerful tool for use not only in evaluation, but also in the intervention process itself. It is yet another way that family preservation programs may enhance client strengths to increase client participation as colleagues in the process of change.

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Evaluating Family Preservation in Nevada: A University-State Agency Collaboration

Christine Bitonti and Joy Salmon

In this paper, concepts from the emerging family-centered paradigm in child welfare and mental health are applied to evaluative research in family preservation: the ecological perspective, enhancement of competence, a consumer orientation, and collaborative relationships. The experience of family preservation research collaborators from the School of Social Work at the University of Nevada, Reno and the Nevada Division of Child and Family Services illustrate these concepts. The researchers apply the theory of isomorphism to the research endeavor to produce eight principles of effective research partnerships derived from family-centered concepts and their own experiences.

A critical shift in the conceptualization, organization and delivery of human services is taking place within many fields of practice, most notably child welfare (Kinney, Strand, Hagerup, & Bruner, 1994; Pecora, Whittaker, & Maluccio, 1992) and mental health (Knitzer, 1993; Rapp & Wintersteen, 1989). This paradigm shift has impacted practice at all levels: policy, administration, training, and client services. While little has been written about how these new ideas influence the research endeavor, the potential impact is considerable. This paper concerns the application of concepts from this new wave of thinking to the practice of evaluative research in the Family Preservation Services program in Nevada.

Sometimes termed family-centered practice in child welfare (Pecora et al., 1992) and the empowerment or strengths perspective in mental health (Rapp & Wintersteen, 1989), the paradigm represents both alternative ways of viewing and interacting with clients and new approaches to developing and implementing service delivery systems. While some aspects of the models differ from one field of practice to another, there are commonalities across disciplines and systems of care (Petr & Allen, 1995). A systems perspective provides a unifying framework for understanding the common themes in this new service paradigm (Becvar & Becvar, 1988).

The first commonality is an ecological perspective at all levels of practice and service delivery: the client, the family, the client-serving organization, and the community (Pecora et al., 1992). An ecological perspective involves the acknowledgment of the context within which one lives

and acts and the relationships that exist and impact upon one's well-being and life outcomes (Germain & Gitterman, 1980). Human services delivered within an ecological perspective are holistic, relational, contextual, reciprocal, and relativistic. The family, in particular, is recognized as the context providing relationship and attachment for its members. Cultural, economic, and social communities are acknowledged as contexts within which a family moves and defines itself. Service providers and systems of care are recognized as creators of the context for change.

A second commonality is a focus on the *enhancement of competence* (Harris, 1995; Kinney et al., 1994; Maluccio, 1981; Pecora et al., 1992). Client assessments in this model encompass not only the identification of risks and vulnerabilities, but also how individual and family strengths, resources, and capabilities moderate these risks and can be used to facilitate change. The assessments are descriptive rather than causally evaluative. They acknowledge the existence, complementarity, and utility of dichotomies--such as problems and possibilities--and thus, enhance a sense of hope and self-efficacy in both client and worker.

Third, the emergence of a *consumer orientation* to service provision insures that services are responsive to the individual needs of a client as defined by the client. This orientation is typified by the co-creation of service goals and methods by client and worker (Balassone, 1994; Center for Study of Social Policy, 1994) and often results in provision of services in natural settings (home and community) rather than the artificial environment of a worker's office. In addition, identified client needs and desired outcomes drive service delivery, not the worker's preferred therapeutic model or approach (Rapp & Poertner, 1988).

The fourth commonality across systems of care is the promotion of *collaborative relationships* throughout all phases of service design and delivery: between client and worker, among staff, between management and line staff, among social service organizations, and between universities and agencies, particularly in the evaluative phase of practice (Kinney et al., 1994; Knitzer, 1993; Kutash, Duchnowski, & Sondheim, 1994). Collaborations of this nature are characterized by reciprocity and recursiveness within a systems framework, a cornerstone of the new service delivery paradigm.

Consistent with elements of the paradigm shift in the human services, staff from Nevada's Division of Child and Family Services (DCFS) and the School of Social Work, University of Nevada, Reno sought to implement a model of collaborative research that would overcome problems encountered in typical "town and gown" partnerships of this nature. Historically, some of the difficulties have stemmed from differences in the organizational cultures of universities and service agencies and differing expectations and needs of the partners involved (Abramczyk, Raymond, & Barbell, 1992).

Peterson (1993) has identified four areas of potential conflict between human service agency and academic cultures: priorities, values, processes, and focus of results. He found agencies

to be oriented toward service rather than research and education. Agencies tend to value immediate answers to questions and short term vision rather than durable answers and long term vision. They tend to be bureaucratic and multidisciplinary, rather than entrepreneurial and unidisciplinary. Approaches to problem identification and resolution are comprehensive and pragmatic in the agency environment, narrow and theoretical in academia. Research results are utilized by agencies to implement entire systems of care within a political context. Universities utilize results to demonstrate the effectiveness of a specific model of intervention in a non-political arena.

Recognizing and honoring the validity of these differing cultural perspectives provides a foundation for effective working relationships between service agency personnel and academics. To ignore the differences or minimize their potential impact on the collaborative research process is to invite frustration at best, failure of the endeavor at worst.

Background

Much of the literature concerning agency-university collaborations has focused on the joint provision of staff and student training and development of field placement opportunities (see, for example, Briar, Hansen, & Harris, 1991; Rabin, Savaya, & Frank, 1994). A renewed commitment in social work education to improve services to public sector clients has fueled the growing interest in collaborative efforts of this nature (Grossman, Laughlin, & Specht, 1992).

Less attention has been paid to research collaborations than to those focused on training and placement. However, the growing demand for accountability in human services has provided the impetus for new partnerships in this arena as well. There is little question that research is critical to policy and program development (Wodarski, 1994). While a substantial research base is available to guide practice and decision-making in the child welfare arena (Pecora et al., 1992), much more is needed.

Successful agency-university research collaborations have occurred in the health and mental health fields, among others. Across the country, schools of social work are engaged in collaborative research ventures in a state hospital (Mokuau & Ewalt, 1993), a Department of Veterans Affairs medical center (Rathbone-McCuan, Harbert, & Fulton, 1991), and a variety of health care settings (Bogo, Wells, Abbey, Bergman, Chandler, Embleton, Guirgis, Huot, McNeill, Prentice, Stapleton, Shekter-Wolfson, & Urman, 1992). Reports of these projects emphasize shared decision-making and governance in the design and implementation of research, developmental stages in the collaborative process, and the importance of research utilization.

Specific problems that have emerged in public sector-academic research collaborations include, among others, insufficient lines of communication between public agencies and universities.

"Few states have consistent systems or processes whereby communication linkages are established and nourished" (McFarland, Diblasio, & Belcher, 1993, p. 429-30). Even when these linkages occur, miscommunication between researchers and program staff is common. The language of academia and research is often confusing to agency personnel, whose concerns about program implementation may seem trivial to a researcher hoping to obtain important theoretical findings.

Past involvement in research on the part of agency staff has proved, at times, a disincentive to collaboration when workers' efforts (often considerable) have gone unrewarded and few attempts have been made to utilize research findings in any practical way (Rathbone-McCuan, et al., 1991). While academic researchers are often focused on publication of findings, workers want results that can be translated into improved practice. If findings are too esoteric for application in the field, workers may feel used and unlikely to participate in future research.

What appears to be missing in the literature relating to agency-university research collaborations is a unifying conceptual framework. The authors are proposing that features of the emerging family-centered paradigm be adapted to the research context. The concept of isomorphism is useful in conceptualizing this application of practice principles to research.

Isomorphism in Practice and Research

The concept of isomorphism suggests that connecting systems have parallel interactional processes that both mirror and influence one another. "Sequences of interaction and more broadly, contexts themselves, become replicated at different levels of a system" (Liddle & Saba, 1985, p. 37). Liddle and Saba describe the isomorphic nature of training and therapy by the following questions, "What is there that is the 'same' about training and therapy?" and "How are the elements of each contained in the other?"...the 'sameness-in-differentness' principle" (p. 30).

When research and practice are viewed systemically, each informs the other. The same isomorphic questions posed for training and therapy can be applied to evaluation and practice: "What is there that is the same about evaluation and practice?" "How are the elements of each contained in the other?"

One could argue that each enterprise entails phases of assessment and intervention and that communication within both the practice and research arenas involve metamessages--covert meanings not always consistent with articulated policies and procedures. Both consumers of evaluation research and consumers of child welfare practice have experienced their respective services as deficit-oriented, intrusive, and punitive/blaming, resulting in defensive and self-protective responses.

