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FAMILY PRESERVATION JOURNAL

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Volume 2 Issue 2 1997

ARTICLES

A Model for Family Preservation Case Assessment

Kam-fong Monit Cheung, Patrick Leung and Sharon Alpert

Behavioral Outcomes of Home-Based Services for Children and Adolescents with Serious Emotional Disorders

Edwin Morris, Lourdes Suarez and John C. Reid

A Multi-Faceted, Intensive Family Preservation Program Evaluation

Michael Raschick

Targeting Families to Receive Intensive Family Preservation Services: Assessing the Use of Imminent Risk of Placement as a Service Criterion

Elaine Walton and Ramona W. Denby

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

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Family Preservation: Collaboration and Teamwork

Tis the season of the National Basketball Association finals and the beginning of the Professional Women's Basketball Association. The skills of collaboration and teamwork required to achieve the ballet of basketball is learned by players over a number of years. On school grounds everywhere, children are learning the techniques and skills necessary to play the game of basketball. Recently, I saw a coach on the sidelines screaming at a young player to make her free-throws, and if she missed, she would have to run laps. This reminded me of traditional services to families which threaten, or at best demand a certain level of performance of parents without providing any true "coaching". I often watch our college coach work from a strengths perspective with the team on minute techniques such as the match-up defense and in-bounds plays. This is the approach that family preservation must employ with families, programs, and their communities.

Since the 1930's, federal, state, and local funding have been by category of need, with most programs being means-tested. In other words, before an individual can qualify (in most cases) for services or resources, they must have a problem which can be met within a specific category. Consequently, state and local programs have built systems around individuals with certain problems and a strong interest in protecting their turf. The skills of collaboration and teamwork are presently ill-defined and rarely practiced, particularly within the categorized funding environment in which most family preservation programs exist.

It is not the purpose of this discussion to define collaboration and teamwork (we all know it if we see it), but rather to suggest that without investing in the development of these skills and the teaching of them to states and agencies, family preservation will continue as yet another categorical program. A major case in point is the "Family Preservation and Support Act" (P.L. 103-66) - funded at almost \$1 billion over five years through the U.S. Department of Health and Human Services (DHHS).

The stated goals of the Act's architects are laudable, to think big, encourage systems change, to serve as a catalyst for collaboration, through the application of family preservation principles and values (see Hooper-Briar, Broussard, Ronnau and Sallee, 1995). While there are certainly a few bright spots in some states, overall these goals have not been met as we near the end of the five-year funding period. The National Resource Centers have provided one-shot training and technical assistance on family preservation skills and outcome measurements, yet the skills and process measurements for collaboration and teamwork (not to mention a national family policy) have not been developed. In most cases, state agencies are lost. Without enthusiastic and continuous coaching, states and local agencies have failed to progress in the areas of collaboration and teamwork. So far, the only major evaluation of the Family Preservation and Support Act currently underway focuses on Intensive Family Preservation programs of the Homebuilders' variety; thus most of the goals, especially agency collaboration and teamwork, are not being addressed.

It is difficult to collaborate and build true teams. In our informal discussion with family preservation program managers in several states, we have found a lack of federal leadership and role modeling in collaboration. With the window closing rapidly on the opportunity for family preservation to become a movement (see Mannes, 1991), we may lose a new way of working with families from a strengths paradigm. The potential of the family preservation philosophy to positively protect and improve the lives of children is now well known to thousands of families and family preservation workers. The results may not always be "documented" in research studies, perhaps because evaluation methodology has not kept pace with family preservation practice. For example, how do you measure teamwork? Million dollar sports franchises have difficulty assessing teamwork other than through winning a championship. Does that mean that there is only one team (the winner) that had teamwork? Of course not. So why, in family preservation, do we conclude that if we cannot measure teamwork or collaboration by traditional methods family preservation does not work?

The tendency is to over-rely upon that which we can define and measure. Unfortunately, DHHS and their contractors have done this by defining family preservation very narrowly as an intensive child welfare program. Some of the more successful intensive models are dogmatic and narrowly defined. We live in a very messy reality. Uncertainty exists and cross-currents of change are occurring. The easiest, most secure approach is to focus on a narrow definition of family preservation and hold to it rigidly. But ultimately, is that what is best for families, and does that truly address the development of collaboration and teamwork?

It is often said that it takes a generation to effect a paradigm shift. We must be committed for the long term and clearly define where we are going with family preservation. We need a collaborative strategy for the short term (the next two years) and the long term. In the short term, DHHS could convene a team of stake holders (family members, workers, administrators and advocacy groups) and model collaboration by working for the reauthorization of the Family Preservation and Support Act. At the same time, another such team can begin to develop, test and train collaborative skills.

We have done a good job of establishing methods of working directly with families and providing services from support to intensive brief services. Not we must learn how to team and collaborate to best serve families - for if professionals and advocates cannot model collaboration and teamwork, then how can we possibly expect families in crisis, often with far less experience and resources, to work together? It is time for those with power and money to coach, not criticize, and it is a time for teamwork.

The articles in this issue address many of the concerns raised in working with programs and families. The articles include a model for case assessment, behavior outcomes for home-based services, an in-depth and multi-faceted evaluation of family preservation, and the identification of families to receive intensive family preservation services. Finally, we have a review of new current resources that will help with training in the area of family preservation practice.

Alvin L. Sallee

A Model for Family Preservation Case Assessment

Kam-fong Monit Cheung, Patrick Leung and Sharon Alpert

The outcomes of family preservation practice have been researched and debated. The effectiveness of family preservation is still inconclusive and many of the findings may only be inferred to specific situations. Few studies have addressed the assessment techniques or outcome factors from a qualitative perspective. This article synthesizes current literature, research and practice, and proposes a practice framework with questioning techniques to assist practitioners in assessing the strengths and characteristics of a family, and making decisions on whether or not family-based services are appropriate for the family. Two actual cases are presented to illustrate how the worker can benefit from having the assessment data derived from this model.

Key Words: Family Preservation; Assessment Model; Child Protection; Case Analysis; Workers' Characteristics; Family Characteristics

The rising need for child abuse prevention was especially visible during 1973 and 1974 when the Child Abuse Prevention and Treatment Act (P.L. 93-247) was introduced, debated and passed. It marked a formal beginning of a national initiative that focused solely on child protection. Another major child protection legislation, the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) further mandated the states to implement action plans that would prevent unnecessary out-of-home placements for at-risk children. Subsequently, home-based services have become an alternative to out-of-home placements that helped children who have been abused and/or neglected. The Family Preservation and Support Act of 1993 further encourages the use of home-based therapy and intensive family service as a favorable option to out-of-home services because of its emphasis on maintaining the integrity and functioning of the family (Tracy, Whittaker, Pugh, Kapp, & Overstreet, 1994), its focus on children's needs within their environments (Thieman & Dail, 1992), and its establishment around a family-centered service continuum rather than a uni-dimensional child-focused action (Pecora, Fraser, Nelson, McCroskey, & Meezan, 1995).

The purpose of this article is to examine the knowledge, skills and values that are required to generate conversations between the caseworker and the client, and exemplify the necessary

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components in family preservation interventions. An assessment model with questioning techniques for examining case effectiveness is derived from this analysis. Based on two actual cases, challenges faced in family preservation practice are illustrated and analyzed with this model. Because of the complexity of family dynamics, these cases also reflect on how caseworkers can provide the same intervention to different families yet ultimate outcomes may be positive in one case and negative in the other case.

Historical Development of Family Preservation

Before a framework can be developed, the history and conceptual ideas of family preservation practice should be identified. As a concept in social work practice, "family preservation" exemplifies the importance of keeping families together; as an intervention method, it includes a variety of services delivered to the client's home that purposefully serve the entire family and intensively provide counseling and guidance for the individual members. These services are commonly referred to as "home-based," "family-centered," and "short-term intensive family preservation" services (Kaplan & Girard, 1994; MacDonald, 1994).

The family service movement in the 1990s stresses the importance of family support and the delivery of diverse services to enhance families' capability to achieve maximum independence. In social work, working with families has been the primary focus of practice. The family-centered focus has established its root in the profession since its colonial times; from the Public Health Movement in the 1850s, the Settlement House Movement in the 1880s, the aftercare work of the Mental Health Movement in the 1900s, the Social Security Movement of the 1930s, the Family-Centered Practice Movement in the 1950s, the Family Movement in the 1970s, the Family Preservation Movement in the 1980s, to the establishment of Family-Centered Services in the 1990s (Hartman & Laird, 1983; Maluccio, 1991; Trattner, 1989). In child protection, the child-centered model has shifted to family-centered -- motivating the entire family for positive change (Whittaker, 1991). This family-focused value is based on the philosophy that given appropriate guidance, families have the strengths and potential to master their own environments, including being responsible parents. Although family intervention methods used by caseworkers may vary, the most important value supporting the continuation of family-based services -- its emphasis on family strengths and potential -- has not changed.

Knowledge, Skills and Values of Family Preservation

Current literature describes family preservation as a short-term, prevention-focused approach to help families restore functioning. Family preservation practitioners who are trained specialists in family interventions maintain a consistent value toward preserving the integrity of the family. Based on a family-based orientation, three key determinants to effective family preservation practice are knowledge, skills and values. The following literature review defines the functions of each of these determinants and identifies a set of critical components for the development of an assessment model.

Knowledge

Family preservation programs have been regarded as a preferred option to serve families with children who are at imminent risk of out-of-home placement. According to Ronnau and Marlow (1993), more than 25 states and 333 programs are offering programs that treat the entire family before considering other options such as out-of-home placement. Determined by the needs and strengths of the family, family preservation services may take many forms and approaches--each serves to keep families together through preventive and collaborative efforts.

According to Maluccio (1991), family preservation services include (1) family resource, support, and education services, (2) family-centered counseling and parenting skill-building services, and (3) intensive family-centered crisis services. These services are based on at least seven theoretical approaches. First, *crisis intervention* is a focal perspective of helping the family in times of a crisis. It emphasizes the use of intensive focused help for each of the family members so that the family will move toward positive change. Second, using the *family systems theory*, family preservation programs identify the dynamic relationships and the adjustment processes that help maintain a family's functions and structure. Third, *social learning theory* suggests that parenting skills can be learned and anger management can be self-directed with appropriate assistance and guidance. Fourth, family preservation is supported by an *ecological perspective* that analyzes human behaviors, social functioning, and their relationships with the multi-faceted environment. Fifth, similar to the family systems approach, a *developmental life-cycle perspective* is adopted as a framework to help the family outline its members' needs, problems, and possible solutions. Sixth, family preservation is a *strength-focused approach* that stresses people's innate drive to achieve competence and focuses on utilizing families' strengths in resolving problems. Seventh, family preservation is a result of the *permanency-planning model* established in the field of child welfare. This model is aimed at promoting a child's growth, physical and mental functioning, and contracting with the family to facilitate decision-making and goal-setting behaviors (Maluccio, 1991; Leung, Cheung, & Stevenson, 1994).

Skills

Social workers' skills applied to family preservation cases include: (1) utilizing available resources in the family networks; (2) linking formal and informal resources to the socially isolated family; (3) coordinating concrete and clinical services among the helping professions to assist the family in crisis; (4) assessing problems and identifying solutions based on family strengths; (5) counseling individual members as well as the family as a unit toward

permanency planning goals; and (6) teaching family members life skills such as parenting, problem-solving, communication and behavior management (Friedman, 1991; Maluccio, 1991).

Values

MacDonald (1994) uses a question to start her criticism of family preservation: "Can a single welfare mother who has been beating her children, or failing to feed and bathe them, be turned into a responsible parent as the result of a one-to-three month infusion of counseling, free food, cash, furniture, rent vouchers, and housekeeping services--all at public expense?" (p.45). Her argument was based on case examples with negative outcomes and the lack of scientific evidence in the field to support the positive outcomes of family preservation. Ironically, her discussions cannot present the "scientific evidence" to prove the failure of family preservation. While it is true that family preservation is an "ideology" that "embraces a nonjudgmental ethic of support for all 'families'" (MacDonald, 1994, p.45), it is also true that family preservation is a reality that instills hope in families and provides alternatives to family members who want to actualize their hopes and accept responsibilities. This reality can only be achieved if child welfare professionals believe in its actualization and if families believe in their potential for change.

The values of family preservation serve as guiding principles in practice. As described by Ronnau and Marlow (1993) and codified by the Family Preservation Institute, these values include: (1) "People of all ages can best develop and their lives be enhanced, with few exceptions, by remaining with their family or relying on their family as an important resource"; (2) "The family members' ethnic, cultural, religious background, values, and community ties are important resources to be used in the helping process"; (3) "The definition of 'family' is varied, and each family should be approached as a unique system"; (4) "Politics at the local, state, and national levels should be formulated to strengthen, empower, and support families"; (5) "The family members themselves are crucial partners in the helping process"; (6) "Family members should be recognized as being in charge in order to resolve their own problems and avoid dependence upon the social service system"; (7) "The dignity and right to privacy of all family members should be respected"; and (8) "Families have the potential to change and most troubled families want to do so" (p.540-541).

Although it is important to have trained specialists handling cases that require intensive treatments, the literature also identifies a set of outcome criteria to determine service priorities. Using the following case examples, the authors intend to address how outcome criteria are connected to practice.

A Framework for Family Preservation Practice

The literature review of current research provides two sets of objective criteria for assessing the relationship between the caseworker's ability to intervene in family preservation cases and family characteristics. The first set is the worker's knowledge, skills and values toward helping at-risk children and their families. The second set is the characteristics of the family system.

Evaluating case outcomes is a practitioner's job. Thieman and Dail (1992) evaluated a statewide family preservation program and assessed the risk of out-of-home placement for 995 families. Three types of risk were factor analyzed: parent-centered risk, child-centered risk, and economic risk. Significant factors of parent-centered risk includes adult relationships, parent's mental health, child care knowledge, motivation, length of parenting experience, use of physical punishment, and use of verbal discipline. Although a child's psychological health is not easily recognizable as a risk factor, this risk is indicated by a child's mental health, school adjustment, delinquent behavior, and home-related behavior. Significant economic risk factors include residence, living conditions, financial problems, and physical needs of a child. As the risk assessment instrument did not predict out-of-home placement, the researchers in the study suggested that these risk factors, which have been used to assess "at-risk" families, can also be used to evaluate service outcomes when combined with both quantitative and qualitative methods of data collection. These "multiple methods of assessment ... with a view toward obtaining the clearest possible picture of the level of functioning of the family" (p.190) allow the practitioner to identify interventions that best suit the family's and its members' needs.

Based on the strengths approach (see Leung, Cheung & Stevenson, 1994) and the research findings reported in a recent study (Pecora, Fraser & Haapala, 1992), a questioning model was developed. The use of worker's characteristics and family characteristics as the assessment criteria is aimed at formulating questions for caseworkers to evaluate the appropriateness of intensive home-based services and identify the missing components to success. These questions can be used as a basis for assessing the risk factors in the family and determining the need for other services including an out-of-home placement.

The Conceptual Framework for Family Preservation Practice is presented in Table 1 on the next page. Following Table 1 is a detailed outline of the necessary competencies required of all parties. After the outline, we present applications of the Assessment Model.

