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A Multi-Faceted, Intensive Family Preservation Program Evaluation

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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.

¹ This article is adapted from a paper presented at the Ninth Annual National Association for Family-Based Services Empowering Families Conference, December 5-9, 1995, Chicago, Illinois. It is based on research done in collaboration with St. Louis County (MN) Social Service Department, and partially funded by the University of Minnesota's *Center for Community and Regional Research* (CURA). The author wishes to thank Ray Critchley, Social Service Supervisor of St. Louis County Social Service Department, who supplied the quantitative placement data; and Tim Ollhoff, the study's Research Assistant, who conducted both the structured and semistructured interviews.

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,

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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

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.

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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.

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 *Wilcox 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,

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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).

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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

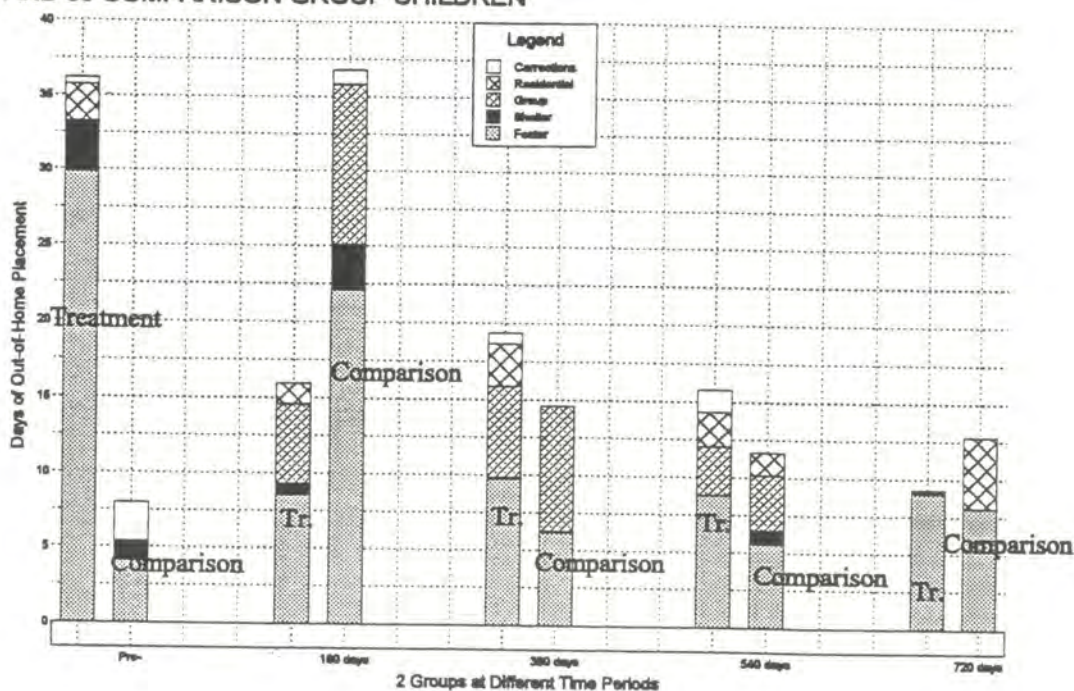


Figure 1

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.

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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)	<i>Wilcoxon Rank Sum</i> <i>1-tailed</i> <i>Probability</i>
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)	<i>Wilcoxon Rank Sum</i> 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).

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"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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