Actively constructing a model of evaluation that supports the development of self-efficacy and actual competence and is both friendly and useful to consumers--in this case, line workers, supervisors, and program managers--may contribute to the replication of this pattern in the arena of practice. The reverse may be true as well. Practice paradigms that are ecological in perspective and consumer-driven, competence-based, and collaborative in nature invite evaluative models that reflect the same principles. An understanding of isomorphism is critical to the intentional creation of systems of care and systems of evaluation that are complimentary rather than conflictual. In the field of family preservation, where the family-centered, strengths-based paradigm is applied almost universally, evaluation approaches must mirror practice to be effective.

Family Preservation Research in Nevada

The development of Nevada's family preservation research project followed the sequence of events identified by Harris (1995) in a study of social work school-agency partnerships, beginning with a significant event that prompts communication about the possibility of collaboration. A university researcher at the School of Social Work, University of Nevada, Reno approached personnel in the Division of Family Services, inquiring about research needs of the Division.

Possibilities for joint projects were identified. Key leaders engaged in dialogue, negotiating elements of the collaboration. The purpose and vision of the project were articulated: a study of the nature and impact of the state's four year-old family preservation program would be undertaken. Resource needs were defined; timelines were established; and the resources were obtained. In true collaborative fashion, both the university and the state agency contributed substantially to the fledgling effort. Funding was obtained by the researcher through a faculty research development program, and the Division provided management and clerical staff to assist the university researcher in conceptualizing the project and obtaining access to data (in the form of closed case files).

The partnership was implemented formally through a memo of understanding between the Division and the School of Social Work. Supervisory and line staff were apprised of the project's intent and methods, although they were minimally involved at this stage due to the nonobtrusive nature of the research design. They were asked at various points to provide information that would enable findings to be interpreted within an appropriate context. The final report of the first phase of the project was shared with staff at all program sites and was subsequently utilized in program decision-making.

Division staff and the university researcher had agreed that the initial study would focus on the considerable data that had been collected in the program's first four years, since not much was known about characteristics of those families who successfully avoided placement and those who did not. A systematic review of closed case records revealed useful information within a

formative research framework. However, summative-level questions--those of most interest to policy-makers--could not be answered in a retrospective, cross-sectional study of this nature. Additional prospective research would be needed to accomplish this aim.

The second phase of research was planned in connection with a grant application submitted by the Division to the National Center on Child Abuse and Neglect (NCCAN) for enhanced family preservation services in Nevada. The grant was subsequently awarded for a 17-month demonstration period. The evaluative component of this project includes experimental and follow-up elements and calls for collection of a variety of outcome data in addition to out-of-home placement, the only outcome measure possible in the original study. The following outcome measures are being utilized: the Child Behavior Checklist (Achenbach & Edelbrock, 1983), Family Satisfaction Scale (Olson, McCubbin, Barnes, Larsen, Muxen, & Wilson, 1992), and the Family Risk Scales (Magura, Moses, & Jones, 1987).

A third stage of this collaborative research will involve integration of the project into the state's five year plan for family preservation and support services with a longitudinal design. At this stage of development, the most useful of the outcome measures will be built into an ongoing system of monitoring and evaluation.

Because of increased rigor of design in the second phase of the project, the university researcher and Division staff faced new challenges--chiefly, how to involve supervisory and line staff more directly in the research effort, since they would have to collect much of the data. Communication and joint problem-solving became all that much more critical to the success of the collaborative venture. Unfortunately, the federal grant application timeframe (approximately six weeks) allowed for little involvement of direct service staff in the conceptualization of the research project. In retrospect, this circumstance proved a critical (but not fatal) flaw in the implementation of this collaborative effort.

Principles of Effective Research Collaborations

To identify key principles in agency-university partnerships, the authors drew on the concept of isomorphism in relation to the four overarching themes in contemporary child welfare practice as well as their own collaboration experiences--both positive and negative. Although far from exhaustive, this set of guidelines is meant to stimulate discussion of the issues involved and, hopefully, motivate others to seek out joint research opportunities.

Ecological perspective. Just as effective family preservation practice must take into account the contexts of family and community, *a successful research collaboration must be systemic and holistic in approach*, taking into consideration the macro environment in which it is embedded. Nevada's NCCAN demonstration project involves seven partners, all of whom have been involved in various ways in the evaluation process. These partners include three county agencies (a child protection agency, a county juvenile services department, and the health district) along with two state agencies (the Bureau of Alcohol and Drug Abuse and the Bureau

of Community Health Services) in addition to DCFS (the state child welfare agency) and the UNR School of Social Work. All of these entities have an investment in the development of family preservation services. The three frontline investigative agencies play key roles in the identification and referral of families in need of intensive home-based services. Their active participation in defining the project's target population and referral procedures was critical to the implementation phase of the project as was their support and sanctioning of staff training in a new risk assessment tool to be utilized in the research.

Second, *internal organizational support for research is a prerequisite to successful collaboration.* This principle is so basic it can easily be ignored, creating problems in research implementation in the future. Both university support for faculty involvement in this applied research effort and agency support for staff participation in data collection were obtained prior to project implementation. The researcher held discussions with both the School Director and College Dean about the difficulties inherent in publishing applied research findings. Possibilities for scholarly output were identified, and the project was justified on the basis of its consistency with the university's newly articulated policy on community outreach.

At DCFS, discussions were held between the mid-level manager charged with implementing the demonstration project and the Division's Deputy Director who approved both the intent of the research and the staff resources necessary to carry it out. The Deputy Director verbalized support for an ongoing evaluation of Family Preservation that would be carried out in stages.

Enhancement of competence. Typically, external program evaluations are perceived by staff as a means to monitor professional activities and uncover evidence of the program's failure to obtain desired results. Even when program successes are observed and noted, the identified deficiencies seem to draw the most attention, particularly on the part of management and policy-makers. Further, workers perceive that research tasks bearing little relevance to their daily activities are imposed upon them at great inconvenience.

A competence-based research collaboration suggests that *the focus of inquiry should be on program strengths and successes and the identification of opportunities for program enhancement.* Workers should be drawn into the process of defining research objectives as early as possible. Their information needs should be considered throughout the conceptualization and design phases of the project. Whenever possible, outcome instruments selected for use in the study should be useful for practice.

In the Nevada NCCAN project, the Family Risk Scales (FRS) were selected as a means of documenting reduction of risk when it occurred in families and to help workers focus on key areas for intervention that would likely increase their success. It is as yet unclear to what extent the workers find this instrument helpful. Early feedback suggests that some staff are neutral toward the FRS, completing the form in a perfunctory way. While it may not add to their sense

of competence, the instrument does not appear to hinder their work. The use of another instrument, the Child Behavior Checklist (CBCL) is far more controversial. The CBCL is viewed as intrusive (because a parent must provide the information) and inconsistent with the program's solution-oriented framework (because it focuses on problem areas).

Had existing line and supervisory staff been more actively involved in the process of selecting outcome measures for this project, perhaps instruments could have been located with greater perceived clinical utility, thereby enhancing worker competence and, at the same time, improving the reliability of data collection. Continued training in the both the intent of the research and application of the solution-focused model of treatment may help to change staff opinions about the use of standardized outcome measures. In time, discussions about the meaning of study results may help workers see the benefits of their participation in program evaluation.

Consumer orientation. As practice moves toward a consumer focus (Tower, 1994), so must evaluative research. No longer can academics focus solely on the publication possibilities inherent in a particular endeavor if they are to achieve effective collaborations with public sector agencies. The needs of a number of distinct audiences must be considered: administrators, policymakers, clients, other professionals, and service funders (Ballasone, 1994). *Collaborative research must be consumer-oriented and user-friendly.*

One of the ways in which academic researchers can become more consumer-oriented is to recognize the political environment in which human service agencies operate, preparing data in many different forms, depending on the audience. In the case of Nevada's NCCAN demonstration project, the information needs of the federal funding agency differ in some respects from those of the Division's top management who must sell the program to the legislature on the basis of cost effectiveness and those of program staff who are interested in maximizing their effectiveness with particular clients. Chambers, Wedel, and Rodwell (1992) suggest that consumer-oriented research must fit the program objectives, be realistic, and incorporate both quantitative and qualitative measures of effectiveness.

Researchers should adopt a developmental approach--long advocated by Whittaker and Pecora (1981) and others in child welfare--recognizing that agencies need time to develop their capacities to conduct and utilize research. This approach entails planning studies in phases that correspond to the expanding information needs of the organization and to growing research sophistication among staff. Thomas (1978) observed more than a decade ago that developmental research represents "the single most appropriate model of research in social work because it consists of methods directed explicitly toward the analysis, development, and evaluation of the very technical means by which social work objectives are achieved--namely, its intervention technology" (p. 480).

The first phase of family preservation research in Nevada involved an exploratory, nonobtrusive study of closed case records--not as rigorous a design as some university researchers might desire, but clearly responsive to the agency's immediate needs and level of readiness for research. Asking such questions as: "What are the characteristics of clients served by the Family Preservation program?" and "What are the differences in patterns of service delivery for successful versus unsuccessful cases?" provided valuable formative-level insights on which subsequent, and more sophisticated, phases of research are now being planned and executed.