Table 1.
A Conceptual Framework for Family Preservation Practice
WORKER'S COMPETENCIES

FAMILY CHARACTERISTICS	A. Knowledge	B. Skills	C. Values
1. Adult History and Functioning	(1) Childhood History (2) Victimization During Adulthood (3) Violence in Relationships (4) Alcohol and Other Drug Abuse (5) Adaptive Functioning (6) Self-Concept (7) Communication (8) Health	(1) Assessing How the Adult's Functioning Affects the Family (2) Analyzing the Adult's Past and Present Problems	(1) People Can Change
2. Parenting Ability	(1) View of Child (2) Expectations (3) Discipline (4) Knowledge of Child Development (5) Physical Care (6) Emotional Care	(1) Providing Alternatives	(1) Hope Can Be Instilled (2) Parenting Skills Can Be Learned
3. Child Functioning	(1) Child's Behavior (2) Child's Psychological Functioning (3) Child's Development (4) Child's Health (5) Child's Alcohol and Other Drug Abuse	(1) Identifying Unmet Needs (2) Reducing Risk of the Child	(1) Stay in the Home Environment
4. Family Functioning	(1) Role Integrity (2) Interaction (3) Home Climate (4) Relationships Outside the Home (5) Resources (6) Response to Intervention	(1) Identifying Strengths and Limitations (2) Providing Treatment (3) Evaluating Outcomes	(1) The Family Can Be Empowered (2) Change Can Be Predicted

A. Knowledge Competencies in Assessing Family's Characteristics

1. Knowledge: Adult History and Functioning

- (1) **Childhood History**
What is the quality of this person's childhood experience?
How does the childhood history affect this person's current functioning intellectually, emotionally, mentally and physically?
- (2) **Victimization During Adulthood**
Is there any history of victimization as an adult?
To what extent is this person capable of protecting him/herself?
- (3) **Violence in Relationships**
Is there any history of violence in relationships?
Who are the victims?
How severe and frequent is the violent behavior?
- (4) **Alcohol and Other Drug Abuse**
Is this person using alcohol (consider the amount, frequency, and degree of self-control)?
Is this person using illegal drugs or abusing other drugs (such as cigarettes or prescription drugs)?
- (5) **Adaptive Functioning**
To what extent can this person handle crisis and control emotions?
- (6) **Self-Concept**
How does this person realistically identify self-concept?
What is the level of this person's self-esteem?
- (7) **Communication**
What is this person's ability to express ideas, feelings, and needs?
To what extent is this person willing to listen to other people's ideas, feelings, and needs?
How constructive is this person's verbal comment?
- (8) **Health**
What is the state of this person's physical health?
Is this person taking medication regularly for any known illnesses?
How do the illness and medication affect this person's physical, mental and emotional functioning?

2. Knowledge: Parenting Ability

- (1) View of Child
How consistent is the parent's view of the child in reference to the child's age and capacity?
Does the parent accept the child's strengths and limitations?
To what extent does the parent's view nurture or prevent the child's growth?
- (2) Expectations:
How appropriate are the parent's expectations?
Are the expectations consistent with the child's age and capabilities?
- (3) Discipline:
What disciplinary practices does the parent use?
How appropriate is the use of discipline in reference to the child's behavior and age?
To what extent can the parent exercise self-control?
- (4) Knowledge of Child Development:
Is the parent able to apply child development knowledge in parenting practice?
How accurate is the parent's knowledge on child development?
- (5) Physical Care:
To what extent does the parent meet the child's basic and physical needs?
- (6) Emotional Care:
How well does the parent nurture the child and meet the child's emotional and social needs?

3. Knowledge: Child Functioning

- (1) Child's Behavior:
How consistent is the child's behavior with age and ability?
What is the nature and quality of peer and adult relationships?
What is the child's pattern of dealing with authority?
What is the child's behavior in school?
What is the child's behavior at home?

- (2) Child's Psychological Functioning:
Is the child able to communicate needs and feelings?
How appropriate is the child's control of emotions?
- (3) Child's Development:
What is the assessment of the child's physical, intellectual, and emotional development?
Is the child's development level consistent with his/her age?
- (4) Child's Health:
How is the child's physical health?
How does the child's physical health affect his/her social and cognitive functioning?
- (5) Child's Alcohol and Other Drug Abuse:
Has the child used alcohol (consider amount, frequency, duration, age of child)?
Has the child used any illegal drugs or abused other drugs?

4. Knowledge: Family Functioning

- (1) Role Integrity
How well do family members fulfill role expectations?
How do family members define role boundaries?
How appropriate is each person's role expectation?
- (2) Interaction
How open is the communication among family members?
Do family members express affection?
How flexible are the family members in making decision concerning the child?
What is the pattern of control over individuals' interactions within the family?
- (3) Home Climate
What is the nature of home climate (calm, frustrated, destructive, chaotic, etc.)?
- (4) Relationships Outside the Home
What is the nature and quality of relationships with neighbors, friends, and extended family?
How supportive are these relationships?

- (5) Resources:
How willing and able is the family to use available resources?
To what extent have external resources been used in the past?
What types of resources are available to meet the family's needs?
- (6) Response to Intervention:
To what extent does the family recognize the problems related to risk?
How concerned is the family for the child?
How willing and able is the family to work with CPS to achieve change?

B. Skill Competencies in Assessing Family's Characteristics

1. Skills: Adult History and Functioning

- (1) Assessing How the Adult's Functioning Affects the Family
Who are the key participants involved?
Where did the problematic behavior occur?
To what degree do problems usually happen? (consider frequency and duration)
What do the family members say and do before, during and after the problem occurs?
How or in what ways have the participants been involved?
- (2) Identifying the Adult's Past and Current Problems:
What repeating patterns of behaviors does the family genogram reveal?
What past events have affected the adult's functioning?
What current problems have the adults experienced at home and in the surrounding environment?

2. Skills: Parenting Ability

- (1) Providing Alternatives and Suggestions:
How does the worker encourage the parent to assume parenting responsibility?
How accessible are extended family members when they are needed?
How do parents identify their willingness to change?
How does change occur to reduce risk?
How do parents demonstrate capacity to be introspective when presented with new information or alternative views of the situation?

3. Skills: Child Functioning

- (1) Identifying Children's Unmet Needs:
What meaning does the child give to the problem?
How does the worker assist the children in meeting their needs?
How can the children be helped in case of an emergent situation?
How soon can the family find ways to fulfill its needs?
How is each person affected by the problem?
- (2) Reducing Risk of the Child:
How does the worker work with the family to reduce risk for the child?
How does the family react to the worker's involvement?
How does the worker explain the child's perception to the family?

4. Skills: Family Functioning

- (1) Identifying Strengths & Limitations of the Family:
Who can provide adequate physical and emotional support for the family?
Where does the family turn to when facing a crisis?
When does the family look for guidance from others?
What method does the family use to increase knowledge, education and skills?
How do family members demonstrate ability to manage stressful situations?
- (2) Providing Treatment
Who felt that the family problem was not his/hers?
Where are the family's preferred treatment locations?
When does the family need external resources?
What referral networks can the family get access to?
What behavioral patterns should the family be made aware of?
How has the family attempted to cope with the problems and what skills are required to resolve them?
- (3) Evaluating Outcomes
Who have been and will be responsible for the family's future plan?
Where can the family locate informal support to achieve independence?
When is the preferable time for family treatment?
What has the family achieved in terms of increasing its motivation, capacity and opportunity for positive changes?
How often have the worker and the family met to re-evaluate the service plan?

C. Values in Assessing Family Characteristics1. Values: Adult History and Functioning

- (1) People Can Change:
 Who is motivated to change?
 Where are the emotional support networks for the family?
 When do family members start perceiving the probability of change?
 What characteristics of the family can predict change?
 How does the family discover and appreciate their strengths?

2. Values: Parenting Ability

- (1) Hope Can be Instilled:
 Who can instill hope in this family?
 Where can the worker start to help the family mobilize their motivation?
 What does this family want to change?
 How can the family be helped to work jointly with the worker?
- (2) Parenting Skills Can Be Learned:
 What parenting skills are important for this parent?
 How does the worker persuade the parent to acquire new skills?

3. Values: Child Functioning

- (1) Stay in Home Environment
 Who is the key supporter in the family?
 What are the risk factors within the home environment?
 What can the family provide for the developmental needs of the child?
 How important is the connectiveness with the child's family of origin?

4. Values: Family Functioning

- (1) Empower the Family:
 Who has shown social and cultural competence in the family?
 Where does the family feel most comfortable as a familiar environment to begin changes?
 What has made the family feel helplessness and hopelessness?
 How does the worker find ways to help the family to increase their confidence?

- (2) Change Can Be Predicted:
 How does the worker affect the family's motivation, capacity, opportunity, belief in potential, and commitment to change?

In summary, the literature supports the importance of assessing family characteristics during initial contacts and suggests that caseworker qualities are essential to effective interventions. If service qualities can be maintained, then family characteristics should be analyzed to predict outcomes and determine service priorities and resource allocations.

Application of the Assessment Model

This assessment model was applied to two actual cases to analyze how the data had helped the caseworker determine service directions. Although only two cases are presented here, each of them represents hundred of cases in actual practice. Clients' identities have been disguised to protect confidentiality. Based on the questioning model, the case summaries are followed by a case analysis.

Terry: A Case with Positive Outcomes

Terry was referred to Child Protective Services after her 8-year-old's teacher noticed that Paul was having trouble sitting still in class. When asked about it, Paul said it hurt for him to sit down. The teacher sent him to the nurse who discovered black and blue welts up and down his back, buttocks, and legs. The nurse questioned him about the bruises and Paul responded that he'd gotten spanked for not watching his 3-year-old sister more carefully, and allowing her to burn her hand on the gas stove. His mother was at the laundromat and had specifically instructed Paul to stay with his baby sister, Amy, at all times.

Paul was very worried about his mother's knowing he had spoken to anyone and expressed fear that it would happen again if she knew. He said he gets spanked whenever his mother is mad at him, but she doesn't always leave bruises. He said it was worse when she was drinking.

After investigating the report of physical abuse of Paul, the worker referred the family to the Family Preservation Unit (FPU) for intensive in-home family treatment. The worker had identified a number of risk factors including physical abuse, neglectful supervision, and expressed concerns about the mother's drinking. The worker went out to meet the family to explain the program and find out what the family members would find helpful.

Initially, Terry did not see the FPU as a source of assistance. She was angry and felt attacked and threatened by the agency's involvement. She was accustomed to managing on her own and was suspicious of outsiders, particularly those associated with child protection. She had been responsible for herself since the age of 16 when she ran away from a physically and emotionally

abusive mother, a stepfather who was sexually abusing her, and three younger siblings she was expected to take care of.

Terry described what it was like to be on her own at that age and had briefly used prostitution as a source of income. She said at least she was getting paid for it. Paul was a child of this profession. Once she learned she was pregnant, she quit and found a job working at a convenience store. She proudly reported that after a year and a half she was promoted to assistant manager and actually had people reporting to her. She felt she had given her children a much better life and was angry that Paul was not more appreciative and willing to help her.

The teacher called complaining that Paul could not sit still, was disruptive in class, and talked during the lessons. His grades were good, but he was always being sent to the office, and the counselor had suggested he might need medication. Terry felt defensive and saw every call as a personal attack.

"I take good care of my kids. I make sure they get new shoes and clothes when they need them, and I got cable so they could learn stuff on educational shows." Terry was 24 years old when the family preservation worker met her. In many ways she was still a child herself, and in others far beyond her years. She did not think it was unreasonable to expect Paul to help out with Amy as she had been responsible for the care of younger siblings most of her childhood. She knew Paul was bored in school, but did not think drugs were the answer. She was "scared to death" when she got home and saw Amy's hand and admitted she had "lost control." "I didn't mean to hit him that hard!"

Terry agreed to work with the worker and said she wanted help getting her kids to mind her. She said that she spent most of the time yelling at them trying to get them to listen, but it never seemed to work. She had arranged her work hours around the children and was home before Paul went to school and Amy went to the neighbors. She got home by 5:00 pm and Paul came home from school and was expected to do his homework and stay inside until she got home with Amy.

When Paul was asked what he would find helpful, he said he would like to be able to go out and play after school before it got dark, and he did not think it was fair that he had to go straight home and wait for his mother to return. Terry was afraid of what could happen to him if he was outside with no one watching him, and reported that there had been several shootings in their apartment complex. Amy said she wanted Paul to be nicer to her and for her mother not to yell so much.

Careful assessments revealed that Terry would frequently get angry that she had to discuss things with her children rather than just tell them what to do. She also felt that not hitting them made her lose power. Home visits allowed the worker to spend time together with Terry, sometimes role-playing as a family that reminded Terry how much fun her children were. Terry

and the worker worked on a plan that included: (1) allowing Paul some time to unwind after school by involving him in the Boy Scouts; (2) encouraging Terry to learn more tools to help her manage her children's behaviors without resorting to physical discipline; and (3) inviting Terry to look at ways her use of alcohol impacted her and her family.

The family was delighted by the worker's company and attention. Terry was not interested in attending Alcoholics Anonymous but was willing to read some of the books suggested by the worker on growing up in an alcoholic family, as well as a book of daily meditation she seemed to enjoy. The social worker also met with Paul's teachers. Terry was pleased and surprised to hear that Paul's behavior was improving since they had given him additional things to do and allowed him to become more of a helper in school and at home.

Terry still yelled at her children, and called the worker one evening to tell her that she had used the belt on Paul after she caught him with her cigarettes. She had not left any marks, but wanted the worker to know. Paul was able to tell his mother in a family session that he was afraid she was going to die if she kept smoking and then they would be all by themselves. That seemed to touch Terry. Although she made no promises to quit, she did tell Paul how much he meant to her and that she intended to be around for a long time. It initiated a new level of communication between them.

Terry was encouraged to network with her friends and relatives. The neighbor who babysat for Amy invited Terry and the children to go to church with her. Terry was introduced to several other single mothers and reportedly enjoyed the experience. When the worker said good-bye to Terry, her world was far from ideal. She continued to struggle financially, was lonely for male companionship and was still drinking "more than I should." What had changed was the quality of interaction between this mother and her children. They had found ways to enjoy each other and this helped Terry relax. She enjoyed her work and hoped to become a manager at some point. She had developed a friendship with the neighbor that afforded her an opportunity to socialize with peers. There were no reported problems with Amy, and Terry modified her expectations of Paul in terms of childcare. Before the worker terminated the case, Terry told her, "I know I was hard on you when you first came out. I thought I could scare you away but you kept coming back. You really did help me and my kids. You taught us how to like each other again!"

Terry was not a particularly inviting or promising client on the surface, but just beneath the carefully woven exterior lived a woman determined to survive in a less than kind world, and committed to creating something for her children that she never experienced.

Maria: A Case with Negative Outcomes

Maria was a prostitute. She had been working the streets since she was 15 with brief intermissions of some short-term relationships. She was 30 years old and looked 50. She was

one of five children who grew up with an abusive alcoholic father and a mother who frequently vanished to escape the torture of her life. She described being locked in a closet with her siblings while her father set the house on fire. She escaped but often wondered if she would have been better off dying in the fire.

She had three children: Rudy, 15, Oscar, 5, and Marissa, 2½. She was reported to Child Protective Services for abusing her oldest son. She had beaten him and his younger brother with a hairbrush and her shoe. She was angry because Rudy had not watched Oscar, and he had gotten into her makeup. She had thrown Rudy's clothes out the front door into the rain and told him to get out, that she never wanted to see him again. Rudy later reported this as one of many such incidents. He was big for his age and had been the caretaker of his siblings and his mother for some time. It was a marriage of sorts and Rudy was angered by his mother's work and the string of men she brought into their home. There was one bedroom and he could easily hear his mother and her visitor in the other room. On two occasions, he had had to get his mother to the emergency room after she had been badly beaten.

Maria felt Rudy had no right to tell her what to do. She was sorry she hit Rudy and knew it was wrong but felt like her father came out in her. She described fits of anger that, like demons, took her over and brought out all the darkness inside of her. She described her story in a voice void of emotion and at times dissociated herself from the experience.

Maria never paged or called the family preservation worker for help. They had regularly scheduled meetings and she was almost always there. When she had to work, Rudy would be waiting there for the worker. He did not think much could be changed in his family, but he liked to have someone to talk to. He was not sure how much more he could take. He talked about wanting to run away but not wanting to abandon his siblings. His mother continued to bring men into the home and started drinking more heavily. She told the worker she did not think she was going to make it and talked about wanting to die. She also said that this worker was the first person who really cared about her. The worker was drawn in by her pain and the desire to help her create something better.

One night after 10:00 p.m., Maria paged the worker from a pay booth. She reported with unfamiliar animation that she attended a local church that had helped her in the past with food and rent money. She said that she had given herself to God and was no longer wanting to walk the streets. She wanted to talk about it more on the visit scheduled for the following day. The worker visited her the next day and found her drunk and disheveled in appearance. She explained, "I forgot about the rent!"

Soon it became clear that things would not happen for Maria. One night in a fit of rage she gave Rudy a black eye and left him alone with his brother and sister. CPS had to take conservatorship of the children. Rudy went to a group home while his younger siblings entered foster care. Maria did not return home for a week and did not attend the court hearing.

Case Analysis

Using the questioning model in data analysis, the authors found that both Terry's and Maria's families shared many common characteristics but the outcomes were considerably different. In terms of similarities, both perpetrators were single mothers with more than one child. They were both involved in prostitution for a period of time. Both were victims of childhood abuse. The abused children were the scapegoats for the mothers' relationship problems with men. Their reasons for using physical discipline were related to the mothers' unrealistic expectations toward childcare responsibilities, anger and rage displaced onto the children, and the mothers' lack of knowledge to appropriately handle stress and crisis. In addition, both families had a history of alcoholic problems. The same family preservation worker provided intensive family services for both families with the same knowledge base, value system, and skill applications.

Both families had demonstrated some of their strengths. Terry was motivated to change for a better life and explained that her brief encounter as a prostitute was only a means of survival. She accepted the responsibility of being a mother when she found out she was pregnant with Paul. She was learning to expect more for her life, including getting a regular job and working her way up. In Maria's case, her self-awareness provided a ground for a home-based therapy referral. She admitted her weaknesses and was aware of her anger and lack of impulse control. Both women had not received any prior professional help but allowed the worker to intervene.

In Terry's case, positive indicators included: (1) improved communication between mother and son; (2) mother's willingness to learn and accept change; (3) mother's re-evaluation of her expectations toward childcare responsibilities; (4) son's participation in the decision-making process; (5) the family's access to informal support network; and (6) the mother's increasing trust of the worker at times of crisis and re-abuse.

On the contrary, Maria's case demonstrated some negative directions of change: (1) mother's passivity and the decreasing level of motivation to be involved; (2) son's intensive feelings of hopelessness; (3) no anticipated change in terms of reducing environmental risk factors (e.g., mother still brought men into the home for her prostitution business); (4) mother started drinking more heavily; (5) re-occurrence of abuse without asking for help even though the mother knew it was available; and (6) mother's inability to pursue getting her children back. Upon evaluation of case effectiveness, it was found that hope and motivation were two major determinants of success. Timely encouragement also plays an important factor before a client felt out of control of the situation.

Discussion

The case analysis in this article concurs with the research finding that a family's characteristics represent major determinant factors leading to positive or negative outcomes (Berry, 1992; Dore, 1993; Smith, 1995; Wells & Whittington, 1993). In these two cases, the families

shared many typical characteristics of abusive/neglectful families such as lack of emotional and economic support, past history of childhood abuse, lack of appropriate parenting skills, and lack of empathy toward the child's behavior. The differences that can predict outcomes can be assessed based on the four family characteristics: adult functioning, parenting ability, child functioning and family functioning.

First, Terry's functioning was demonstrated when she showed motivation to change her situation and engaged herself in an open communication system with the worker and her family. Maria's unstable mood and increasing alcohol abuse problem disabled her drive and functioning to make changes. She confined herself in a closed environment that did not allow for communication.

Second, when Terry's parenting ability was evaluated, she was able to view her unrealistic expectations as a problem and willing to make adjustments. On the contrary, although Maria knew that she had inappropriately used harsh discipline on her son, she was incapable of controlling her emotions when administering discipline again and reverted to the defense mechanisms of denial and withdrawal.

Third, in the assessment of child functioning, Terry's son was able to connect his emotion with Terry, which touched Terry's heart. Even with intensive counseling, Maria's son became more depressed and desperate about his future and showed signs of hopelessness. Finally, in the assessment of family functioning, the most crucial outcome indicator is Terry's willingness to work through her problems.

In general, cases with similar characteristics during initial assessment can demonstrate major differences in outcomes. These differences include: (1) family members' intellectual, emotional and physical **capacity** to connect with each other; (2) parent's **motivation**, view of opportunity, and belief in potential; (3) family members' **commitment** to engage and avail themselves in the treatment process; and (4) level of **predictability** that is supported by a safety network (Tracy et al., 1994) and not inhibited by alcohol and other drugs or the primary caregiver's mental status.

Conclusion

Can family preservation work? Is it an effective means of intervention for multiproblem families? These questions have not been fully addressed in the literature. Some studies indicate that family preservation has been working for specific populations but the findings lack general application to other populations (see discussions in Dore, 1993; Faria, 1994; Fong, 1994; MacDonald, 1994; Ronnau & Marlow, 1993). Other studies only state that family preservation is effective in specified conditions but these conditions may not be well defined (see discussions in Feldman, 1991; Fraser, Pecora & Haapala, 1991; Jones, 1985; MacDonald, 1994; Schuerman, Rzepnicki & Littell, 1994). One of the problems in conducting family

preservation research is related to the multiplicity of variables. The testing of multiple variables requires a significant amount of time and resources. Although many research projects have studied the outcomes of family preservation, they have not presented a systematic framework with clinical guidelines for practitioners. This article captures major components in family preservation practice and proposes a series of assessment questions that are organized by the family's characteristics and the worker's competency areas (knowledge, skills, and values). Not only do these questions help researchers identify major outcome predictors, but they also provide a practical framework for caseworkers to identify potential variables and barriers for effective interventions so that prompt service planning or referral decisions can be made. Further research to test the use of this model is recommended.

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Behavioral Outcomes of Home-Based Services for Children and Adolescents with Serious Emotional Disorders

Edwin Morris, Lourdes Suarez and John C. Reid

The current study evaluates the effectiveness of an intensive home-based treatment program, Families First, on the behaviors of children and adolescents suffering from mental disorders and being at risk for out-of-home placement. The sample included 85 youngsters and their families from a semi-rural community. The Diagnostic Interview for Children and Adolescents-Revised (DICA-R) was administered to the children, and the Child Behavior Checklist (CBCL) was completed by a parent at pretreatment and posttreatment. The families participated in a 4-6 week, intensive home intervention where crisis intervention, social support services, and needed psychological services were offered. The results indicated that both externalizing and internalizing behavior problems in youngsters with different diagnoses of mental disorders were significantly reduced at posttreatment as indicated by their CBCL scores. Furthermore, youngsters with a diagnosis of Oppositional Defiant Disorder seemed to benefit the most, as evidenced by the improved scores on most subscales of the CBCL. Youngsters with mood disorders and conduct disorders seemed to benefit in their most deficient areas, internalizing behavior problems and delinquent behaviors, respectively. Finally, after participating in Families First, more than half of the youngsters in the sample were able to stay home with their families.

The enactment of the Adoption Assistance and Child Welfare Act (P.L. 96-272) required state child welfare agencies to make reasonable efforts to prevent out-of-home placements. The legislation endorsed the concept of attempting home-based services prior to out-of-home placement. The act inspired various family preservation programs, some targeted at families of children with emotional disorders (Petr, 1994). The passage of the Family Preservation and Support provisions of the Omnibus Reconciliation Act of 1993 (P. L. 103-66) further challenged states to implement system-wide family preservation and family support services (Briar, Broussard, Ronnau, & Sallee, 1995). These services were conceptualized to prevent out-of-home placement by providing an array of brief, home-based services (Nelson, Landsman, & Deutelbaum, 1990; Whittaker, Kinney, Tracy, & Boothe, 1990). In addition to these legislative initiatives, family preservation programs and other family-focused services

have been promoted by several private organizations and foundations, such as the Edna McConnell Foundation (Clark, 1985).

Family preservation has emerged as a national movement recognized for its efforts to keep families together. Family preservation has received strong support in a number of states because these programs focus on maintaining children in their natural homes and offer a less expensive alternative to out-of-home placements. Also, widespread political and financial support for family preservation has spawned a significant increase in the number of these programs. The Omnibus Budget Reconciliation Act of 1993 has provided entitlement funding encouraging states to develop or expand family preservation services (P. L. 103-66, 1993). More than thirty states currently incorporate family preservation services into their array of protective services offered by child welfare systems (Center for the Study of Social Policy, 1992).

Family preservation programs have evolved from the broader categories of home-based services that served families in their homes and communities, and family-based services, which focused on the whole family, rather than the individual (Pecora, Haapla, & Fraser, 1991). Historically, the vast majority of family preservation efforts target children and families referred to protective service agencies for abuse or neglect. Family preservation is based on the notion that families are more responsive to change at times of crisis (Kinney, Madsen, Flemming, & Haapala, 1977). These family programs endorse the philosophy that out-of-home placements of children can be avoided by modifying family behaviors through the provision of home-based services. Such short-term, intensive, crisis-intervention programs are used when children are "at imminent risk" of being taken from their families (Barthel, 1992). Typically, family preservation programs include the following elements: clinical and concrete services are delivered in the home of the client families; a therapist is available to clients 24 hours a day; the duration of intervention is short ranging from four to six months; and therapists have small caseloads (Pecora et al., 1991).

Because of the recent proliferation of family preservation programs, evaluation of their effectiveness seemed crucial to caseworkers and researchers. These evaluations have often relied on one single outcome measure, the child's placement after the program. Kinney et al. (1991) reported that by the end of 1990, Homebuilders had seen 5,314 cases and 73% had avoided placement twelve months after termination. Other programs designed to work specifically with adolescents and their families reported success rates of 66% (Nelson et al., 1990) and 87% (Tavantzia et al., 1985) of the cases averting placement at a twelve month follow-up.

Although reports of these programs were encouraging, more recent studies and critiques are less conclusive (Rossi, 1992). An evaluation of five family preservation programs in New Jersey concluded that the participating families had fewer children placed but the effects of treatment dissipated after nine months (Feldman, 1991). Heneghan and colleagues (1996),

reviewed 46 family preservation program evaluations selected from a search of 802 references and concluded that the evaluations are methodologically difficult and show no benefit in reducing rates of out-of-home placement. Although preventing placement is a desirable outcome of the family preservation model, questions have been raised concerning the overemphasis on placement prevention outcomes and it has been suggested that there is a need to consider other outcomes (Werbach, 1992). Only six studies of those reviewed by Heneghan, et al. (1996) included family functioning as an outcome measure; however, the impact of these home-based services on the child's functioning has been systematically neglected as an important variable for evaluating family preservation programs.

In a recent study, Meezan and McCroskey (1996) evaluated the effectiveness of a home-based family preservation program using measures of family functioning, parent mental status, and children behaviors. They found that no significant improvements in family functioning were evidenced at the end of the program for service or comparison groups. Only small but significant improvements were evidenced in the service group after a year of participation. In addition, no significant difference in placement rates were found for either the service or comparison group. In this unique study examining children behaviors, school aged children's behavior, as rated by parents, was more improved at the end of the program than that of children in the comparison group. Moreover, although parental mental status was assessed, the children's psychological functioning was not reported in this study.

The purpose of the present study was to evaluate the impact of a family preservation program on the behavioral functioning of children with a serious emotional disturbance. The results of one home-based child treatment project were examined. The original project began in 1987 as a two-site pilot demonstration. The model was identified as the Families First Project. It is a preeminent family preservation program in Missouri and one of very few in the country that has attempted to serve children with severe emotional disturbance. The two primary goals of Families First were: developing home and community-based crisis programming to serve child welfare clients who have mental disorders, and developing a model for an integrated delivery system of community-based mental health services. This study examines the effectiveness of the Families First Project at one of the original sites.

Method

Subjects

The sample consisted of 85 children ranging from ages 4 to 17, mean age of 11 years old (52 children and 33 adolescents) and their families. There were 49 males and 36 females. Seventy-five percent of the sample was Caucasian and 25% was African-American. All the subjects and their families participated in the Families First Program in a semi-rural community. Children selected to participate in this program had to meet the following criteria: 1) be less than 18 years old; 2) be in crisis and at risk of being removed from their home for hospitalization or residential treatment; 3) have a mental disorder; and 4) have accompanying school problems.

In addition, the child must have had at least one family member willing to cooperate with the Families First team.

The children and adolescents, in addition to being at risk for out-of-home placement, showed internalizing or externalizing behaviors and met the diagnosis for at least one DSM-III-R psychiatric disorder. Refer to Table 1 for the percentage of children and adolescents in the sample who were diagnosed with each of the psychiatric disorders.

Table 1
Percentages of DSM-IV Diagnoses of the Children and Adolescents
in the Families First Program

Diagnosis	Percentage*
Mood Disorders	25.9
Anxiety Disorders	2.4
Attention Hyperactivity Disorder	14.1
Oppositional Defiant Disorder	25.9
Conduct Disorder	22.4
Adjustment Disorder	5.9
Other	3.5

* percentages do not add up to 100 given that some youngsters had concurrent diagnoses

Instruments

The Diagnostic Interview for Children and Adolescents-Revised (DICA-R). The DICA is a structured diagnostic interview based on DSM-criteria developed by Herjanic and Reich (1982). It can be administered to both children and adolescents. Various internalizing and externalizing diagnoses (e.g., Major Depressive Disorder, Generalized Anxiety Disorder, Conduct Disorder) are included and good reliability, validity and parent-child agreement have been found (Welner, Reich, Herjanic, Jung, & Amado, 1987).

The Child Behavior Checklist (CBCL). The CBCL was developed by Achenbach (1978) as a broad-band measure of a child's externalizing and internalizing behaviors, as reported by a parent or other caretaker. It contains 113 items, which are rated on a three-point scale; 0 (not

true) to 2 (very true or often true). Separate norms were developed for children from ages 4-5, 6-11, and 12-16 years-old by gender (Sattler, 1992). Good reliability and validity are reported for the scale (Achenbach & Edelbrock, 1983).