A consumer-oriented approach also suggests that *researchers should demonstrate flexibility in the implementation of designs.* Modifications may be required in response to unanticipated field constraints. In fact, Nevada's NCCAN project experienced one of the serious implementation problems identified by Haapala, Pecora, and Fraser (1991): lack of full participation and support from referring workers, which resulted in an insufficient case flow to insure an adequate comparison group. It became necessary to reduce expectations about the possibility of achieving an experimental design, emphasizing the longitudinal aspects of the study instead.

Collaborative relationships. In the new child welfare paradigm, collaboration is not simply a new "buzzword." It defines the essence of practice, just as it must for effective research, particularly in the family preservation arena. The old model of university-based research in which the academic selected tools, imposed them upon staff, collected and analyzed data in isolation, and drew conclusions with little consideration of context is unlikely to yield useful information for those who need it most. Now, *academic researchers and program staff at all levels must communicate openly and directly* to identify researchable questions, design studies, and solve problems that emerge along the way. They must forge a common language--sufficiently technical, but free of unnecessary jargon--that facilitates direct involvement of all parties at each stage of the process and promotes two-way communication.

In Nevada, ownership of the process and products of family preservation research is shared jointly by DCFS and the UNR School of Social Work as Mokuau and Ewalt (1993) suggest they should be. When information about the research project is needed--as it was recently in statewide planning meetings for comprehensive family support and preservation services, the DCFS program manager and the university researcher presented jointly. Each partner has a unique role to play, of course, but both perspectives are needed to convey an accurate picture of this research endeavor. In collaborative presentations, the DCFS manager generally focuses on the purpose of the study, how results will be utilized in planning, and how the project fits into the Division's long-range vision for program evaluation. The researcher addresses technical aspects of design, measurement, and data analysis.

The university researcher in Nevada's family preservation research project is not isolated from line and supervisory personnel as is sometimes the case in university-state agency collaborations. Time and distance constraints do pose challenges in this regard as programs are

approximately 30 to 50 miles from the university. However, research team members have visited all program sites and have met on several occasions with supervisors as a group. Initially, the researcher trained staff directly in the use of outcome measures and returns to the field periodically to reinforce their proper administration and to answer questions about the project. In addition, staff members have called the university directly with pressing issues and questions. Staff have been vocal and honest in expressing observations about the data collection process in which they are significantly involved.

The final--and perhaps most important--principle of effective research collaboration is the notion that *all parties involved must engage in an overt process of negotiating needs and interests*. While the university researcher may adopt a consumer orientation in relation to agency management and staff, such a stance does not preclude a focus on issues and needs important to the academic. On the contrary, in an effective collaborative process, those needs will be acknowledged and addressed.

The process of negotiation is made easier when the academic has participated significantly in the practice world and understands the culture of the agency and when agency staff have taught courses or served as field instructors in academic programs. Regardless of the past experiences of the parties involved, however, recognition of the differing cultures of state agencies and universities is essential to the success of the research endeavor. Nothing can substitute for honest discussion and debate about the technical, ethical, practical, and political issues involved in research and the expectations of those who are most closely involved.

Summary

The recognition within child welfare practice and policy development that new models of intervention are needed--models that involve clients as active partners in the helping process and forge new collaborations in the macro environment--is a refreshing trend in the field. The authors contend that the paradigm shift occurring in the practice arena must be mirrored in the evaluative process in order to maximize research effectiveness.

Researchers and agency personnel have only to look to the specific components of the changing ideology to find guidance for creating vital, relevant research collaborations. Adopting an ecological perspective and a competence-based, consumer-oriented research strategy that recognizes the respective research partners as equals appears a potentially useful strategy for breaking down traditional barriers in state agency-university research collaborations.

Novel solutions for emerging problems in these collaborative efforts must be sought: 1) how to effectively involve direct line staff who must often carry out the data collection in an outcome-oriented study, 2) how to recognize all the likely consumers of the research and anticipate their questions and information needs, 3) how to communicate effectively despite considerable geographical distances between partners, and 4) how to respond to changing

conditions in the macro environment. Nevada's partners in family preservation research have not found all the answers to these questions, but the commitment to do so propels the long-term research project forward and keeps investment in the process high.

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The Family Partners Credit Card: A Token Economy System Adapted for Intensive Family Preservation Services to Enable Families to Manage Difficult Behavior of Adolescents

Jude Nichols and Barbara Peo Early

Increasingly, families referred for Intensive Family Preservation Services have not experienced a crisis of maltreatment, focused on the parent; rather these families have children with chronic behavioral difficulties for which their parents lack the skills to cope. These are the same families whose children were formerly placed in residential programs. This paper presents The Family Partners Credit Card System, incorporating behavioral techniques developed to treat children in out-of-home placements into a family preservation model. Two case examples illustrate how the system has been modified to train biological or adoptive parents in parenting skills, enable them to teach their children pro-family behaviors, and reinforce new behaviors through a credit card that monitors an ongoing balance of credits and fines.

Intensive Family Preservation Services (IFPS) seek to prevent out-of-home placement of children. Traditionally, the families of these children are at "imminent risk" of separation due to a crisis of abuse or neglect (Kinney, Haapala, & Booth, 1991). Increasingly, however, families referred for IFPS have not experienced a crisis of maltreatment, focused on the parent. Rather these families have children, often adolescents, who display chronic behavioral and learning difficulties for which their parents lack the skills to cope (Werrbach, 1992). These are the same families whose children were formerly placed in residential or treatment foster care programs where various behavioral techniques have been used successfully to build adaptive behaviors and decrease maladaptive ones (Schwartz, I., AuClaire, P., & Harris, L, 1991).

The purpose of this paper is to present the Family Partners Credit Card system, incorporating techniques that were developed to treat children in out-of-home placements (Hawkins, J., & Catalano, R., 1990) into a family preservation model, thus preventing such placement. The system combines training biological or adoptive parents in parenting skills, enabling them teach their children pro-family behaviors, and reinforcing new behaviors through a credit card that monitors an ongoing balance of credits and fines.

Literature Review

Behavioral Contracting within Families

The behavioral contract has been used extensively over many years by clinicians working with the families of children with behavioral difficulties (Stuart, 1971; 1972). Behavioral contracting recognizes the family, rather than the child, as the client. Contracts are based on the assumption that families have played a role in the etiology of behavioral difficulties by modeling and reinforcing antisocial behavior, and by neglecting to reinforce prosocial behavior. By extension, families can facilitate change when they learn to model and reinforce prosocial behavior. Working indirectly through the parent to affect the child's behavioral targets of change, clinicians work with parents as "mediators" in the natural environment, so that the parents may then modify the behavior of their children. Parents as mediators of change reassert parental authority and shift the emphasis from negative control through punishment to positive control through reinforcement (Morton and Ewald, 1987).

Stuart (1971) found that the important factor in contracting was not the contract itself, but the interactive process of negotiating the contract and the facilitation of communication. Rather than the linear concept of a parent's merely reinforcing a child's behavior, the parent and child are seen in a mutual exchange of reinforcers (Stuart, 1971). In behavioral contracts, parties exchange both privileges and responsibilities. Therefore, each must accept the idea that he or she should compensate the other fairly for that which is received, and that each has the responsibility to grant privileges, but on a reciprocal basis.

Behavioral contracts include five elements: privileges, responsibilities, sanctions, bonuses, and a means of recording (Stuart, 1971). Privileges are gained when one performs responsibilities. For adolescents, privileges may include time with friends, allowance, television, or use of the car. Responsibilities, such as school performance, maintaining curfew, and doing chores, are required in exchange for privileges. They are the desired responses of the children and the reciprocal reinforcers for the parents. Behavioral contracts include sanctions for failure to meet responsibilities. Ideally, an adolescent is motivated to complete responsibilities through the expectation that if she does not, she will not earn privileges. However, sometimes it is "worth it" for an adolescent to fail to perform a responsibility and forfeit a privilege, because the alternative is more reinforcing than is the privilege. Thus, sanctions can "tip the balance" to make compliance worthwhile. Imposing sanctions also gives the parent a calm outlet for expression of anger at the child.

Bonuses are awarded when the child complies exceedingly well. Bonuses help families counteract the tendency to engage in "negative scanning" (Stuart, 1971, p. 6) in which parents tend to ignore positive reactions on the part of their children, thus weakening them; and severely punish negative responses, thus strengthening them through negative attention. Finally, behavioral contracts require a means of recording - a monitoring form. The monitoring form

cues the individuals as to how to respond to earn privileges, and signals each when to respond to the other.

Token Economy in Residential Programs

The token economy, a specific form of behavioral contracting that includes all of its five elements, was developed for use with groups of psychiatric patients, students, or inmates in institutional and residential settings (Ayllon & Azrin, 1968; Braukmann & Wolf, 1987; Phillips, Spiegler, & Agigian, 1977). In the token economy, an explicit system of reinforcement incentives were intended to both strengthen desired behaviors and to increase motivation to perform them.

Members of the institutional group earn a specific number of symbolic points or tangible items such as poker chips for performing previously chosen target behaviors. Tokens may also be lost for performance of unwanted behaviors (Spiegler & Guevremont, 1993). At a specified point, a remaining balance of tokens may be exchanged for backup reinforcers (or privileges) selected from a menu of activities and commodities that are salient for each individual and for which a specific token cost has been predetermined (Spiegler & Guevremont, 1993). The "cost" of privileges is based on supply and demand, with those privileges in high demand and low supply costing more than those in low demand and high supply. Thus, token economies combine the properties of positive reinforcement that encourage desirable behaviors, with those of response cost that discourage undesirable behaviors (Milan, 1987).

The Token Economy and Behavior Disordered Adolescents - Achievement Place and The Teaching Family Model

Following its development for psychiatric inpatients, the token economy system was adapted for use in group home residential rehabilitation programs for juvenile offenders. Applying knowledge from research begun at the University of Kansas in the late 1960's, Wolf, Phillips, & Fixen (1972) established the teaching family model for Achievement Place, a rehabilitative group home for boys (Phillips, 1968; Maloney, Fixsen, & Elery, 1981; Fixsen, D. & Blase, K., 1993). The underlying assumption of the model was that an adolescent's behavior is a function of, "past behavior-environment interactions (learning history), currently ongoing behavior-environment interactions, and genetic and organismic variables" (Braukmann & Montrose, 1987, p. 138). In addition, deviant behavior learned earlier is exacerbated in adolescence by "inappropriate parenting, deviant peers, and school failure" (p. 138). Therefore, changes in behavior should best occur in teaching environments with varied and salient reinforcers.

At Achievement Place, married couples called teaching parents maintained a family-like home with a small group of adolescents in a cottage. Teaching parents were trained in behavioral

methods and skill teaching--including the token economy. The teaching family model involved a level system of the token economy in which the new residents participated in a daily system, exchanging points each day for backup reinforcers (Phillips, 1968; Braukmann & Montrose, 1987). Once familiar with the system, the boy advanced to a weekly system in which he could exchange points only once a week. Finally, as the boy approached the time of his leaving the program, he moved to the merit system, where all points for appropriate behaviors were eliminated and replaced with social reinforcers of praise. The goal of this and any reinforcement program was to gradually fade or withdraw contingencies while ensuring generalization of the behavior within the natural environment, thus decreasing dependence on the system (Masters, Burish, Hollon, & Rimm, 1979).

The Credit Card System

The credit card system, a further variation of the token economy, was developed by Spiegler and Agigian (1977) in the late 1960's to motivate psychiatric inpatients to perform basic self care behavior and independent living skills in preparation for discharge. Instead of points or tokens, each patient received numerical "credits" that were recorded daily in one column on his or her printed "credit card". Credits were earned for learning and practicing the skills needed for independent living.

Another column of the credit card was reserved for the spending of credits. Here were recorded the spending of earned credits on chosen activities or commodities as backup reinforcers, as well as the spending of earned credits on privileges. "Spending privileges" (Spiegler & Agigian, 1977, p. 131) refers to the spending of credits on behaviors that may be personally reinforcing but are considered maladaptive or antithetical to the goals of the program. At the end of each day, the balance was computed and carried over to the next day's card. As time passed, reliance on the credit card was faded and a new system using natural reinforcers was shaped.

The issuance of tokens, points, or credits, while withholding the back-up until later, has the advantage over general behavioral contracts and typical reinforcement systems of eliminating the need for immediate provision of reinforcers (Masters, et al, 1979). By giving a token in lieu of the tangible reinforcer, one may significantly "bridge the delay" (Phillips, 1968, p. 214) between the time of the behavior and the time of the back up reinforcer. The disadvantage of token economies in residential settings is that they are not part of the youth's natural environment. Thus, generalization to the home and family may be problematic.

Additionally, the token economy system depends on organization and resources such that a supply of back-up items or activities is always readily available. Clients must "buy into" the system and value the tokens in order for the economy to be effective (Masters, et. al., 1979). Investment is more likely in a group setting than in a biological or adoptive family, since the group applies more peer pressure to conform from those already socialized. Finally, the

management of a token economy requires organization, patience, and consistency of response from those in charge of the system, taxing to a family already under stress.

Following their review of the outcome of the token economy behavioral contracting in teaching family group homes, Braukmann and Wolf (1987) concluded that the original assumption that learning would generalize to the young peoples' family and community environments was naive. Either the youths did not have parents to whom to return, or the parents were not interested in changing their own practices that contributed to their children's problems. The authors noted that the developers of the model concluded that these youths need "adequate families" (p. 154) to carry them through the turbulence of adolescence. Thus they suggested long term special foster care programs.

This pessimistic conclusion suggests the typical solution of removing the problem child, rather than the problem, from the family. An alternative is for family preservation workers to take advantage of the intensity and intimacy of their model to adapt the credit card system for effective use in the home with biological or adoptive families and so prevent placement. Family Partners is doing just that.

The Family Partners Credit Card System

Family Partners is an intensive, home-based, family preservation program of the School for Contemporary Education (SCE), a non-profit special education school in Annandale, Virginia. Its family workers have borrowed techniques from Community Teaching Homes (CTH), SCE's treatment foster care program for children in need of specialized foster care. The population of identified clients at Family Partners is similar to that of Community Teaching Homes. Of the families referred to Family Partners in its first year of operation, the presenting problem for 83.3% (n=24) was difficult child behavior.

The case managers of CTH have long taught a credit card system to their teaching parents, one based on concepts of the teaching family model (Wolf, Phillips, & Fixen, 1972). Where at CTH, all families use such a system, at Family Partners, family workers are using the system with only about 20% of the families--those who believe they can work with such a system and are willing to use it to encourage their children's new and adaptive behaviors. It was assumed that universally applying an unaltered CTH credit card system, developed for professional foster parents, within the diverse biological or adoptive families at Family Partners, would likely meet with failure. Thus, the family workers at Family Partners have simplified and modified the system to be realistic for use in intensive home based services for some of the families coping with their adolescents' behavioral difficulties. Such adaptation highlights the positive aspects of the token economy system and fosters a positive view of families as colleagues, reflecting the family preservation and strengths based perspectives.

The Family Partners Credit Card System is a process consisting of a family worker teaching positive parenting skills to parents, parents using these skills to teach pro-family behaviors to their children, and the strengthening and maintenance of those pro-family behaviors through monitoring and reinforcement of the credit card itself. To illustrate the process, the credit card format will be described, and then the steps for teaching parents how to teach their children will be demonstrated through case examples.

The Credit Card Format

The credit card is a daily monitoring form (see Figure 1) that documents a running balance of credits and fines for a child or adolescent's generic target skills as well as for individualized targets. Unlike the credit card in institutional settings, the Family Partners system does not continuously carry over the credit balance. Rather, credits are exchanged the following day for expected daily privileges and special earned privileges.

Figure 1

FAMILY PARTNERS CREDIT CARD

Name: _____
Date: _____

CREDITS					T	BEHAVIORS	FINES		T
						1.			
						2.			
						3.			
						4.			
						5.			
Total credits:						Today's balance:		Total fines:	

PRIVILEGE BALANCE: _____	
<p style="text-align: center;">Privileges</p> <p>200+ 175 150 125 100 75 50 25</p>	<p style="text-align: center;">MAJOR FINE</p> <p>(Major fine = loss of privileges over 100 credits for _____ hours.)</p> <p>Time Received: _____</p> <p>Time and Date Privileges Resumed: _____</p>

Most credit cards include two generic target skills needed for family life: following instructions and accepting correction. In addition, children may be expected to master individualized target behaviors identified by the family as areas of difficulty and/or areas to assist family functioning. To the left of the target behaviors listed on the card are limited spaces for "credits" or points to be recorded for each successful enactment of those behaviors--in regular increments. To the right of the targets is a smaller number of boxes for recording of fines issued for failure to exercise the new skills--usually costing twice the amount of the credits for that behavior.

Having a limited number of boxes available for credits and fines is intended to reduce parental anxiety about the manageability of the system. Emphasis on reinforcing appropriate behavior

over fining inappropriate ones is addressed by having more space and opportunity on the card to reward than to fine. The family worker stresses the concept of effective praise as a method to increase and maintain desired behavior and encourages the parent to use the credits section to "catch the kid being good."