Procedure

Subjects were referred to the Families First program by a mental health professional if the child was at risk for out-of-home placement. An initial screening was performed at the family's home. Each child was assessed for psychiatric disorders through the Diagnostic Interview for Children and Adolescents-Revised (DICA-R) (Herjanic, & Reich, 1982). One parent, usually the mother, completed the Child Behavior Checklist (CBCL) (Achenbach & Edelbrock, 1986) at this time.

Each subject and his/her family selected for the Families First program was assigned to a treatment team. The teams were typically composed of two masters-level social workers and a half-time masters or doctoral-level supervisor. Intensive home-based counseling for 4-6 hours a week was provided. In addition, the program incorporated a 24-hour, seven-days a week, in-home crisis intervention for four to six weeks. Each therapist was assigned two cases and was responsible for providing social support services (e.g. transportation, budgeting, and home repair), supervision and consultation, and extensive interagency treatment planning. Other services available to families in Families First included outpatient, inpatient, occupational therapy, speech therapy, psychiatric evaluation, psychological assessment, and medication management. Of the children and adolescents in the sample, 51% were also receiving group, family, or individual therapy while participating in Families First and 26% were taking medication. At the end of the 4-6 week period, one of the parents or caretaker completed the CBCL for his/her child to determine any changes in behavior.

Follow-up sessions were conducted 6-12 months after the families had participated in Families First. At this time, out-of-home placement occurring any time after termination from the program was assessed.

Data Analysis

Data were analyzed in a quasi-experimental, one-group pretest-posttest design. All analyses of CBCL pretest-posttest differences were compared using Wilcoxon matched-pairs signed rank tests.

Results

Demographic Differences

To determine if children's CBCL scores at pretest and posttest differed for males and females, separate Wilcoxon matched-pairs signed rank tests were conducted. For both males and females, CBCL's externalizing, internalizing, and total scores decreased from pretest to posttest (all $p < 0.004$).

In addition, similar analyses were conducted to explore the program's effectiveness by the age of the child. The sample was divided into two groups; youngsters 12 and under comprised the children's group, whereas those older than 12 comprised the adolescent's group. Children's total and externalizing scores on the CBCL decreased ($p < 0.0001$) from pretest to posttest. Adolescents' total, internalizing, and externalizing subscale scores on the CBCL decreased from pretest to posttest (all three $p < 0.0001$).

Child Behavior Differences

The CBCL's total T-score distribution at pretest ranged from 44 to 87. The posttest total T-score distribution ranged from 36 to 84. Total scores for the CBCL decreased from pretest to posttest ($p = 0.0001$). Table 2 contains a summary of the pretest and posttest means and standard deviations.

The internalizing and externalizing subscale scores were analyzed separately. Internalizing scores on the CBCL decreased from pretest to posttest ($p = 0.0001$). Externalizing scores on the CBCL also decreased from pretest to posttest ($p = 0.0001$) (see Table 2).

Table 2

CBCL's Internalizing, Externalizing, and Total T-Score Means and Standard Deviations for the Pretest and Posttest

CBCL Scales	Pretest Mean (SD)	Posttest Mean (SD)	*p value
Internalizing Scale	63.08 (10.86)	57.88 (11.43)	.0001
Externalizing Scale	70.54 (10.01)	63.51 (11.86)	.0001
Total Score	68.67 (9.51)	62.07 (11.47)	.0001

* significance level for testing the difference between the two distributions for 3 tests at .05 was .017.

Taking each of the individual subscales of the CBCL, seven of the eight subscales had pretest distributions that significantly differed from posttest distributions (see Table 3). These subscales were withdrawn, anxious/depressed, social, thought, attention, delinquent, and aggressive. Scores on each of these subscales on the CBCL significantly decreased from pretest to posttest.

Table 3

T-Scores' Means and Standard Deviations for the Subscales of the CBCL at Pretest and Posttest

CBCL Subscales	Pretest Mean (SD)	Posttest Mean (SD)	*p value
Withdrawn	63.49 (10.39)	59.45 (9.02)	.0002
Somatic	58.81 (8.15)	56.72 (7.28)	.0078
Anxious/Depressed	63.93 (10.67)	59.38 (9.62)	.0001
Social	63.36 (9.97)	60.56 (9.45)	.0001
Thought	62.01 (9.34)	58.78 (8.11)	.0031
Attention	66.38 (11.27)	61.93 (9.18)	.0001
Delinquent	70.25 (8.90)	64.74 (9.64)	.0001
Aggressive	71.31 (12.88)	64.28 (11.74)	.0001

* significance level for testing the difference between the two distributions for 8 tests at .05 was .0062.

To determine which diagnostic group of children benefited most from the program, separate Wilcoxon matched-pairs signed rank tests were conducted with the three most frequent categories of disorders: oppositional defiant disorder (ODD), mood disorders (MD), and conduct disorder (CD). CBCL's total and subscale scores for 22 children and adolescents diagnosed with ODD decreased from pretest to posttest for externalizing ($p = 0.0019$) and internalizing ($p = 0.0027$). In addition, scores on seven of the eight subscales showed significant decreases from pretest to posttest. Refer to Table 4 for a summary of the means at pretest and posttest, as well as p-values for the total, externalizing and internalizing subscales, and each of the eight subscale scores.

For the 22 children and adolescents in the MD group, total, externalizing/internalizing, and each of the eight subscales scores for CBCL at pretest and posttest were analyzed. Total and

internalizing subscale scores decreased from pretest to posttest, $p = 0.0015$ and $p = 0.0001$, respectively. Refer to Table 4 for a summary of means for all the different subscales.

For the 19 youngsters in CD group, the externalizing subscale score difference from pretest to posttest significantly decreased ($p = 0.0044$). When looking at the individual subscales, the delinquent subscale decreased from pretest to posttest ($p = 0.0002$), as well as the aggressive subscale ($p = 0.004$). Refer to Table 4 for a summary of the means and standard deviations for all the different subscales.

Table 4
Means and Standard Deviations for ODD, MD, and CD
on the CBCL at Pretest and Posttest

CBCL scales	ODD Pre	Post	p-value	MDD Pre	Post	p-value	CD Pre	Post	p-value
Internalizing	64.45	55.73	.0027	65.91	59.68	.0001	59.63	56.16	.2357
Externalizing	69.00	60.23	.0019	70.41	66.55	.0174	70.63	62.37	.0044
Withdrawn	65.91	58.55	.0038	62.73	61.82	.5863	59.47	57.21	.6348
Somatic	56.91	54.82	.1331	60.86	56.41	.0083	60.42	57.63	.2236
Anxious/ Depressed	64.82	59.32	.0065	66.77	60.91	.0002	59.74	57.47	.3828
Social	61.32	56.73	.0022	64.32	61.23	.0168	62.05	57.47	.4844
Thought	62.68	56.73	.0062	62.09	59.36	.3834	62.58	59.42	.1689
Attention	65.00	59.32	.0053	66.91	63.77	.0119	65.21	61.74	.1316
Delinquent	68.23	62.64	.0074	70.36	66.18	.0086	73.79	65.53	.0002
Aggressive	69.55	61.50	.0040	71.55	68.64	.1590	69.47	62.58	.0040
Total	68.00	58.36	.0002	70.00	64.45	.0015	67.00	60.47	.0098

* significance level for testing the difference between the two distributions for 11 tests at .05 was .0045.

At follow up, children and adolescents of the families participating in Families First were assessed for out-of-home placement after termination in the program. Of the children and

adolescents in the sample, 64% remained home with their families, while 36% were placed in foster care or court custody.

The major findings of this study were as follows: 1) children and adolescents participating in Families First significantly improved their overall behavior as indicated by the decrease in CBCL's Total score from pretest to posttest; 2) specifically, both internalizing and externalizing behaviors in children and adolescents significantly decreased as reported by their parents; 3) youngsters diagnosed with Oppositional Defiant Disorder seemed to benefit in a wide range of areas as evidenced by the significant decrease of problem behaviors in most of them; 4) children and adolescents diagnosed with a mood disorder also seemed to benefit from the program as evidenced by the decrease in the CBCL's internalizing scores from pretest to posttest; 5) children and adolescents with Conduct Disorder diagnoses decreased their externalizing scores, specifically the aggressive and delinquent behavior from pretest to posttest; 6) both female and male children seemed to benefit from Families First as indicated by their scores on the CBCL; 7) nearly two-thirds of the children and adolescents in the sample remained home with their families at the time of follow-up.

Before discussing the implications of these results, several limitations need to be mentioned. First, although a child behavior measure was used to determine the program's effectiveness, in addition to out-of-home placement as an outcome measure, discretion should be taken when evaluating the results, given that they are based on the parents' report of their children's behavior. Reports from other persons related to the child (e.g. teachers) may provide a different perspective or confirm behavioral difficulties reported by the parents. However, because of the short, intense nature of this intervention, a thorough assessment with multiple informants was not feasible. Second, other treatments, such as medication, group or family therapy, and educational counseling among others, were provided concurrently to most of the children while they participated in the Families First Project. Although most of these treatments were in place before the families involvement in Families First, caution must be taken when interpreting these results given that these other services were not statistically controlled. Finally, because of the quasi-experimental design of the study, which did not include a control group, comparisons with a no-treatment group could not be made. Although stronger evidence for the effectiveness of Families First would have been provided, if the study included a control group, it is unlikely that the magnitude of the change in the children's behavior was due to non-experimental variables. At any rate, follow-up studies should include the above mentioned controls.

Despite the above shortcomings, this study is one of the first to evaluate the children's functioning as a measure of program effectiveness. Specifically, children's behaviors were evaluated by their parents, who completed the CBCL, at the beginning and at the end of their participation in Families First. The reduction of internalizing and externalizing types of problem behaviors in children and adolescents at the end of Families First provides evidence for the potential effectiveness of this program. As a preliminary evaluation of this program,

the results are encouraging and will hopefully motivate further more rigorous outcome studies about Families First's effectiveness as a family preservation program.

In addition to Families First's effectiveness across different ages and for both genders, its impact on specific groups of children and adolescents with mental disorders was evaluated. Youngsters diagnosed with Oppositional Defiant Disorder seemed to benefit the most as shown by improvement in the broad band areas measured by the CBCL. Although children diagnosed with a mood disorder did not show the same improvement in those areas, a significant decrease in the total and internalizing scores, their most deficient area, indicated that these children seemed to benefit from the program as indicated by their parents. Similarly, youngsters diagnosed with Conduct Disorder showed improvements in the area of externalizing behaviors, specifically delinquent and aggressive behaviors. In general, these groups of children and adolescents with mental disorders showed improvement in their most deficient areas at the end of their participation in Families First, providing evidence for the program's effectiveness with these specific diagnostic groups.

Consistent with previous evaluations of family preservation programs (i.e. Nelson et al., 1990), this study found that Families First was successful in maintaining children and adolescents who participated in the program at home after termination. Nearly two-thirds of the youngsters who participated in Families First remained home at the time of the follow-up interview. However, 34% of youngsters in this sample were placed out of home in the care of the court or foster parents. One explanation for youngsters being placed outside of their homes may be that the children's behavior problems may not be the only factor affecting their placement outside their families. Other family or environmental factors, such as parental mental health problems, substance abuse, as well as financial pressures, and lack of social support may disrupt family life and have a detrimental effect on the child. Therefore, further studies should evaluate the impact of the parents' functioning, social supports, and environmental stressors in determining out-of-home placements for children with emotional problems. Perhaps future studies can include other outcome measures, such as family functioning that because of time restrictions were not collected in the present study. Finally, other sources of information, particularly from persons related to the families or individual children, may prove useful in the evaluation of family preservation programs.

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A Multi-Faceted, Intensive Family Preservation Program Evaluation

Michael Raschick

This evaluation of a county intensive family preservation services (ifps) program makes several important methodological contributions to assessing post-treatment placement patterns of ifps clients. It is the first published ifps evaluation that utilizes an interval-level, overall measure of restrictiveness of placement, and one of the few that has followed placement patterns for a full two-years after treatment. The study is also a good example of complementing placement data with measures of family health and stability, and with qualitative feedback from former ifps clients. Finally, this study demonstrates the potential for doing methodologically sound evaluations of local ifps programs.¹

Introduction

Intensive family preservation services (ifps) have become a popular approach in working with families with child welfare issues. This treatment approach holds considerable promise because of its focus on *strengthening* families versus depending upon formal helping systems to assume parenting responsibilities for children. Although ifps have been extensively researched, there are some significant gaps in this research. Studies have failed to include effective measures of overall restrictiveness of placements; they have seldom followed up on treatment families for an extended period of time; and they have frequently neglected measuring family well-being and/or qualitative client-satisfaction.

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Limitations of Past *ifps* Research

Gaps in Analyses of Placement Patterns

The failure to effectively measure overall levels of restrictiveness of placements.

Experts in the field emphasize the need to develop more sophisticated measures of placement in doing *ifps* research (Pecora et al., 1995; Pecora, 1991). An important part of this need has been the lack of effective indices of overall restrictiveness of placement patterns. Nearly all studies have focused on *rates* of entering placement (these include, Feldman, 1991 and AuClaire & Schwartz, 1986; Pecora, Fraser, Bennett, & Haapala, 1991; and Yuan, McDonald, Wheeler, Struckman-Johnson, & Rivest, 1990). Rates reflect the proportion of children who are placed during a given time period (or the proportion of families having children placed during a given time period). Only a few studies have gone beyond rate measurements to look at restrictiveness. Furthermore, when restrictiveness has been addressed, this has been done with overly simplistic, *nominal-level* measures and statistical tests. For example, Kinney, Haapala, and Booth (1991) and Pecora, Fraser, Bennett, and Haapala (1991), both look simply at the respective percentages of placements in different types of out-of-home settings (e.g., corrections, residential treatment, group homes, and family foster care). In assessing the number of days spent in different types of placements, AuClaire & Schwartz (1986) provide a somewhat more sophisticated analysis of restrictiveness. They still, however, depend upon nominal level data and descriptive statistical analysis.

Pecora et al. (1995) recognize the general need for *ifps* researchers to utilize higher-level statistical models, including new "measures of placement-related outcomes that are more sensitive to variations in service" (p. 164). Similarly, in discussing the importance of supplementing placement outcomes with interval-level data about individual and family adjustment, Bath and Haapala (1994) emphasize the importance of measures that "yield continuous rather than categorical outcomes" and thus allow for "more powerful statistical tests" (p. 393). Somewhat surprisingly, though, no *ifps* evaluation up to this point has utilized interval-level measures of placement restrictiveness that would, for example, determine relatively *how much more restrictive* residential treatment is than foster home care. As is discussed below, this study introduces a particular interval-level, scaling technique to determine placement restrictiveness.

The lack of long-term follow-up of placements patterns.

Another limitation of past studies is that they have almost always tracked children's placement patterns for relatively brief periods of time after treatment. For example, Feldman (1991), AuClaire and Schwartz (1986), Wells and Whittington (1993), Fraser, Pecora, Fraser, Bennett and Haapala (1991), and Schuerman, Rzepnicki, Littell, and Chak (1993), each had 12 month follow-up periods; and Yuan, McDonald, Wheeler, Struckman-Johnson, & Rivest, 1990,

followed up on placements for only 8 months. This is despite the fact that several *ifps* scholars have identified long-term follow-up as a key need. They have emphasized the possibility that *ifps* teaches families effective parenting skills that they are able to use *preventively* with younger siblings of currently "identified (child) clients" in order to prevent *future* placements (see e.g., Pecora et al., 1995). Rossi (1992b) recommends collecting placement data at least two-years post-treatment (although cautions against going much beyond this because of normal maturation being a possible confounding variable).