The actual numerical values for credits and fines are set dependent on the cognitive abilities of parent and child and the reality of each situation. Credits for positive performance of target behaviors may range from 10 to 25, with the decision about the amount assigned left to the discretion of the parent. The approximate ratio of credits to fines should be 4:1--that is the parent should strive to give credit four times as often as giving fines. An alternative method for determining points in families where this flexibility may result in parent-child power struggles over the number of credits or fines earned, involves establishing set credit and fine amounts prior to executing the program (see Figure 2).

Figure 2

SUGGESTED CREDIT AND FINE VALUES		
Credits	Target Behaviors	Fines
25	Follows Instructions	50
10	Accepts Correction	20
25	Keeps Curfew	50
10	Completes Chores	20
25	Completes Homework	50
25	Verbal Respect	50
10	Requests Permission	20

In the far right column is the total number of points (credits minus fines) for each target is calculated for that day. Summing the points provides "today's privilege balance." The lower portion of the card allows the family to generate privileges specifically chosen by the family members for the child using the system, to reflect the uniqueness of the families' values, routines, and financial constraints. Also included are the "costs" in earned credits that the child must pay to purchase those privileges for the next day.

To the right of the privileges is a section to record "major fines." While minor fines are recorded for expectable failures during the process of learning targeted skills, major fines are imposed for serious infractions of family rules that might increase the risk of the child's being placed.

Such behaviors include running away, physical aggression, or stealing. Major fines result in an immediate loss of special privileges, those above 100 points of worth, for a period of one or two days. Unlike minor fines, these fines may not be earned back.

The Process for Teaching Skills and Reinforcing Behaviors

Before beginning use of the credit card, parents first learn new parenting skills, and then teach their children the target skills they desire. Two Family Partners families will illustrate this process.

Client Family Examples

The Goodwin family consists of two parents; their 16 year old adopted twins, John and Jane; and a biological son, age 12. The white, middle class family became involved with Family Partners because Jane's difficult behavior threatened her removal to residential treatment or group foster. Jane struggles with neurological and learning deficits that contribute to her being uncooperative at home. When she became assaultive towards her adoptive mother, the Court placed her on "inactive probation."

Ms. Goodwin and her daughter had engaged in escalating power struggles, and the worker felt that providing structure to these interactions via the credit card might modify both parent and child's disruptive patterns.

Mr. and Ms. Goodwin are proud of their attempts to work with their special needs children and the professionals involved. The parents readily accepted a system that had been explained as proven to be effective in specialized foster homes (CTH). In acknowledgment of their motivation, their credit card reflected the teaching parent model closely. Behavioral goals chosen for Jane included: follows instructions, accepts correction, physical and verbal respect, and honesty (see figure 3).

Figure 3

FAMILY PARTNERS CREDIT CARD

Name: Jane
Date: 3/15/95

CREDITS				T	BEHAVIORS	FINES		T
25	25	25		75	1. Follows Instructions			-
25				25	2. Accepts Correction	50		50
25				25	3. Physical Respect			-
25	25			50	4. Verbal Request			-
50	10	25		85	5. Honesty/Cooperation			-
Total credits:				260	Today's balance:	210	Total fines:	50
PRIVILEGE BALANCE: <u>165</u>								
Privileges					MAJOR FINE			
200+ Off Property					(Major fine = loss of privileges over 100 credits for _____ hours.)			
175 Spend Money					Time Received: _____			
150 Later Bedtime					Time and Date Privileges Resumed: _____			
125 Friends In								
100 Make Phone Calls								
75 Entertainment Items								
50 Receive Phone Calls								
25 Snacks								

The Smithers, an African-American family, currently consists of Ms. Smithers; Mr. Woods, the father of Ms. Smithers' two youngest children; and Ms. Smithers' daughter, Sara, age 17. Four younger children are currently in foster care due to abuse and neglect. The family resides in a two bedroom apartment and receive support services from the Department of Social Services.

Family Partners was asked to fortify the family and assist with Sara's return home from a 12 month placement in a group home. The referral problems were difficulty with communication between mother and daughter and their conflicting opinions regarding expectations.

Ms. Smithers managed her household despite little formal education and working two jobs as a house cleaner. She did not have skill or experience in her home or work life with monitoring

forms such as the credit card. In addition, her long work hours left her little free time to spend on monitoring. Thus, the Smithers' credit card was adapted further. The printing was enlarged and boxes were crossed out to clarify where earned credits might be recorded. The method for adding and subtracting credits was simplified by pre-determining all credit amounts at 25 credits, thus streamlining and facilitating the use of the card. Specific behavioral goals that Sara and her mother chose to put on the credit card were: follows curfew, follows through, verbal respect, and completes chores (see Figure 4)

Figure 4

FAMILY PARTNERS CREDIT CARD

Name: Sara
Date: 5/28/95

CREDITS				BEHAVIORS	FINES	ADDITIONAL CREDITS
x	25	x		CURFEW	*	
25				FOLLOW THROUGH		25
25	25			VERBAL RESPECT		
MY ROOM 25	BATHROOM 25	KITCHEN 10	VACUUM 25	CHORES	50	
SUM: 75 + 75 + 10 + 2 = 185 - 50 + 25 = 160						
PRIVILEGE BALANCE: <u>360</u>						
Privileges				MAJOR FINE		
350 + up = Later Curfew				★ (Major fine = loss of privileges over 200 credits for <u>48</u> hours.)		
300 = Girlfriend Spends Nights				Time Received: <u>9:00 a.m.</u>		
250 = Friends in				Time and Date Privileges Resumed: <u>5/30 at 9:00 a.m.</u>		
200 = Phone						
Today's Balance: <u>160</u>						

Teaching Interactions

Following the identification with the family of generic and individualized target behaviors, the worker's next step is to introduce parents to the skills they need to teach their children those pro-family target behaviors. First, the worker demonstrates the parenting skill of "teaching interactions," that consists of five specific steps (Braukmann and Wolf, 1987): 1) explain the target behavior to the child with the steps involved in performing it; 2) explain the rationale for the behavior in the child's terms; 3) ask the child if he or she understands; 4) offer an opportunity to practice, and 5) reinforce even that practice with praise, feedback, and credits.

The family worker stressed teaching interactions and corrective teaching with Ms. Goodwin. The structure of the credit card was intended to modify both parent and child's pattern of escalating power struggles. It included the positive target skill of "following instructions." The family worker showed Jane's mother how to teach Jane this four step pro-family behavior (a,b,c,d), using the above five step teaching interaction (1,2,3,4,5). Ms. Goodwin demonstrated her skill with the following: 1) "Jane, I want to talk with you about how to follow an instruction...to follow an instruction you first a) look at the person, b) say o.k., c) do it quickly, and then d) come back and say you are done; 2) By following instructions you are showing adults that you are responsible and you are more likely to get permission to do things or have special privileges; 3) Do you understand?; 4) Would you like to practice the skill of following an instruction by putting your school books in your bedroom?" (Jane gives eye contact, says o.k., takes her books upstairs, and comes back to her mother to say she's done); 5) "Jane, Great job! You looked at me, said o.k., put the books away, and told me when you were done...you have just earned 25 credits for practicing following instructions."

Effective Praise

Another skill the family worker introduces to the parent is "using effective praise" when the adolescent demonstrates what the parent had taught and wants him or her to repeat. Effective praise consists of four steps: 1) notice and praise the behavior; 2) describe what was done well; 3) explain the rationale for why he or she liked it; and 4) provide credit as a positive consequence.

The Goodwins practiced effective praise when both parents recognized Jane's efforts upon their return from church. Mr. Goodwin said: 1) "Jane, What a wonderful surprise to come home and find brunch ready for us!" Ms. Goodwin followed, 2) "I really appreciate that we can all sit down together, eat, and talk about family plans for the day; 3) Now we'll be able to go to the textile museum that you've been eager to go to! 4) Great brunch! You've earned 50 credits for cooperation."

Positive Correction

"Positive correction" is a third parenting skill in which parents are asked to respond to their child's failure to perform a target skill with both the correction of a fine and a teaching opportunity to earn back part of the fine. This more complicated process involves eight steps: 1) express empathy for the child's situation; 2) describe the inappropriate behavior; 3) announce the fine; 4) describe what the parent wanted the child to have done; 5) support with a rationale that is developmentally relevant to the youth; 6) ask if he or she understands; 7) following the imposition of the fine, offer another opportunity to perform the desired behavior; and 8) if the child complies, provide positive points or credits (fewer than that which would have been given had the behavior had been performed the first time), along with praise. By allowing the child to earn back part of her fine through correcting her behavior, positive behavior is further encouraged.

The family worker encouraged Ms. Smithers to follow through on her ability to correct her daughter in a positive manner through the skill of positive correction. Ms. Smithers was able to handle the following difficult situation with her daughter that might have ended up with both escalating their emotions and behaviors. Ms. Smithers said, 1) "Sara, I know you are tired when you get home from school; 2) however, we have an agreement that you will clean up the morning kitchen mess...when I came home today the dishes were still in the sink and the table was covered with crumbs; 3) you have earned a 50 credit fine for not completing your chore; 4) when you get home from school, please be sure the dishes are put into the dishwasher and the table is wiped off; 5) when you follow through on our agreements you are demonstrating responsibility and I am more likely to trust you with things like using the car on weekends; 6) do you understand?; 7) would you complete your chore now; 8) great job, you have earned 10 credits and demonstrated to me that you do care about fulfilling agreements."

However, within a few weeks of working with the Smithers family, it became apparent to the family worker that a primary difficulty for Ms. Smithers was her lack of follow-through on promises and agreements regarding privileges made to her daughter. Thus the credit card was further modified to include the area of "Additional Credits" (see Figure 3). This addition allowed Sara to earn additional credits, to exchange for money that Ms. Smithers would have to pay Sara when she did not follow through with her promises. This subtle consequence for the mother was not intended to highlight irresponsibility and undermine her fragile parental authority, but rather it was included to enhance the probability of her being more consistent with her daughter.

Major Fines

Finally, parents must learn how to impose a "major fine" in a manner that does not eliminate their children's motivation to work for credits. Ms. Smithers gave Sara a major fine when she

broke her curfew. Ms. Smithers said, "Sara, you did not return home last night; you have earned a major fine for not reporting your whereabouts. The fine goes into effect now (9AM) and privileges over 200 credits will resume in 48 hours. Remember, it is important to continue earning credits while the fine is in place so that when you come off you will have a privilege balance high enough to allow you to go out. Do you understand?"

The Goodwins found that while the credit/minor fine system worked well, and they appreciated the structure that the system provided with regards to privileges. During the initial six week trial, the number of credits Jane earned increased, while her fines decreased. Jane averaged between 750 and 1000 credits per week out of a possible 1400; she incurred increasingly fewer minor fines. However, the mother had a tendency to levy extreme major fines under circumstances that did not warrant the amount. On one occasion, the parents called the family worker and acknowledged that they had given an unreasonable fine, wondering how to modify it without diminishing their parental control. This situation provided an opportunity to stress the teaching component and to review parental expectations. Ms. Goodwin was able to admit that she overreacted at times. The resulting change was that Mr. Goodwin interacted more with Jane around the credit card, and Ms. Goodwin backed off.

Conclusion

Jane Goodwin's pre-test scores on the Child Behavior Checklist (Achenbach, 1991) confirmed that her overall problem behaviors were in the clinical range, with particular concern in the area of aggressive behavior (T score = 76). Whereas the family worker's assessment of family functioning on the Family Assessment Form (Children's Bureau of Los Angeles, 1989) showed no areas of parent-to-child interactions or parent-to-child communications to be problematic. So for the Goodwin Family, the intent of the credit card was more to help organize and structure Jane's experience in the family. Close examination of the post test scores on the CBCL revealed that after working with the credit card, Jane's overall T score improved from 78 to 73, while her T score for aggressive behaviors dropped from 76 to 69. These changes suggest that the credit card had been effective, where other techniques had not, in motivating Jane to change her behavior.

The Smithers family presented a different profile. The CBCL revealed that the only profile type in which Sara's behaviors were in the clinical range was that of "withdrawn," contributing to a clinically significant internalizing score (T = 66). On the other hand, the worker indicated that several items of "Family Interactions" on the Family Assessment Form were problematic. The mother was seen to have difficulty "taking appropriate authority" and there were problems in the "quality and effectiveness of communication." Following work with the credit card, the worker scored these same interactions as improved. These findings indicate that the major contribution of the credit card may have been in organizing Ms. Smithers to be more consistent and positive in rewarding Sara's adaptive behaviors.

The Family Partners Credit Card System combines the reciprocal exchange and major components of a behavioral contract with the symbolic delay of reinforcement of the token economy. The system has been modified to be effective in motivating change in parent-child interactions in families where adolescents are at risk of placement due to the family's difficulty in managing difficult behaviors. At the core of the credit card is the concept that parents learn new and adaptive parenting skills based firmly on two principles. First, the opportunities for rewarding a child's positive behavior should outweigh the opportunities for correcting misbehavior. Second, incidents of misbehavior should be seen as opportunities to build on family strengths to teach positive alternatives.

The success of such a credit card system with biological or adoptive families in an Intensive Family Preservation setting rests with the workers' flexibility in continuously adapting a system designed for use with formed groups in institutional settings to one appropriate for family groups within the home. Some modifications may be geared toward the visual structure of the credit card form to simplify the process. Others are related to creatively introducing parents and children to the interactions required of family members to implement the system. The family worker adapts the system to the unique needs of the family, not the family to the system. Thus, the possibility increases--in keeping with the values of family preservation--of removing the problem, not the child, from the family.

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Toward the Development of Ethical Guidelines for Family Preservation

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Abstract

Family preservation workers need a standard set of ethical guidelines to assist them in providing their service in a proper manner. This paper describes how ethical codes have been developed for the "traditional" mental health care disciplines and why such codes are not sufficient for the type of work done in family preservation. The paper further provides examples of the types of ethical dilemmas family preservation workers encounter as well as suggestions for workers, supervisors, and agencies in dealing with such dilemmas.

Ethical guidelines and standards for professional practice are important components of all approaches to psychotherapy. In addition, all professional organizations promulgate standards of ethical practice and expect that members practice according to published codes of ethics. Although there is considerable overlap among the codes accepted by the different professions (e.g., counseling, marriage and family therapy, psychology, psychiatry, social work), each has its own standards with minor differences in terms of format or focus. All these codes, however, share a focus on traditional approaches to mental health service delivery (i.e., office based therapy). Furthermore, none of the extant codes give specific, explicit attention to ethical concerns and issues related to family preservation services. We use the term "family preservation" as a broad term inclusive of services described as intensive in-home, family-based, and family preservation.

The absence of attention to non-traditional approaches to therapeutic service delivery in these ethical codes presents family preservation workers with challenges as they attempt to chart a course toward ethical practice. This challenge exists because workers must attempt to comply

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with ethical standards which may not be compatible with aspects of non-traditional work. For example, the concerns about dual relationships evident in many codes of ethics raise questions about some common aspects of non-traditional work where boundaries tend to become more blurred. This blurring of boundaries occurs because the bulk of services are delivered in the family's home and because attention is given to both "hard" and "soft" services. Similarly, many issues exist regarding the traditional interpretation of the mandate to maintain confidentiality given the broader focus of family preservation on the home and community. This systemic vision necessitates working closely with other providers and larger systems on a regular basis and in a less formal way.

In addition, questions exist about how to handle a number of issues that are unique to family preservation and thus are not addressed in the existing codes of ethical practice. Situations that occur routinely in family preservation are unheard of in traditional office-based therapy. Without any direction from a code of ethics, the non-traditional worker is left to her or his own judgment as to what is an appropriate response to these issues. Optimistically, this decision making occurs in the context of supportive supervision and agency teamwork, but there are no carefully developed and accepted guidelines as there are for traditional therapeutic service delivery.

History of Concerns for Ethical Practice

Broderick and Schrader (1991) suggested that the ethics of clinical practice were first outlined in the Oath of Hippocrates (ca. 460-370 B.C.), which is still administered to medical students even today. Current codes of ethical behavior are essentially an elaboration and refinement of the ideas contained in the Hippocratic Oath. Although there are minor differences in content, format, and method of development between the different codes, there are overwhelming similarities. For our purposes in understanding how these codes were developed and modified over time, it will suffice to focus on those of the American Psychological Association, the National Association of Social Workers, and the American Association for Marriage and Family Therapy. The codes of these three organizations demonstrate not only typical content but also a typical process of development.

The 1992 Ethics Code of the American Psychological Association (APA) represents the ninth version. Previous codes were published in 1953, 1958, 1963, 1968, 1977, 1979, 1981, and 1990. According to Crawford (1992), the process of developing an ethics code for psychologists began in 1935 when the APA membership totaled only some 2,300, and a special committee was appointed to consider ethical matters and to resolve complaints on an informal basis. She described the history of the development of a code of ethics for psychologists including the following events. In 1939, this special committee recommended the appointment of a standing committee to consider ethical complaints. This committee did not consider the

timing right for the development of a code of ethics. However, in 1948 they recommended that work begin on a formal code of ethics for psychologists.

Crawford (1992) described how the Committee on Ethical Standards for Psychology was formed in 1948 under the chairmanship of Nicholas Hobbs and began work to identify ethical issues. This committee sent letters to the APA membership asking them to describe situations and issues that they had encountered that were of ethical significance. This request yielded more than 1,000 replies that were classified into the following six categories: public responsibility, clinical relationships, teaching, research, writing and publishing, and professional relationships. The committee studied the responses of the members and in 1953 published the Ethical Standards of Psychology. These standards were adopted initially on a trial basis for three years.