In most studies that have followed up for a year or more, improvements have been found for the initial 6-month, post-treatment period, but these have not maintained themselves (see e.g., Wells & Biegel, 1992, assessment of current research).² However since *ifps* studies have lacked precise measures of placement restrictiveness, the question of whether *ifps* has significant long-term benefits has not been fully assessed.

The failure to Complement Placement Data with Assessments of Family Well-being and with Qualitative Measures of Client Satisfaction

Policy-makers have an understandable interest in determining whether their *ifps* programs are effectively reducing placements, especially in respect to placements that are highly restrictive and/or expensive. However, they sometimes do not appreciate the limitations of placement outcome studies: although placement patterns should certainly be included in any *ifps* evaluation, they can not, by themselves, validly assess a program's effectiveness. One important reason for this is that placement decisions tend to be based on a variety of factors, many of which are only indirectly related to a given child's need for placement--for example agency-wide initiatives to reduce placement rates. Furthermore, while out-of-home placements frequently represent undesirable outcomes, they are sometimes in children's best interests (Bath & Haapala, 1994; Pecora et al., 1995; Rossi, 1992a; Rossi, 1992b).

Since placement outcomes tell only one part the story, they need to be complemented by other types of research if *ifps* assessments are to be valid. There are at least two other kinds of analysis that agencies should try to include in their *ifps* evaluations. One involves measuring the level of *ifps* clients' functioning as parents, families, and/or children (Pecora et al., 1995). The other elicits qualitative feedback from clients about their experiences with the program (Rossi, 1992b; Pecora et al., 1995).

²Two exceptions are Feldman's (1991) and Jones' (1985) *ifps* evaluations. They both found statistically significant, long-term differences between treatment and comparison groups in cumulative numbers of placements--Feldman at 12-months post-treatment and Jones at 5-years (Feldman, 1991; Jones, 1985).

The importance of assessing family health and stability.

It is critical to measure the quality of family functioning in evaluating *ifps* outcomes (see, for example, Pecora et al., 1995). A wide variety of well-validated, standardized instruments exist to measure parent, child, and/or whole-family adjustment (see Pecora et al., 1995, pp. 91-162 for a summary of many of these).

The need to qualitatively assess client satisfaction with *ifps* services.

Ifps scholars emphasize the need for doing more qualitative research (Wells & Biegel, 1992; Wells & Freer, 1994; Rossi, 1992b; also see the discussion of Rodwell, 1995, on sound qualitative methods for *ifps* evaluators). Few qualitative studies have been published (Pecora et al., 1995). Qualitative interviews of *ifps* child or adolescent clients have been even rarer (one of the only ones published is Well & Whittington, 1993). The lack of qualitative work is unfortunate since, as Pecora et al. (1995) observe, "a mix of both (qualitative and quantitative) approaches produce the strongest information for documenting program development and effectiveness" (p. 26). Qualitative work can enable researchers:

... to move beyond the cost-effectiveness and cost-benefit conundrums present in quantitative research.... [and] to look at the intangible issues of importance to practitioners, including the 'meaning' of service; how families experience family-based services; and whether families feel empowered by them (Rodwell, 1995, pp. 191-192).

This is especially important in local (*site-based*) research since, as new *ifps* programs develop, "qualitative information is needed to oversee whether proper adjustments to local conditions are being made" (Rossi, 1992b, p. 188).³

The Characteristics of the *ifps* this study evaluated

Intensive Family Based Services (IFBS) is a program designed to provide short-term, time-intensive, in-home services to families. Its workers typically have only about ten families on their caseloads and see each of them, in their homes, from two to five hours per week over a three to six month period.

Although IFBS shares the core features of the basic intensive family preservation model (e.g., intensive, short-term, home-based services), it also has two somewhat unique characteristics. One is that it is much more prevention-oriented than most intensive family preservation

programs. It targets families who voluntarily seek help and who are not currently involved in the child protection system. This contrasts with most *ifps* programs (and almost all that have been formally evaluated) that mandate clients to receive services after they have been identified high-risk for neglect, abuse, or placement.

The fact that IFBS is "preventively-" versus "crisis-" oriented allowed this study to side-step a major sampling conundrum: that of reliably determining whether a child is "at risk of imminent placement." Pecora et al. (1995) describe the latter as "the greatest challenge currently facing the field" (p. 48).⁴

Second, IFBS also has a more structured educational approach than many intensive family preservation programs. Utilizing a curriculum that includes video and audio tapes, readings, and workbooks, it teaches parenting, budgeting, home management, and family communication skills (Gilley, 1993). At the same time, it is strongly rooted in family-systems theory, with both problem-centered counseling and didactic education addressed to the family as-a-unit.

Methodology

This evaluation had three distinct components, focused respectively on 1) placement outcomes; 2) family and child functioning, as measured through standardized scales; and 3) qualitative measures of client satisfaction.

Analyses of Placement Outcomes

Overall methodology and hypotheses.

The sample for this part of the study consisted of the sixty-five children from thirty-three families who completed the program in 1991 (three years before the study began), and an eighteen-family comparison group that included thirty-nine children.⁵ The comparison group was comprised of families who were screened for IFBS services in 1991, but rejected primarily because of lack of vacancies in the program at the time. These families were selected for the study through a multi-stage process, involving both child welfare and research staff, to ensure they had met the criteria for IFBS in 1991.

⁴For discussions of the methodological problems of using the risk of imminent placement sampling criterion see Fein & Maluccio, 1992; Pecora et al., 1995; Rossi, 1992b; Bath & Haapala, 1994; Rossi, 1992a; Feldman, 1990b; Pecora, 1991; and Tracy, 1991.

⁵The average age of children was 9.0 years for the treatment group and 9.9 for the comparison group. However, consistent with the county's family-system orientation, neither IFBS nor comparison group case records differentiate between "identified children" and their siblings.

³Although major qualitative studies have been rare, some examples do exist. See, for instance, Haapala (1983) and Fraser & Haapala (1988). Furthermore, Rodwell, 1995, provides a good discussion of applying qualitative methodologies to *ifps* evaluations.

After the comparison group was formed, it was unexpectedly found that children from the comparison group had, on average, experienced significantly more out-of-home placements than treatment group children. As is discussed below, this led to some analyses of changes in placement patterns from before *treatment/intake* (before *treatment* for the treatment group and before *intake* for the comparison group) to after *treatment/intake*.

The placement patterns of treatment and comparison groups were compared at six-month intervals from 180 through 720 days. The mean days of placement for children in both groups was calculated for each time period. Restrictiveness of placement was also measured, both categorically (looking, for instance, at the percentage of children in residential treatment versus in foster care) and on an interval-level. The study's interval-level analyses used the *Restrictiveness of Living Environment Scale* (ROLES) to derive ratings of overall placement restrictiveness (ROLES is described in detail below).

The study also assessed the respective proportions of treatment and comparison group children who were placed out-of-home at any time during the 720 days period.

Hypotheses regarding placement outcomes were that:

1. The overall restrictiveness of treatment group placements would be less than that of the comparison group.
2. A greater proportion of comparison group children than treatment group children would experience out-of-home placements during the 2-year period.

Although not a central focus of the study, placement costs of comparison and treatment group children were also compared.

Data analysis.

Inferential statistical analyses of differences in placement outcomes between the treatment and comparison groups was done through the *Wilcoxon Rank Sum* test. It is preferable to use this statistical test instead of a t-test or other type of parametric analysis because of the clearly *non-normal* distribution of placement data. That is, placement outcomes, at least in preventive programs, are characteristically highly skewed due to there being many youngsters who never experience *any* placements, as well as a small group who are in placement for disproportionately long periods of time.

All the placement outcome hypotheses were analyzed at various points in time. For the treatment group, these time periods were generally defined by the number of days following termination of IFBS, whereas the starting point for comparison group time-frames was the date of families' initial intake. The time periods considered were pre-treatment/intake, 0-180 days,

180-360 days, 360-540 days, 540-720 days, 0-360 days, 0-540 days, and 0-720 days. The 540-720 and 0-720 periods are especially significant because of the paucity of studies looking at long-term effects of *ifps*.

Because of the significant differences between treatment and comparison groups in their pre-treatment/intake placement patterns, *changes* in placements between the two periods were also analyzed. This was based on the assumption, suggested by other studies, that past or current placements help predict future placements (see e.g., Barth, Courtney, Berrick, & Albert, 1995, pp. 85 & 88-89; Fraser, Pecora, & Lewis, 1991, p. 219; and Pecora et al., 1995, p. 78). That is, more post-treatment/intake days of placement would be expected in the treatment group than the comparison group, since children from the former had, on average, experienced more placement days before treatment/intake.

Use of an overall measure of restrictiveness, the *Restrictiveness of Living Environment Scale*, was a unique aspect of this study. Hawkins, Almeida, Fabry, and Reitz (1992) developed ROLES through surveying 159 Pennsylvania child care professionals. Study participants were guided through a multi-step process to rate each of 27 types of child residential settings (e.g., foster care, residential treatment, and juvenile corrections) according to their relative "restrictiveness." They were initially asked to consider each setting's restrictiveness in 3 areas: its "physical facility"—including variables relating to its size, privacy, and "institutional look"; the setting's "rules and requirements that affect free movement, activity, or other choice"; and "the voluntariness with which children and youths enter or leave the setting permanency." Participants were instructed to use 8 criteria to assess each of the 27 settings in these 3 areas. Two of the 8 criteria involved the degree to which the particular area limited, 1) "personal choices such as the type of food to eat, when to eat, the temperature of the room, the decor of the room, personal clothing, and privacy"; and 2) [the degree to which the particular area limited] "the frequency, variety, or equality of social relations outside the family, with normal peers, adults, or younger children" (Hawkins, Almeida, Fabry, & Reitz, 1992, p. 55).

On the basis of the above, participants assigned a 10 to the setting they found most restrictive and a 0 to the one they found least restrictive. They then selected the setting that they felt was closest to the midpoint of these two extremes and assigned that setting a 5.

Participants used these three standards--of settings they respectively viewed as "most", "least", and "mid-range" restrictive--to rate the remaining 23 settings on their relative levels of restrictiveness. All participants' ratings were then averaged in order to assign a ROLES score to each of the 27 types of residential setting.

The final ROLES' scores of the 6 settings relevant to the study were:

- "home of natural parents"--2.0
- "specialized foster care"--4.5
- "regular foster care"--4.0
- "group home"--5.5
- "county emergency shelter"--6.0
- "residential treatment center"--6.5
- "youth correctional center"--9.0 (Hawkins, Almeida, Fabry, & Reitz, 1992, p. 56).

Since county records did not distinguish between specialized and regular foster care, all foster care placements in the study were rated 4.2.

In order to calculate an individual child's ROLES score for a particular period of time, each day a child was at a given type of setting during that period was multiplied by the ROLES score for that setting. The resulting total was divided by the total number of days in the time period. For instance, if--during the initial 180 day post-treatment period--a child spent 90 days at his natural home (a setting with a 2.0 ROLES score), 60 days in foster care (with a 4.2 ROLES score), and 30 days in residential treatment (having a 6.5 ROLES score), that child's ROLES score for those 180 days would be $285/180$ or 3.48 (i.e., $[(90 \times 2) + (60 \times 4.2) + (30 \times 6.5)] \div 180$).

A .10 standard of statistical significance was used in all the placement analyses because it seemed to be the most conducive to "pragmatically rational decision-making" at the local level.⁶

Measures of Family and Child Functioning

Ten families from the treatment group and five from the comparison group were randomly selected to participate in a multidimensional analysis of family health and stability as measured through three widely-used standardized scales. The scales used were: 1) the General Functioning Index subscale of Family Assessment Device-Version 3 (FAD), used to measure families' overall psychological health; 2) the Interaction Behavior Questionnaire (IBQ), designed to look at conflict and/or negative intra-familial communication; and 3) the Child Behavior Checklist (CBCL), which evaluates problematic/dysfunctional child behaviors. All three instruments were administered face-to-face in participants' homes, taking a total of about

⁶While site evaluators should conscientiously maintain basic principles of sound research methodology, standards of statistical significance may not need to be as rigorous as is traditionally required in academic research. This stems partly from the difference between utilizing research to make complex policy decisions on the basis of "the best information available," and using it to advance a professional body of knowledge.

Issues around statistical significance can be especially problematic in *ifps* research. These services appear to have "small" enough effects to be indiscernible with the small sample sizes that are typically available in site studies (Rossi, 1992a).

30 minutes per family (for brief discussions of the FAD and the CBCL, see Pecora et al., 1995; also refer to Wells & Whittington, 1993, for an example of the application of all three scales, and to Meezan & McCroskey, 1989, and Walton, 1996, for examples of using the CBCL and the FAD respectively).

Qualitative Analysis

Ten sets of parents and five adolescents, all of whom had received Intensive Family Based Services in 1991, were randomly selected to participate in the qualitative portion of the study. Semistructured, in-person interviews were used. Questions were designed partly to elicit participants' overall satisfaction, although a more important objective was to obtain specific descriptions of what they most and least liked about the services. Parent and adolescent participants were asked:

- ♦ to describe, in their own words, what working with IFBS was like.
- ♦ ... whether they felt that the program had helped the child/adolescent who was the primary focus of services, and, if so, how.
- ♦ ... whether they felt that working with IFBS helped them *as a family*, and, if so, how it had helped them as a family.

The qualitative interviews were conducted in participant's homes and each took about 30-60 minutes.

Results

Out-Of-Home Placement Patterns of Treatment and Comparison Groups

Figure 1 shows the average number of days in placement, during different periods of time, for children in the treatment and comparison groups. Note that all children in each group were included in calculating these means, even those who did not experience any out-of-home placements. That is, total days of placement experienced by treatment group children was divided by the total number of treatment group children in the sample (i.e., 65) and the same procedure was followed with the comparison group (using the 39 children sample size as the divisor). Before intake/treatment, children in the treatment group had, on average, experienced about four-and-one half times the number of days of placement of children in the comparison group (i.e., 36.2 versus 8 days). One would, therefore, normally expect more pronounced patterns of post-treatment/intake placements for the treatment group relative to the comparison group; that is, that treatment group children would, on average, experience many more days of placement after IFBS services were completed than would comparison group children after their families' intake. This, however, was not generally true (see Figure 1). Most significantly, at

the end of 720 days, the cumulative mean days of placement for the entire post treatment/intake time period was 16% greater for comparison group than for the treatment group—41.5 days versus 35.8.