The ethical standards have been revised on a regular basis since 1953 to better meet the needs of psychologists as they have attempted to resolve ethical issues and concerns. These revisions have addressed new ethical issues that have emerged over time as the practice of psychology has changed. Subsequent APA Ethics Committees have modified the standards based upon input from members and published articles that have questioned the standards or called for additional guidelines.

For example, Margolin (1982) argued that insufficiencies of the APA ethical standards for marriage and family therapy have not been fully appreciated. She stated that guidelines regarding therapist responsibility, confidentiality, and informed consent are particularly ambiguous and complicated when multiple family members are seen together in therapy. Margolin suggested the need for further clarification around the following questions: "Who is the Client? How is confidential information handled? Does each family member have an equal right to refuse treatment? What is the role of the therapist's values vis-a-vis conflicting values of family members?" (p. 788). The most recent revision of the ethical standards was adopted by the APA Council of Representatives in August of 1992. Still, many of the questions raised by Margolin remain unanswered, and there is no recognition of ethical issues and concerns unique to non-traditional therapy.

The profession of social work has followed a path similar to that of psychology in developing ethical guidelines. Reamer (1995) described the code of ethics of the National Association of Social Workers (NASW) and its developmental history. Following its organization in 1955, the Delegate Assembly of NASW set out to develop a code of ethics and has periodically revised it as the values and vision of the profession have changed. The code emphasizes the importance of the social worker's personal conduct as well as his or her ethical and professional responsibility to clients, colleagues, employers, the profession, and society. The code contains general principles related to ethical conduct that are intended to aid the social worker in his or her interaction with clients and fellow professionals.

The NASW adopted its first code of ethics in 1960 only five years after the association was formed (Reamer, 1995). Calls for revisions to the code began almost immediately. Reamer (1995) stated that, "soon after the adoption of the 1960 code, however, NASW members began to express concern about its level of abstraction, its scope and usefulness for resolving ethical conflicts, and its provisions for handling ethics complaints about practitioners and agencies" (p. 896). In an effort to address these concerns, the code has been revised four times. Reamer described these revisions. First, in 1967, the code was revised to include an addition which addressed the need for all NASW members to work in a non-discriminatory fashion with minorities and other groups which normally receive limited aid or attention. Next, in 1977, a task force was established by the Delegate Assembly of NASW to revise the code and enhance its relevancy. The result of this task force was the 1979 code which included six sections of principles to guide practice and a review of the enduring social work values upon which the code is based. Since 1979, the code has been revised twice. In 1990, several principles related to fee setting and solicitation of clients were modified to address concerns about possible restraint of trade expressed by the U.S. Federal Trade Commission. Finally, in 1993, the code was amended by the NASW Delegate Assembly to include five new principles. Three of these related to problems associated with social worker impairment and two related to problems of dual relationships.

Even with these recent revisions, the NASW code of ethics does not address ethical issues unique to non-traditional therapy. In addition, these types of concerns are not addressed in the literature. We could not locate any published articles that addressed the ethics of family preservation according to the social work code of ethics. In fact, two recent articles dealing with concerns around dual relationships (Kagel & Giebelhausen, 1994) and the ethical-clinical tensions in clinical practice (Dean & Rhodes, 1992) highlight the absence of attention of non-traditional approaches to treatment. Dean and Rhodes (1992) stated that, "in recent years, interest in social work ethics has increased dramatically" (p. 128). Furthermore, they noted that "more attention is being given to refining codes of ethics, analyzing conflicts of interest, probing technology's ramifications, understanding moral development, and exploring the theoretical underpinnings of social work ethics" (p. 128). Although there has been increased attention to ethics in general, no specific attention has been given to the ethics of non-traditional practice. Similarly, Kagel and Giebelhausen (1994) discussed many implications of dual relationships for ethical practice but only in terms of individually-oriented and traditional practice.

The history of the development of ethical standards for marriage and family therapists by the American Association for Marriage and Family Therapy (AAMFT) is very similar to that of the APA and the NASW. Preister, Vesper, and Humphrey (1993) described the evolution of a professional code of ethics for marriage and family therapists. The first code was approved in 1962 and was in effect until 1975. Since then, the code has been revised by AAMFT at least every three years. There have been eight versions of the code from 1962 through the most recent version that was approved by AAMFT in 1991. Preister, Vesper, and Humphrey detailed how the *Ethics Code* has changed in terms of content and format since it was first approved.

They also described the process of revision used by the AAMFT Ethics Committee. The process includes reviewing the code and recommending changes to the AAMFT Board which then approves and adopts the revised code for the entire AAMFT membership. As with the APA and the NASW, these changes have come as a result of input from the members and published critiques and have sought to better address emerging ethical issues.

For example, Wendorf and Wendorf (1985) criticized the field of marriage and family therapy for maintaining a limited, non-systemic viewpoint on ethics. They provided a critical review of the literature on family therapy ethics and called for a more systemic analysis. In particular, they used systems theory to reexamine ethical issues around family secrets, therapist deception, and therapist advocacy of feminist values.

Green and Hansen (1986, 1989) also were critical of the field's management of ethical issues, but for a more pragmatic reason. In two studies, they sampled family therapists and found that the *AAMFT Code of Ethics* was helpful but inadequate. Many ethical concerns therapists were confronting that were not covered in the code included: treating a family if one member does not want to participate; feeling confident of your training and qualifications; seeing one family member without the others present; informing clients of values implicit in the mode of therapy; dealing with parental requests for information differently from children's requests for information; and sharing your values and biases with families.

Preister, Vesper, and Humphrey (1993) noted that the *AAMFT Code of Ethics* serves three preventive functions: establishing practice guidelines that prevent ethically questionable situations from deteriorating; presenting guidelines describing safe and effective practice; and establishing and maintaining a perception among members, consumers, and others that marriage and family therapists practice safely and with client interests foremost in their minds. These same considerations are also important for family preservation work.

Just as previous changes in codes of ethics have come from concerns about the completeness of the standards for covering relevant issues, attention should be given to those issues that are unique to non-traditional therapy. The first step would be to review ethical issues facing non-traditional therapists. This process would sensitize us all to the relevant issues and may indicate potential solutions. Ultimately, standards of ethical practice and a code of ethics should be developed for family preservation. This could occur with revisions to the codes of the traditional disciplines or with the development of a code for non-traditional therapy that could be commissioned by a group such as the National Family Based Services Association. Whomever develops the code matters less than that a code is developed. This paper serves to initiate and encourage this process.

Ethical Dilemmas in Family Preservation

Some aspects of family preservation give rise to related questions of ethical practice. For example, Levenstein (1981) included the following in her list of "potential ethical pitfalls" for the family preservation worker: coercing clients to participate; maintaining confidentiality; managing intrusiveness; respecting the family's style of living; and managing the "skills mismatch" between the actual skills of the worker and the services that he or she is asked to deliver (p.229). More recently, Anderson (1991) encouraged workers to ask themselves if they are fostering an "unhealthy dependency" or "laying the foundation for family empowerment" (p. 180). He also called attention to the fact that the time limits characteristic of family preservation "may result in the dropping of a family before its service needs are met" (p.180).

Consider the following actual dilemmas that family preservation workers have reported to the authors:

- After an in-home family preservation session early in the treatment relationship, the family invited the therapist to stay for dinner.

- After beginning family preservation in a small town, the therapist realized that the grandmother of the identified child client was someone who formerly cleaned her home for pay and picked pecans freely from her yard. The child and mother lived with the grandmother. One night the therapist returned home to find the entire family happily picking pecans from her front yard.

- An adolescent in a family being seen by a family preservation worker ran away from home after a family fight. Although the family was involved with the county's child protective services, no placement was immediately available. The worker and family discussed the possibility of the adolescent staying overnight with the worker in the worker's home as a respite. The mother supported the overnight plan.

- A family's neighbors were naturally curious about a family preservation team's frequent appearances at a nearby home. The family was anxious about maintaining confidentiality. Neighborhood children curiously asked members of the team who they were and how they knew the family.

Suggestions for Family Preservation Workers in Managing Ethical Issues

As further attention is given to the ethical issues surrounding family preservation, clarity and consensus regarding ethical practice will likely develop. Furthermore, a code of ethics specific to family preservation will probably be created. In the mean time, family preservation workers

and agencies need to begin considering their position on some of the common ethical issues. Without a common code of ethics for family preservation, the responsibility falls to individual agencies and workers to determine what is acceptable ethical practice. What follows are some suggestions and perspectives for workers and agencies when dealing with ethical family preservation issues.

1. Understand that ethical concerns are commonplace in family preservation due to the close proximity of the worker and family. Be careful not to consider confusion or concerns about ethical matters as evidence of inadequate knowledge, skill, or experience.

2. Heightened sensitivity to ethical concerns is necessary for effective family preservation and should be appreciated by supervisors and administrators.