MEAN DAYS OF PLACEMENT FOR 65 TREATMENT
AND 39 COMPARISON GROUP CHILDREN

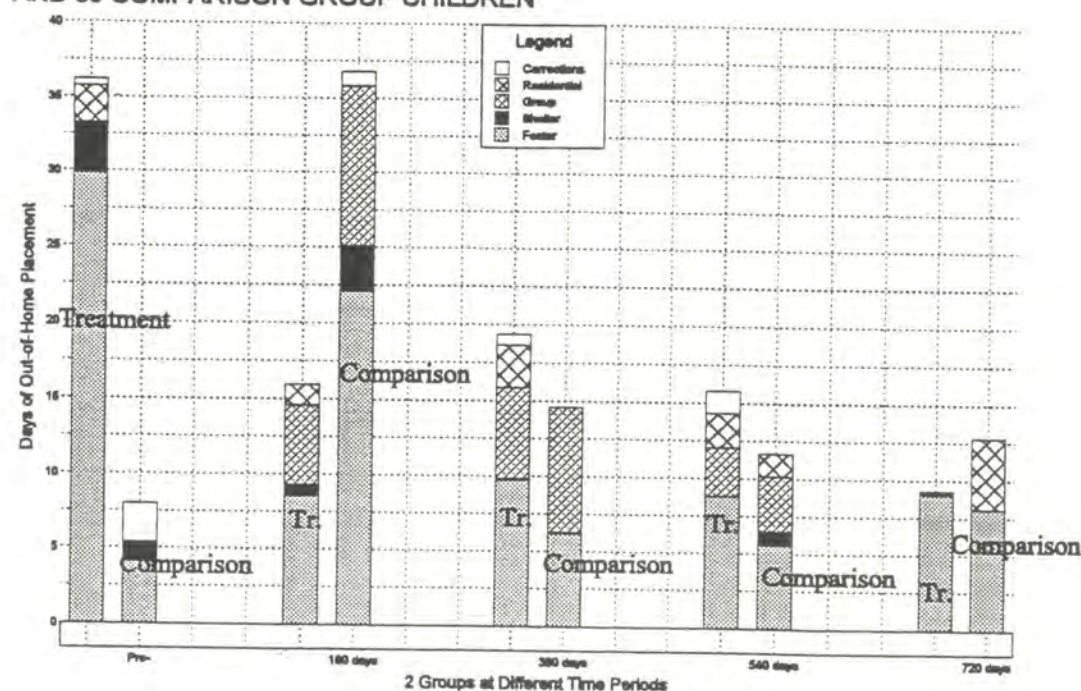


Figure 1

Figure 1 also suggests that treatment group children experienced *less restrictive* placements. Most important in this respect is the fact that, during the last (540-720 day) reporting period, nearly all of the treatment group's days of placement involved foster care (9.03 days out of a total of 9.31 or 97%)—which is one of the least restrictive (and least expensive) forms of placement; whereas more than one-third of the comparison group's days of placement were in residential treatment facilities (i.e., 8.05 out of 12.79 days or 63%)—one of the most restrictive types of placement.

ROLES scores were calculated at different time periods to determine whether there were meaningful differences in overall restrictiveness between the treatment and comparison groups. Table 1 shows that the treatment group had smaller overall restrictiveness scores for all but three time periods. These differences were statistically significant at the .10 level for the periods 0-180 days, 0-360 days, and, significantly, for the 2-year period taken as-a-whole.

Table 1
Comparison and Treatment Group
ROLES Scores for Different Time Periods

Time Period	Mean ROLES' Scores of Treat. Grp. (N=65)	Mean ROLES' Scores of Comp. Grp. (N=39)	Wilcoxon Rank Sum 1-tailed Probability
0-180 days post treatment/intake	2.2586	2.5834	0.325
180-360 days	2.3352	2.2300	.1927
Cumulative 0-360 days	2.2929	2.4117	.1033
360-540 days	2.2848	2.1980	.2458
Cumulative 0-540 days	2.2914	2.3439	.3590
540-720 days	2.1160	2.2168	.2180
Cumulative 0-720 days	2.2470	2.3146	.0962

The analysis also included two key ROLES *change scores*--between pre-treatment/intake and the 540-720 days period, and between pre-treatment/intake and the 0-720 day period. As is shown in Table 2, in both cases the treatment group showed smaller increases in the mean level of restrictiveness of children's residential settings.⁷ These differences were statistically significant at the .10 level.

⁷Pre-treatment/intake scores were lower than post-treatment/intake since ROLES scores for the former reflected the average level of residential restrictiveness *from the time of a child's birth* until intake/treatment.

Table 2
Comparison and Treatment Group
ROLES Change-Scores

Time Periods Being Compared	Mean Change in ROLES' Scores of Treatment Group (N=65)	Mean Change in ROLES' Scores of Comparison Group (N=39)	Wilcox Rank Sum 1-Tailed Probability
Pre-Treatment/ Intake and the 540-720 Days	.0909	.2101	.0734
Pre-Treatment/ Intake and the 0-720 Days	.2224	.3080	.0599

Table 3 shows that there were sizeable, although not statistically significant, differences between treatment and comparison groups in the proportion of children placed out of their homes at some point in the 2-year post-treatment/intake period.

Table 3
Numbers of Children Placed During Entire 720-day
Post-Intake/Treatment Period Compared with the
Numbers Remaining in Their Natural Homes

	Treatment Group	Comparison Group
Number of Children Placed	15	14
Number of Children Remaining in Home	50	25

Finally, the average per child placement costs were much lower for the treatment group--\$621.40 versus \$824.67 for comparison group children. These figures were derived from the average per diem rates charged to the county by different settings. Therefore all children were included in these calculations, including those who had not experienced any out-of-home placement.

Standardized Measures of Family Health and Stability

There were not any statistically significant differences between treatment and comparison group scores on any of the three standardized instruments measuring family functioning. Possible explanations of this unexpected result are discussed below.

Qualitative feedback from IFBS consumers

Six of the ten sets of parents indicated that IFBS "helped their family as a whole"; two said that it had not; and two had mixed responses. Three of the ten said that the program had helped their child who was the focus of intervention; five said that it had not; and two had mixed responses (for instance, saying that it helped in the short, but not, long-run). Two of the five participating adolescents believed that IFBS had helped them personally, and three felt that it had not. Similarly two indicated that the program had helped their families, and three said that it had not.

When responses to all of the questions were topically organized, some important themes emerged. Listed below the three most frequently mentioned response categories, with sample of quotations under each:

1. The program did a good job of teaching parenting skills (mentioned by 8 respondents).
"It brought out parenting skills. They could see things I couldn't see.... [Thanks to learning parenting skills] We were in a team instead of Jane being able to play us against each other.... Now we are united.... Now we know we can say 'no' and 'no' is 'no' -- we don't have to answer immediately, but we can chew on the answer for awhile."

"Mom is more open, she'll talk to me.... It also helped with Mike [her younger brother]. Mom has ideas of what to look for and how to deal with situations with him."
[quotation from an adolescent]
2. IFBS workers genuinely cared about them as individuals (7 respondents).⁸
"Bill and Sue weren't just putting in time--they really cared. They told me to call them anytime if there's a problem.... I felt comfortable with Bill and Sue. I never felt like they didn't have time for us... like it's time to go. I had the opportunity to vent and get feedback--and not in a critical way, but in a positive way.... They were very flexible and caring.... It helped me feel I wasn't alone."

⁸This finding is consistent with Kovacevic & Johnston's 1995 qualitative finding regarding the central importance of very close therapeutic relationships in ifps.

"We went to the beach and talked... and went up to pick berries.... It was fun.... It helped straighten me up.... I was into drinking, drugs, running away, and skipping school.... It helped me with my self-esteem, which was part of the reason I wasn't going to school." [from an adolescent]

3. The services were highly accessible (7 respondents).

"Bill and Sue told me to call them anytime if there's a problem.... It was like a therapy session where they came to you--you didn't have to go to them.... They would meet with me at school when I didn't have time at home. They were very flexible and caring."

"I couldn't even believe that they would come on our time to our own home. I've never had anybody that would call me.... She [the worker] called me at the time when Jim takes his nap and helped me when we decided to take his bottle away.... "

Although they did not occur as frequently, some comments were critical of IFBS. These fell into the three categories that are listed below with accompanying sample quotations:

1. The program failed to provide specific enough or appropriate parenting advice (3 respondents).

"At the beginning of the program, they discussed what they were going to do... and I thought I could get some good ideas and some help.... But at the end, I didn't feel like they had met their goals, and my expectations weren't met.... The biggest thing I wanted help with was finding appropriate consequences for the boys.... I kept records of what the boys did and my responses [as part of the IFBS interventions] and I didn't feel like I got the kind of feedback that I needed. Their feedback was often too general."

"They told my mom that they would give her ways to help to deal with the problem of my punching, but they never did." [an adolescent]

2. The educational component of IFBS wasn't helpful (3 respondents).

"It was different for me because I wasn't a young mother: the educational part didn't teach me anything new, but the counseling part helped.... You're automatically in a program for young mothers that haven't experienced raising teenagers yet."

"We watched some tapes. The tapes were kind of boring.... They didn't really suck you in or anything."

3. The program did not spend enough time on dealing directly with kids as opposed to family issues (mentioned by 3 respondents).

"It might be good to spend more individual time with kids. The only meetings I remembered were with the whole family and that's not where you're going to tell your true feelings if those are the people you're hiding things from." [an adolescent]

"[What was most helpful to me was] One-on-one when Diane would take me places.... I felt like I could talk to her about anything.... We went to the beach and talked... and went up to pick berries and things like that. It was fun.... [But] I didn't like the family meetings... I couldn't talk and open up in front of my step-dad.... During these meeting it felt like I was alone against my parents. Mom would usually stick up for my step-dad and I wouldn't say anything]. It would be good if there was a family-based program for young, teen parents." [an adolescent]

Discussion

Placement Outcomes

The consistent trend of the data suggested that IFBS services reduced average duration and restrictiveness of out-of-home placements. As in other studies, this was clearly evident during the initial 6 month period after treatment/intake. However, unlike most other studies, these changes seemed to maintain themselves over a substantial period of time. In this respect, the average overall level of restrictiveness, as measured by ROLES, was less for the treatment group for the full 720 day period. Similarly, ROLES *change scores* suggested that the treatment group experienced less residential restrictiveness over the entire 0-720 day period, and this was also true for the 540-720 day period.

Standardized Measures of Family Health and Stability

As indicated above, there were no statistically significant differences between the treatment and comparison groups in any three of the standardized measures of family health and stability. This unexpected finding may have been partly due to the small sample size. Probably as significant, however, is the likelihood that the three scales used to measure family functioning were insufficiently focused on the *specific* objectives of IFBS. This is a major potential danger in using any standardized family functioning instruments for *ifps* research since none have been specifically developed to measure the *unique objectives* of *ifps* programs, much less those of particular *ifps* programs. For example, the Child Behavior Checklist (CBCL) focuses primarily on dysfunctional and/or "problematic" child behaviors, such as frequent "sulking." And it may not be a realistic primary objective of IFBS (nor would it be for most other *ifps* programs) to *extinguish such behaviors*. Instead *ifps* programs like IFBS strive to teach families *healthy coping mechanisms* and the *skills to provide their children with basic structure and nurturance*--whether or not particular "problem behaviors" remain. The complete alleviation of problems/stressors is neither a realistic, nor necessary, condition for multi-stressed families

to thrive. Several *ifps* experts provide good discussions of these and other challenges in utilizing standardized instruments to measure family functioning of *ifps* clients (Pecora et al., 1995, p. 91-162; Bath & Haapala, 1994; and Walton, 1996).

Former Clients' Qualitative Feedback

Participants' positive, open-ended feedback about IFBS suggests that the program was meeting its core objectives of a) providing highly accessible services, b) forming close helping relationships where clients felt workers *genuinely cared* about them, and c) effectively teaching parenting skills.

Although not as frequent, there were also negative qualitative responses. One of the two negative response categories questioned the value of a primary IFBS service approach--helping families through didactic education. Another faulted the program for failing to provide specific guidance on parenting skills, which is a central program objective. The third negative category asked that IFBS place less emphasis on one of its central missions--to work with families *as a unit*--and more on one of its less emphasized objectives--establishing close, therapeutic working relationships the adolescent clients, apart from the family as a unit. Although each of these categories represented only three respondents, they do suggest areas for possible program improvement. For instance, although a *family* focus must be a key component of any *ifps* program, workers need to keep in mind that some families may also prioritize workers helping adolescent clients *individually*.

Consistent with the generally positive nature of qualitative responses, six of the ten sets of parents indicated that the program had helped their families, and only two said that it had not. More difficult to interpret is the fact that a) most respondents from both groups did not feel that the program had helped the child/adolescent identified client and b) three of the five participating adolescents did not believe that IFBS had helped their families.

There is a possible explanation for the discrepancy between participants' generally positive qualitative responses and parents' feeling that the program had failed to help their child/adolescent identified client. This may reflect common unrealistic parental expectations of programs completely ameliorating parent-child stresses, versus the more realistic *ifps* goal of *strengthening* families. This interpretation is consistent with the fact that, even though many parents were uncertain about whether their child had been helped, most felt that their family as a whole was strengthened. It is also consistent with many participants' apparent satisfaction with the *helping process* itself (for instance, with the close relationship with workers), as indicated by their qualitative responses.

The fact that most parents suggested that their families had in some way been strengthened through IFBS and most also seemed to be highly satisfied with the program's helping process, has significant long-term preventative implications. Family functioning of treatment families

may be sufficiently improved to prevent younger siblings of currently "identified children" from later developing serious problems, especially if these families felt comfortable enough about their initial experiences with IFBS to readily reinstate services in the future *as soon as problems started to arise*. This would be consistent with the earlier cited observation of Pecora et al. (1995) about *ifps*' potential long-range impacts.

The feelings of most adolescent participants that neither they personally, nor their families, had been helped by IFBS suggests a program deficiency (although the small sample size of this component of the study precludes definitive conclusions). This may be related to open-ended comments by several participants that IFBS failed to adequately focus on working *individually* with children.

Conclusion

This study had several important outcomes. The placement data, although not definitive, suggest that children whose families participate in IFBS are less apt to be placed out of the home than comparable children whose families were not involved in the program.

Perhaps as important as the placement outcomes themselves, the study suggests two directions for future research. One is emphasizing measurements of overall restrictiveness versus depending exclusively on placement rates. This is methodologically sound since restrictiveness data add a whole new dimension to assessing placement patterns, and thus increase measurement *precision*. Focusing on restrictiveness is also consistent with a commitment to children's psychosocial health and well-being.

Secondly, future research should evaluate placements over even longer time frames than the two-year period used in this study. Long-range evaluations could further test the hypothesis that intensive family-based services help prevent future placements of younger siblings of identified child clients.

While reaffirming the importance of using standardized measures of family functioning, this study points to some of the challenges in doing this. The most important of these challenges ensure that the instruments selected closely match the specific outcome objectives of the *ifps* program being evaluated.

The qualitative findings suggest that IFBS families tend to highly value the personal caring and exceptional accessibility they see IFBS as exemplifying, and they generally feel strengthened as families through their participation. It seems quite possible that this means IFBS is serving a long-term preventative function.

Finally, this study demonstrates the promise of conducting small-scale, site-based *ifps* evaluations at the local level. Three important principles of doing this effectively are: 1)

ensuring that the evaluation focuses on specific program objectives; 2) incorporating sound research methodologies, including control and/or comparison group designs in measuring placement patterns; and 3) complementing placement research with assessments of family functioning and qualitative client feedback.

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Targeting Families

To Receive Intensive Family Preservation Services: Assessing the Use of Imminent Risk of Placement as a Service Criterion

Elaine Walton and Ramona W. Denby

The process for targeting families to receive intensive family preservation services was examined for 71 child welfare agencies in the United States. The focus of this exploratory/descriptive study was the concept of imminent risk of placement as a criterion for providing services. Findings indicated that agencies had difficulty defining imminent risk and were unable to successfully restrict services to imminent risk cases. Several factors besides imminent risk were identified in relation to the targeting process.