3. Become thoroughly familiar with the code of ethics that you currently follow, and identify areas of it that may be incompatible with aspects of your family preservation work. Discuss these areas with colleagues and supervisors in order to develop solutions.

4. If you find yourself confused or uncomfortable about the conduct of family preservation work, you may be caught in an ethical dilemma and should seek consultation from peers and supervisors.

5. When facing an ethical dilemma, do not hesitate to honestly share the dilemma with the family and inform them that you are seeking supervision.

6. Consider family members as partners in resolving ethical dilemmas. Workers are more likely to make mistakes when keeping ethical issues and their solutions to themselves.

Suggestions for Family Preservation Agencies and Supervisors

1. Separate clinical and administrative supervision. This encourages workers to come forward early with ethical concerns. Asking for help on an ethical concern should not result in negative performance evaluations.

2. Convene regular conversations about ethical concerns and solutions. Ethical issues need open discussion. Discussions are most productive when workers, supervisors, administrators, agency attorneys, and clients share responsibility for creating solutions.

3. Consider creating formal ethical guidelines within your agency that fit your program model.

4. Join together with other agencies to discuss ethical family preservation concerns. Through shared experiences agencies can develop better solutions and plans for preventing ethical problems.
5. Be proactive rather than reactive in the establishment of ethical guidelines. When policies and procedures are reactive, they are more likely to be rigid and to blame the worker.
6. Include training on ethical issues associated with family preservation during orientation for new employees.
7. Consider having workers share your agency's ethical guidelines with families at the beginning of treatment. Reviewing ethical guidelines at the onset of therapy benefits families and the workers by sensitizing them to questionable conduct. In addition, this process fosters a sense of partnership regarding ethics between the family and worker.
8. Make regular attention to ethical concerns and issues a standard component of supervision. For example, during each supervision session, the supervisor might ask the workers if they have any ethical concerns in their current work. Supervisors should be available to go with workers as needed to review ethical concerns with families and resolve dilemmas.

Summary

Ethical guidelines serve important protective functions for clients and therapists in all approaches to psychotherapy. Existing ethical codes, developed to guide office-based therapists, are incompatible with many aspects of family preservation. Without relevant codes, family preservation workers are left to struggle by themselves with ethical dilemmas frequently experienced in family preservation such as confidentiality and the therapist-client boundary. This article contains specific suggestions for family preservation workers, supervisors, and agencies that seek to maintain ethical family preservation practice. We hope that a family preservation code of ethics will be developed in the near future and view this paper as a stimulus toward that end.

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Current Resources

Evaluating Family-Based Services. Peter J. Pecora, Mark W. Fraser, Kristine E. Nelson, Jacquelyn McCroskey & William Meezan. Aldine de Gruyter. New York, NY. 1995.

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One of the few certainties in evaluation research is the potential for error-or, as the authors of *Evaluating Family-Based Services* wisely advise us, "what *can* go wrong *will* go wrong" (p. 215). Such has been the case with family based services as the field has moved from simple one-group designs to large experimental studies, presenting every increasing opportunities for error. The good news is that much has been learned in the process.

Evaluating Family Based Services, a new and welcome addition to the growing literature in this field, reflects the collective experience and expertise of five prominent researchers in the family based services arena. Contributions by specialists in constructivist research, evaluation and social policy, and systems change supplement the more quantitative, program-specific approach of the co-authors to offer a comprehensive examination of family based services evaluation.

As the authors note, this is not an introductory research text, but one which assumes a basic familiarity with research and evaluation methods and terminology. This assumption permits a focused effort on the unique challenges of evaluating family based services programs--such as targeting services and assessing placement risk. For those readers needing a "refresher" course, however, this volume offers useful reviews of such topics as sampling, evaluation design, human subjects protection, data analysis, and report writing.

Critics of the use of placement prevention as the sole outcome measure of program success will appreciate the substantial attention paid to the assessment of services and interventions, family functioning, child functioning, parent functioning and social support. Chapters on each of these topics offer conceptual definitions of these domains as well as discussions of specific instruments that have been used in existing studies. Child functioning remains the most elusive area; while the authors describe a range of promising instruments, they acknowledge that the instruments have been used primarily for clinical assessment, not extensively for purposes of research or evaluation.

Placement prevention and cost efficiency, however, are not neglected in this book. The authors present various issues that have plagued the measurement of placement including competing definitions, placement as service failure, and organizational/environmental influences on rates of placement. Various approaches to measuring placement--the use of hazard rates, days in placement, and restrictiveness of placements--are discussed. A chapter on measuring program efficiency provides an overview of cost-effectiveness and benefit-cost analysis, but individuals preparing to undertake such an evaluation will likely need more assistance than can be provided in one chapter.

Evaluating Family-Based Services should be read by researchers and research-oriented practitioners alike. Anyone who has been involved in family based services research or evaluation--as the evaluator struggling to maintain a sound design in a changing service environment, the field coordinator dealing with client attrition and disgruntled workers, or the social worker trying to fulfill dual roles of service provider and data gatherer--will identify with the issues and dilemmas described in the chapter subtitled: "Doing Research in the Real World".

After two decades of work, the field is still debating definitional, measurement, and implementation issues, but with a deeper understanding of each. We can take heart in the fact that these authors have survived and persevere in this most heavily scrutinized area of child welfare research. Despite past, present, and unknown future hurdles, we are reminded that there is much work to be done and every reason to keep moving forward.

The Civil Rights of Homeless People: Law, Social Policy, and Social Work Practice. Madeleine R. Stoner. Aldine De Gruyter. Hawthorne, NY. 1995.

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The Civil Rights of Homeless People identifies laws, potential legal arguments and strategies which may assist advocates in challenging the onslaught of antihomless activity across the nation; and demonstrates how the interaction of law and social policy practice advances entitlement, equity and empowerment goals.

The book's central thesis is that judicial advocacy has made it possible to advance and protect the interests of homeless people in the face of hostile legislation and public sentiment. Utilizing the paradigm of the judiciary as power broker, and numerous case examples, the book demonstrates the value and efficacy of collaboration between the social work and legal professions in the quest for social change and equity.

The book presents a very useful introduction with an inspiring section on the history of advocacy law. Part One provides a review of litigation regarding homeless persons and their entitlements to shelter and emergency assistance, income, child welfare, education, mental health services, and voting. Part Two reviews litigation attempting to reverse the national trend to criminalize homelessness and includes a final chapter focused on the limitations of judicial advocacy and useful suggestions for interprofessional collaboration. Family preservation issues are primarily addressed in chapter four, "Public Child Welfare", which delineates strategies that have resulted in permanent housing and the opportunity for homeless families to remain intact.

The Civil Rights of Homeless People possesses many strengths including the provision of resources, via case studies, for creativity in sociolegal advocacy; the definition of key terms of judicial and homeless advocacy work; and a unique focus on the need for, and efficacy of interprofessional work.

The only apparent weaknesses were inherent in its greatest strength. The very thorough description of cases that helped illustrate each area of discrimination and related strategies created a sometimes dry and repetitive tone. This also allowed for little development of the interdisciplinary roles and collaborative suggestions delineated in the final chapter. Nonetheless, this book presents a step in the right direction.

The Civil Rights of Homeless People should prove a very useful resource for practitioners and educators regarding the plight of the homeless and the study of the application of law to social problems.

From Case Management to Services Coordination for Children with Emotional, Behavioral, or Mental Disorders: Building on Family Strengths. Barbara Friesen & John Poertner (Eds.). Paul H. Brookes. Baltimore, MD. 1995.

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Barbara Friesen and John Poertner have assembled a collection of 21 chapters devoted to case management, systems of care, and policy issues in children's mental health issues. Many of the chapters in this book extol the need to design and implement services that are specifically tailored to the needs of children. However, it is clear that the majority of programs described in this collection have borrowed heavily from interventions developed for adults who face severe mental illness. Thus, there is a continued need, recognized throughout this text, for good empirical research on case management services and other specialty programs specifically designed to help children and families.

What is clearly explicated in these pages are the various systems barriers that hinder the development of adequate, accessible, and effective children's mental health services. Indeed, one of the key issues that planners must face is that a variety of systems are involved in the care of children. Ultimately, this creates a plethora of potential stakeholders and also fragments funding streams. It is in the area of systems level development and basic primers on funding mechanisms that this volume makes a strong contribution. While this is an area that may be less exciting reading for most students, practitioners, and academicians, it is naive to expect interventions like case management or any model program will integrate and bring rationality to children's services. Indeed, flexible funding strategies, extending purchasing power to case managers, or empowering families both emotionally and fiscally (like the Illinois Family Assistance Program described in this text) are likely to create the needed incentives to bring coherence to children's services.

This book succeeds as a sampler of new developments in the area of children's mental health service and can serve as a useful adjunct text in graduate level courses. The practitioner who is looking for specifically detailed or how to sections will probably be best served by exploring works referenced in the text.



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