Key words: Decision making; Imminent risk; Intensive family preservation services; Targeting

Intensive family preservation services (IFPS) are generally designed for families with children at imminent risk¹ of out-of-home placement. There is evidence, however, that even when imminence of risk of placement is set as the primary criterion for inclusion in IFPS programs, decision makers are inconsistent in adhering to that policy (Schuerman, Rzepnicki, & Littell, 1994). Moreover, the criteria used for targeting families for services are unclear. The purpose of this study was to examine those issues.

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Background

Intensive Family Preservation Services

Programs that provide IFPS generally focus on family preservation through the short-term application of family therapy, communication skills training, and assistance in addressing basic needs such as food, employment, and housing. The elements common to most programs based on this approach are that the caseworkers: (a) accept only families at immediate risk of child placement; (b) meet with families as soon as possible after referral; (c) provide services 24 hours a day, 7 days a week; (d) deal with the family as a unit; (e) provide services primarily in the home; (f) provide services based on need rather than on categories; and (g) provide intensive services on a short-term basis.

Targeting Families for Intensive Services

"Targeting" is the term used to describe the decision making process in determining which families should receive IFPS. That decision-making process is important for several reasons. First, although family preservation programs are considered cost-effective (in comparison to substitute care), they are still relatively costly (Yuan, 1990). Agencies simply cannot afford to provide intensive services indiscriminately to vast numbers of families. Second, IFPS programs were not designed to serve the full range of families in need of assistance (Whittaker, 1991). Third, by not targeting, IFPS programs may miss groups of families who most need services (Feldman, 1990). Fourth, the lack of targeting can result in "net-widening" (i.e., services are delivered to groups of families who may function well without them) (Feldman, 1990). Finally, targeting allows IFPS programs to be more precise and scientific in their service delivery (Feldman, 1990).

In general, the objective of IFPS programs is placement prevention--hence the imminent risk of placement criterion. When imminent risk cases are not the target, services need not be as intensive (Kinney, Haapala, Booth, & Leavitt, 1988; Nelson, 1988). Customarily, measurement of success in IFPS programs rests on the assumption that, in the absence of service, all families referred would experience placement. Consequently, the way in which agencies target families for service is crucial to any comparative analyses of a program (Feldman, 1990; Littell et al., 1993; Rossi, Schuerman, & Budde, 1979; Schuerman et al., 1994).

Imminent Risk of Placement

As the criterion for targeting families for IFPS, the use of imminent risk of placement is a practice whereby services are directed to families who would have a child placed into substitute care unless something were done to improve the family situation. Circumstances commonly

associated with imminence of placement include legal status of the child (e.g., declaration of dependency) and the decision of a worker, supervisor, or placement committee to remove a child from the home (Feldman, 1990, p. 29).

Is Imminent Risk of Placement Used as a Targeting Criterion?

Although imminent risk of placement is the stated service criterion in most IFPS programs, researchers have found that "relatively few . . . families served would have had a child placed in substitute care in the absence of service" (Schuerman et al. 1994, p.22). Moreover, Rossi et al. (1994) concluded that, when presented with 50 case histories, a panel of 20 child welfare experts did not use imminent risk as a criterion to define a target for either "ordinary services" or IFPS. It appears from these findings that imminent risk may not be a primary service criterion and that imminent risk cases are not the cases exclusively served by IFPS programs. If IFPS programs are not serving imminent risk families as they are intended to, the next logical question is "why not?" Arguably, IFPS programs cannot be expected to reduce placement rates if they are not actually serving those families who are on the verge of placement.

Decision-Making and Imminent Risk

It is not known why some IFPS programs do not use imminence of risk as a criterion. However, an exploration of the decision-making process surrounding imminent risk reveals some clues. Five issues directly linked to decision-making theory may be attributable to the nonuse of imminent risk: (a) difficulty in predicting risk (Meddin, 1985), (b) exactness in projecting placement time periods (Denby, 1995), (c) designation of who determines risk (Denby, 1995), (d) vagueness associated with the process of decision making (Nasuti, 1990; Stein, 1984), and (e) feasibility and threat to successful program outcomes (Berry, 1991; Berry 1993).

Many authors have attempted to understand and document the decision-making process in child welfare (for example, Boehm, 1967; DiLeonardi, 1980; Giovannoni & Becarra, 1979; Phillips, Shyne, Sherman, & Haring, 1971; Rosen, 1981; Stein & Rzepnicki, 1983; Streshinsky, Billingsley, & Gurgin, 1966; Wolock, 1982). Denby (1995) identified some of the factors involved in making decisions on whether to deliver IFPS. These include risk assessment, eligibility or statutory criteria, the decision makers themselves, parental and child characteristics, and the ambiguity associated with a clinical/theoretical framework. According to Berry (1993) there is no conclusive, uniform decision-making information to guide workers in choosing the appropriate target groups for IFPS, and there exists a scant literature base which has considered directly the relationship between program success and imminent risk. Even more limited is research which concerns the decision-making process employed by IFPS workers in relation to imminent risk (Rossi et al. 1994).

Method

In spite of negative reports on the routine use of imminence of risk such as those provided by Rossi et al. (1994), child welfare agencies continue to declare the use of the criterion in practice (Feldman, 1990). In order to examine more closely actual current practice and policy, a survey of agencies providing IFPS was undertaken. An exploratory/descriptive design was employed involving both qualitative and quantitative research methods. The design was a cross-sectional, interview, survey research method, using a parallel sampling technique. The *Imminent Risk Survey* (Lewis & Walton, 1993) combined closed- and open-ended questions in exploring agencies' use of the concept imminent risk. The survey was designed to collect information in six categories: (a) importance of the concept, (b) definition of the concept, (c) success in using the concept as a service criterion, (d) hindrance to its use, (e) who determines the level of imminence, and (f) mechanisms used for determining imminent risk.

Sample

A nationwide sample of 100 agencies that provide IFPS was randomly selected from the *Annotated Directory of Selected Family-Based Services Programs* (National Resource Center on Family-Based Services, 1991). It was discovered that 25 agencies were not appropriate for the study because: (a) they no longer operated an IFPS program or did not regard their current services as IFPS; (b) they never were an IFPS program to begin with; (c) they were not abreast of the issues surrounding imminent risk and therefore an unreliable or unknowledgeable respondent; or (d) the address and phone number was incorrect or untraceable. In addition, four agencies received the initial cover letter and were scheduled for a phone interview but at the established time (and after repeated attempts) were too busy to complete the survey. Data were collected from the remaining 71 agencies. By chance 50 of the agencies contacted were contract agencies (i.e., agencies who provide the actual service to families) and 21 were referring agencies (i.e., agencies who screen and refer cases to contracted agencies to provide intervention). The respondents were all supervisors or administrators.²

Data Quality and Reliability

A pre-test was conducted in order to provide an initial assessment of the validity of the *Imminent Risk Survey*. The following guidelines, as specified by Babbie (1993) were used: (a) The entire instrument was tested to ascertain the applicability of all questions; (b) the instrument was pre-tested in the manner intended for the actual study (i.e., a cover letter followed by a telephone interview); and (c) the selection of subjects was non-random and kept

flexible. (In this case, a sample of respondents from three family preservation agencies located in Columbus, Ohio, was purposively selected and administered the instrument.)

The pre-test respondents assessed the clarity and organization of the instrument, comprehension, and appropriateness and applicability of questions. For the most part, issues of design, length of time to complete interviews, and content validity were the focus.

Inconsistencies were found to be largely the result of incorrectly categorizing respondents. This observation lead the researchers to re-categorize respondents by "referring" and "contract" workers in the actual study. In short, the pre-testing lead to refinements in the interview format, changes in survey questions, and alterations in the selection of the sample.

Data Collection and Analysis

Telephone interviews lasting an average of 45 minutes were conducted with agency respondents. One interviewer, trained in the use of survey methods, gathered all data. A pre-test was conducted with local agency personnel to provide an initial assessment of the survey instrument (e.g., to examine mechanical problems or ambiguities). Data collection began the summer of 1993 and extended through the summer of 1994.

Responses to the qualitative portions of the survey form were analyzed using content analysis whereby themes emerging from interview responses were identified and subsequently organized. Specifically, the data analysis process involved: (a) data reduction, (b) data displays, and (c) conclusion drawing/verification (Miles & Huberman, 1984). Quantitative data were analyzed using (a) descriptive statistics to express the characteristics of the sample and the relationships among variables, (b) t-tests to examine the potential differences by agency status (i.e., referring versus contract), and (c) chi-square to examine the relationship between referring and contract agencies on selected variables.

Results

Description of the Sample

Although all the agencies in the sample described their programs in terms of family preservation services, they differed in many respects. About one-half of the agencies surveyed represented private, nonprofit agencies and another 38% included public child welfare agencies. Moreover, 70% of the respondent agencies were considered contract agencies, and the remaining 30% were referring agencies.

One-third of the sample served fewer than 50 families yearly. Conversely, 42% of the sample served over 100 families per year. The largest source of referrals (i.e., 50%) for the entire sample was the local Child Protective Services unit. Forty-six percent of the families served

²

Supervisors and administrators were selected for the sample because they are responsible for making the targeting decisions, and the objective of the study was to learn more about the decision making process. Nevertheless, it is acknowledged that supervisors and administrators may lack firsthand experiences with practice.

each year were referred from either other professional agencies (23%) or the community at large (23%). Sixty-three percent of the agencies employed six or fewer therapists. Few (20%) employed more than twelve therapists. In terms of caseload size, the findings were consistent with what was expected, given the number of workers employed. A relatively low therapist-client ratio was maintained, with nearly one-third of the sample reporting that no more than four cases were handled by each worker at any given time. Of the remaining sample, 30% reported carrying 5-8 cases at a time, 30% carried 9-10 cases, and only 13% carried caseloads of more than 14. Nearly one-half (47%) of the sample typically kept a case open for 12 weeks or less. For the other half of the sample, cases remained open anywhere from 13 weeks to over 6 months.³

The majority (77%) of the IFPS programs sampled began operation between 1980 and 1990. In terms of the treatment model used, a family systems approach was the treatment model of choice for 35% of the sample. However, another 35% of the sample reported a varied choice in the type of intervention models used (e.g., a combination of approaches, "agency-specific" methods, or no identifiable approach at all). Seventy-three percent of the respondents identified child abuse and neglect as the presenting problem in at least one-half of the cases.

Emergent Themes

Several themes emerged in response to the open-ended questions--the most predominant of which are presented herein. It should be noted, however, that the tables only reflect the number of times a particular response was given. For some questions multiple responses were possible, and there has been no attempt to insure that every agency was represented in the tally.

Definition of imminent risk. In response to the question, "How does your agency define imminent risk?" a variety of conditions and criteria were provided (Table 1). Most noteworthy were the responses "no working definition" and "we do not use imminent risk." Other responses included criteria or conditions such as: (a) "a child who is about to be placed immediately," (b) "placement that occurs within 3-7 days," (c) "potential for placement, time-frame unspecified," and (d) "definition of imminent risk is decided by referring agencies."

³

Normally IFPS is crisis oriented with interventions of 4-8 weeks. Agencies who provided longer-term interventions were included in the study because: (a) they described their services as IFPS, (b) the referring agencies designated IFPS as the treatment of choice, or (c) either agency ostensibly subscribed to the "imminence of risk" criterion for service.

Table 1
Definition of Imminent Risk

RESPONSE	TALLY	
	Referring Worker	Contract Worker
A child who is about to be placed immediately due to a neglectful or abusive home	7	4
Abused, neglected, or delinquent child where all community resources have been exhausted and placement will occur within next three months	1	2
Child who will be removed within next 30 days because of severe home conditions	2	1
No working definition	4	7
A child who will be placed within 1-2 days because of abuse and neglect	1	4
We do not use imminent risk as a service criterion	2	5
Defined by a risk assessment scale	1	-
A child with a potential for placement, time-frame unspecified	3	7
Depends on referring agency's definition	-	10
Placement will occur within 3-7 days	-	8
Definition varies worker-to-worker	-	2
Risk of placement within 15 days	-	1

Note: Multiple responses were possible, and not all respondents are represented.

Criteria used for accepting a family into service. The eligibility criteria used in agencies is displayed in Table 2. When respondents were asked to identify the criteria used to decide case eligibility, five primary themes emerged: (a) "parent must be a voluntary participant," (b) "child must be at imminent risk," (c) some sort of "age specification," (d) "residence restriction," and

(e) "loosely defined criteria." Contract workers identified a greater variety of criteria than referring workers, and referring workers more frequently reported imminent risk as a criteria (39% of respondents) than contract workers (23% of respondents).

Table 2		
Criteria Used for Accepting a Family into Service		
RESPONSE	TALLY	
	Referring Worker	Contract Worker
Parent must be voluntary	7	19
Child must be at imminent risk	12	21
Age specification	4	9
The parent or care giver must be the alleged maltreater	3	0
Residence/catchment area restriction	4	7
Very loosely defined eligibility criteria	3	8
All community resources have been exhausted	-	5
Services are expected to remedy the family situation	-	5
No mental illness/pathology	-	3
Must be referred by the Dept. of Human Resources	-	7
Criteria specified by referring source/funder/grant	-	4
Family must be nonviolent (safety issues for workers)	-	3

Note: Multiple responses were possible, and not all respondents are represented.

Strategies used to restrict referrals to imminent risk. Respondents were asked to identify strategies employed by their agencies in order to restrict referrals to cases at imminent risk of placement (Table 3). Respondents frequently reported that no particular strategy was used to restrict cases. In cases where respondents were able to identify a restriction strategy, screening

teams were most often the identified method in preference to the use of rating instruments or the restriction of service to those cases with some sort of placement action (i.e., shelter care, foster care, placement court order).

Table 3		
Strategies/Procedures Used to Restrict Referrals to Cases at Imminent Risk of Placement		
RESPONSE	TALLY	
	Referring Worker	Contract Worker
Screening teams composed of contract and referring workers	7	6
No strategy	9	19
Rating instruments used		
- yes	7	13
- no	14	38
A particular placement action		
- yes	2	8
- no	19	43

Factors hindering agencies from limiting cases to imminent risk. In response to the question, "What hinders your agency from limiting IFPS caseloads to imminent risk cases?" five key factors emerged (Table 4). First, respondents stated that the need to do "prevention work" hinders them from targeting imminent risk cases. Second, respondents identified the lack of services to families who are troubled as another factor which prevents them from limiting cases to imminent risk. One respondent commented: "The need is too great to just serve imminent risk cases." Third, agency philosophy was identified as a factor which hinders the use of imminent risk as a service criterion. The focus on prevention provides for the perspective that "everyone is imminent risk." Fourth, the fact that there is no specific way of defining imminent risk hinders agencies from limiting services to this client population. A final factor for contract workers was the "clash" of sorts between contract and referring agencies. Repeatedly, contract agency respondents stated that their contract with the county or state forced them to serve whomever is referred.

Table 4**Factors Which Hinder Agencies From Limiting Their Cases to Families Truly at Imminent Risk of Placement**

RESPONSE	TALLY	
	Referring Worker	Contract Worker
Our definitions of imminent risk are not clear -- we need more specific criteria	5	-
Sometimes there's a need for us to do "prevention work" -- though a case is not imminent risk now, it will eventually explode if something isn't done	6	11
Services just aren't available to families who need services badly but fall out of definitions of imminent risk. Imminent risk is only a small percent of the total service need	4	7
Our agency philosophy that says -- "you don't let a case get to its worse shape. Everyone is imminent risk, everyone deserves service"	5	4
Contract with the county forces us to serve whomever they want us to	-	14
Court orders -- mandates imposed by judges	3	-
Misuse of our services by other professionals -- not understanding what we are about	-	3
Reunification work/foster care work	-	3

Note: Multiple responses were possible, and not all respondents are represented.

Strategies to assure that IFPS are not bypassed. One survey question focused on the procedures agencies used to make sure children were not inappropriately bypassed for IFPS (Table 5). It was determined that both groups of agencies make a concerted effort to maintain open lines of communication with one another about availability to receive referrals. Several contract workers reported that they do not feel that making such assurances falls under the auspices of their service delivery. Nevertheless, there was a variety of responses from contract workers.

By contrast, the referral workers most frequently indicated all recommendations for placement must go before a staffing team which assesses a case to determine if IFPS has been considered.

Table 5**Strategies/Procedures Used to Make Sure Family Preservation Services are Not Bypassed**

RESPONSE	TALLY	
	Referring Worker	Contract Worker
"Reasonable efforts" -- all recommendations for placement must go before a staffing team	10	7
Close communication between the Dept. Of Human Resources and the service providers	6	21
Child welfare advocacy at the legislative level	-	4
Multitude of community services -- there are various layers of services. Some type of service is offered to everyone	-	3
Not our role -- we are just service providers, that's the lead agency's responsibility	-	8
Resource building -- timely evaluation of all referrals and ongoing monitoring of cases on waiting lists -- referral where necessary -- referring worker works with case until we get to it	-	6
None	-	4
Multi-disciplinary teams screen referrals	-	4

Note: Multiple responses were possible, and not all respondents are represented.

Cases inappropriate for family preservation. Displayed in Table 6 is a report of the criteria for determining which cases would be ineligible for IFPS and referred directly to substitute care. Most frequently mentioned were: (a) "severe/life threatening abuse" and (b) "noncompliant/uncooperative parent." A variety of other criteria (e.g., chemical dependency, mental health, or mental retardation) were considered by contract workers but not mentioned by referring workers.

Table 6

Cases Deemed Inappropriate for Family Preservation
and Referred Directly to Substitute Care

RESPONSE	TALLY	
	Referring Worker	Contract Worker
Serious/severe, life threatening abuse -- child in danger -- we cannot assure safety -- high level of aggression and violence	14	24
Noncompliant, uncooperative parents	3	12
Perpetrator with severe chemical dependency concerns -- especially if in denial	-	14
There is no such case -- our philosophy is that all cases are family preservation cases	-	5
This type of decision is not up to us, it's up to the referring agency	-	6
Long history of abuse -- numerous and lengthy past placements -- usually involves older children and previously tried services -- unresponsiveness to services	-	5
Mental health or mental retardation involvement (parent or child)	-	9
Sex perpetrator in the home -- parent cannot protect child from abuse	-	6
Service provider in danger	-	5
Significant behavior problem on the part of the child	-	4

Note: Multiple responses were possible, and not all respondents are represented.

Factors hindering agencies from receiving cases referred directly to placement where placement could have been prevented through IFPS. The final category of emergent themes is presented in Table 7. The lack of resources, worker subjectivity, and the lack of awareness on the part

of referring agencies as to the type of services that can be provided, all hinder agencies from receiving those cases in which placement might have been prevented.

Table 7

Factors Which Hinder Agencies From Receiving All of the Cases
Referred Directly to Placement Where Placement Could Have
Been Prevented by Providing Family Preservation Services

RESPONSE	TALLY	
	Referring Worker	Contract Worker
Lack of service availability -- lack of resources	10	32
Worker subjectivity -- workers will refer case for substitute care without considering other viable alternatives	6	-
This type of case would be the exception in our locality -- we do a good job of providing services; therefore, I cannot think of specific factors	5	-
Family lives in an area where services aren't provided. Geographically inaccessible	-	3
Lack of awareness on the part of the referring agency as to what services we can provide/the need to better train workers to refer cases	-	7
Referring worker doesn't believe home-based services are appropriate	-	3
Communication problems between us and the referring division	-	3
We are a fee-for-service agency -- referring departments decide who will receive services	-	3

Note: Multiple responses were possible, and not all respondents are represented.

Differences Between Contract and Referring Agencies

The contract and referring agencies were compared on five variables (Tables 8 and 9). As indicated by the mean scores in Table 8, the differences between the two groups are negligible on all but one variable. The referring workers felt much more confident than the contract workers that they had been successful in assuring that appropriate cases were given services and not bypassed. Contract and referring agency respondents agreed that the use of imminent risk is only "somewhat important" in service delivery. Likewise, both groups of respondents indicated that they are only slightly-to-moderately successful at restricting intensive services to those cases at imminent risk. There was also no difference between the two groups on the percentage of families served who have at least one child at imminent risk of placement (i.e., 51% to 75%).

Table 8						
Attitudes of Referring and Contract Workers on the Use of the Service Criterion "Imminent Risk"						
Response	Referring Worker (n=21)		Contract Worker (n=50)		t	p
	Mean	SD	Mean	SD		
Importance of concept "imminent risk" ^a	2.09	1.22	2.00	1.24	.298	.767
Success at restricting referrals to just those cases at imminent risk ^b	2.48	1.32	2.68	1.27	.598	.553
What percent of families you serve have at least one child at imminent risk ^c	2.90	1.54	3.16	1.26	.668	.509
Success at assuring that appropriate cases are given family preservation services and not bypassed ^b	1.57	1.60	3.30	2.75	.330	.002

^aScale values ranged from 1 (very important) to 4 (not needed)

^bScale values ranged from 1 (highly successful) to 4 (not at all successful)

^cScale values were as follows: 1=0-25%; 2=26-50%; 3=51-75%; 4=76-100%

The two groups of workers differed in response to the question, "who determines imminent risk" (Table 9). Respondents from contract agencies indicated that referring agencies decide which cases are at imminent risk of placement, while respondents from referring agencies believe that it is contract agencies and screening groups who equally decide a case's imminence of risk ($p < .001$).

Table 9					
Referring and Contract Workers' Perception of Who Determines the Level of Imminent Risk by Percent in Each Category					
Variable	Total	Referring Workers n=21	Contract Workers n=50	Chi-square	p
<i>Who Determines Imminent Risk</i>					
Referring Agencies					
Contract agencies	51%	14	66		
Screening group	24%	43	16		
	25%	43	18	15.860	.000
		100	100		

Note: Screening groups included representatives from both referring and contract agencies

Discussion

The results of this study are consistent with the findings of previous researchers who determined that imminent risk, as a criterion for targeting families for IFPS is fraught with problems. First, the difficulty associated with predicting imminent risk was noted. Second, who determines imminent risk was identified as a significant factor, and there were conflicting viewpoints (e.g., contract workers generally felt inappropriately excluded from that decision-making process). Third, there was a great deal of vagueness and imprecision associated with decision making, and that vagueness seemed related to a desire to incorporate various criteria (e.g., the desire to do early prevention work) into service delivery decisions.

Based on the findings it appears that contract and referring agencies' service motivation can sometimes conflict, producing diverse perceptions of the target population and differing viewpoints on what actually constitutes an imminent risk case. Referring agencies appear to have more rigid criteria and are often responding to community pressure or court order. Contract agencies are often motivated by program success and may be reluctant to take imminent risk cases because they are often viewed as the most difficult. Moreover, contract workers seem to have a desire to provide "true" intensive services to those they believe will benefit most.

Both referral agency respondents and contract agency respondents agreed that imminent risk, as a service criterion, was only somewhat important in making service delivery decisions.

Moreover, they agreed that agencies were largely unsuccessful at restricting cases to an imminent risk population. In fact, nearly one-third of the cases served were not imminent risk cases. Respondents reported that services are delivered to some imminent risk cases, early prevention cases, cases in which workers are attempting to document "reasonable efforts," and cases of reunification and potential placement disruption. This variety in the types of cases served makes the impact of IFPS on out-of-home placement rates unclear and clouds results from program evaluations that are based on out-of-home placement as a primary outcome variable.

Conclusions

It seems disheartening, if not strange, that after so much emphasis in the literature, so few agencies have defined imminent risk for themselves--let alone used it. Perhaps the use of imminent risk as a criterion is untenable and impractical and should be abandoned. Practitioners and researchers are still struggling to answer the question "What are IFPS programs really good for?" These programs have been traditionally presented as a way to cut costs through preventing out-of-home placements--hence the imminent risk criterion. They might more appropriately be presented as merely effective ways to help troubled families. The question then remains, "Which troubled families are likely to benefit most from these services?" The answer may be elusive because of the way in which practitioners, administrators, and researchers conceptualize the question. For some decision makers, selecting families for special services is an issue of dividing up a limited resource--a little bit like the process of selecting only a few of the starving masses to receive an adequate diet rather than equally distributing a few crumbs to everyone. Perhaps a more appropriate model for conceptualizing the decision making would be to compare it to the process of identifying the specific nutritional needs of each person--given their unique strengths, deficiencies, and set of circumstances. Then treatments would be designed to match the specific needs--acknowledging that some treatments would be more intensive or costly than others. Although IFPS may not be measured and analyzed as simply as vitamins and minerals, it appears at times that the families in need of child welfare services are much like the "starving masses." In fact, service providers may feel so overwhelmed by the needs that they lose motivation for designing a rational decision making process for determining which families get help. The challenge for future research is to accurately measure families' "nutritional" deficiencies along with their strengths and resources so that specific treatments can be tailored to fit. When we have accomplished that task, we will know what IFPS programs are good for.

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Review of Current Resources

Family Centered Services: A Handbook for Practitioners. Bonnie K. Williams (Ed.). The National Resource Center for Family Centered Practice, School of Social Work, The University of Iowa. Iowa City, Iowa. 1995

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The introduction to this edited handbook describes its intent -- to serve as a "resource for administrators and practitioners in public and private human service agencies who are in the process of developing, maintaining, or enhancing services to families" (ix). Its twenty-two chapters describe family centered services (Chapters 1-3); discuss contact, assessment, and intervention roles (Chapters 4-11); demonstrate a variety of applications of family centered services (Chapters 12-20); and discuss burnout and termination (Chapters 21-22).

This work is well organized for introducing the reader to the concept and application of family centered services, and the references and recommended reading lists are comprehensive. However, the chapters are uneven. At best, they combine rich content with clear application guidelines. In some instances, however, the well-intended attempts to make material accessible result in oversimplification, dilution of content, and a disjointed style.

The first chapter, describing family centered services, states that they were designed for multi-problem families with children in placement, ignoring the history of this mode of intervention. The owning and elaboration of family centered services as a family preservation intervention is a more recent development. The chapter uses many lists and quotes from other sources without always providing the text to integrate them well, and the discussion of systems theory is mechanical and disconnected.

The second chapter, which provides a brief look at application of family centered services to a variety of situations, suffers from many of the same difficulties as the first, often too sketchy to read well or to provide much guidance for practitioners or policy makers. Chapter 3 discusses Cross's six levels of cultural competence and offers principles for cross-cultural assessment and intervention and a plan for increasing cultural competence.

The next two chapters on contact and assessment describe many of the elements of good family practice (e.g., building a relationship, respecting resistance, assessing strengths) and offer some

special techniques for family assessment (e.g., genograms, ecomaps, interviewing for solutions). Each of the next six chapters--covering goal setting and roles of enabler, teacher, advocate, inter-agency coordinator, and intra-agency coordinator--provide valuable information on family intervention skills.

Chapters 12-20 report on the application of family centered services to work with child maltreatment, juvenile delinquency, domestic violence, depression, chemical dependency in adolescents and adults, and refugee families. All chapters follow a similar format: definition of the problem area, significance, assessment, and intervention. Again, the chapters are uneven in terms of style and depth. Chapters 21 and 22, while containing solid information on burnout and termination, read like brief after-thoughts.

The handbook shows the editor's and contributors' struggle with a difficult task: translating the theoretical and empirical child and family literature into readily usable practice and policy tools and guidelines for readers who may not have a social work or similar background. The challenge is to simplify without impoverishing.

Building Skills in High-Risk Families: Strategies for the Home-Based Practitioner. Jane Peterson, Paula E. Kohrt, Linda M. Shadoin, Karen J. Authier. Boys Town, Nebraska. Boys Town Press.

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High Risk Families is a video series and workbook designed to assist caseworkers in orienting themselves to the practice of family preservation demonstrating practical and effective skills in working with this population. Most noteworthy in both the video series and workbook are the true to life examples of families in crisis and the reactions of workers internally and externally to the demands of these experiences.

Respectful of both family norms and values, while remaining clear about the need to reduce risk of harm to children, this package guides the worker in identifying personal biases and expectations that may interfere with the objectives of the work if not honestly examined and managed. Additionally emphasized is the value of listening without judgment or answers. It is pointed out that all too often in the role of helper, we become paralyzed by our own definitions of help and are subsequently unable to hear the families' definition. We are reminded of the value of being heard and the reality that most families already have the answers but are mired in the "how to's".

The videos provide situational settings and challenges commonly facing family preservation workers, and through role play demonstrate effective ways to respond to the most formidable of challenges. These examples would be an excellent introduction to the work for new staff who are anxious to know what to do when faced with difficult situations. The family preservation workers and clients are believable and provide an opportunity to observe the dynamics and scope of the work in a manner that may alleviate some concerns new staff have about how to respond.

Clear and measurable goals are established and monitored through case examples and a number of interventions are employed in this effort. Skills and interventions are highlighted and discussed in detail between case scenarios. One worker's efforts with a developmentally disabled parent around the need to maintain structure and consistency with her children is particularly well done. Demonstrating the unique challenges of this population and the

extraordinary patience and sensitivity of the worker, this scenario would be helpful to both new and tenured staff who struggle with both the limitations of the client as well as their own.

Scenes occur in the clients' homes and family preservation workers are often seen assisting in family chores while talking with parents about the problems they are facing. The workers are obviously there to meet the needs of their families and willing to extend themselves in this effort. Also emphasized is the practice of inviting the family to use more of what is working. Using a strengths approach allows the family to see areas of success and define their objective as expanding what they are already doing. This makes change seem within reach and prevents the family preservation worker from becoming entangled in the family system's energy around problem areas.

The workbook complements the video elaborating on skills and interventions utilizing a cognitive behavioral approach to problem solving. Chapters represent stages and components of effective intervention and use case examples to expand on material presented. Particular attention is given to the foundation of this practice in its absolute respect and reverence for the family itself despite difficulties presented.

Issues addressed include family culture, building relationships, detecting abuse/neglect and intervention techniques. A variety of interventions are detailed with examples of when they would be most effective in addition to exercises allowing the reader to practice new skills.

This program is a model for family preservation practice. Staff new to this work would greatly benefit from the practical tools and knowledge presented. For this reviewer it served as a reminder of why we are in this work and the riches afforded to us in this practice.



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