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**LOOKING INSIDE THE BLACK BOX
OF INTENSIVE FAMILY PRESERVATION SERVICES**

by

DARIA V. HANSSEN

A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

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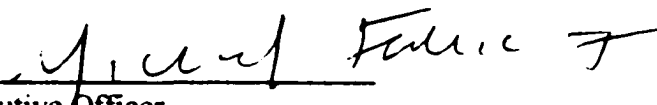
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This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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Abstract

**LOOKING INSIDE THE BLACK BOX
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by

Daria V. Hanssen

Adviser: Professor Irwin Epstein

Intensive family preservation services (IFPS) were designed to stabilize at-risk families and avert out-of-home care. These home-based services are targeted to families at imminent risk of child placement. IFPS services have been the focus of many prospective, randomized, experimental studies to determine the effectiveness of programs with regard to placement prevention (Pecora, Whittaker and Maluccio, 1992). Because of emphasis on "gold-standard" methodologies (Epstein, 2001), few "black box" (Bickman, 1987) studies have been conducted to shed light on specific services and combinations of services that are provided to at-risk families and how they are related to various treatment outcomes.

This dissertation study is based upon evidence derived from a single, highly-regarded IFPS agency. Employing a retrospective "clinical data-mining" (CDM) methodology (Epstein and Blumenfield, 2001) the study makes use of available information extracted from IFPS client records. The study had several objectives: 1) to specify more precisely IFPS practice by describing services and combinations of services families actually received; 2) to determine relationships between family and client characteristics, interventions received and placement prevention; 3) to test the feasibility of the CDM methodology by comparing study findings with those derived from previously published experimental studies.

Qualitative case information was extracted, coded according to pre-existing conceptualizations of services, and transformed into a quantitative SPSS data-base along with demographic, referral information, psychosocial assessment and service outcomes. Univariate, bivariate and multivariate data analysis was conducted.

Findings confirm the use of a range of IFPS services consistent with IFPS program theory. With regard to service outcomes, findings suggest that family education and advocacy are most influential in placement prevention. More specifically, IFPS services prevented placement for multi-problem families, those where children had an emotional disturbance, those where children presented unmanageable behavior at home and at school, where domestic violence was an issue, and in promoting the reunification of children and families. Additionally, it was found that family violence significantly decreased following services.

A more complex understanding of IFPS interventions and outcomes than is possible through experimental studies will assist in articulating clearer linkages between family preservation theory and practice, as well as social work education.

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Chapter I

Introduction

A recipient of services is quoted as saying:

I believe our worker gave us back our self-esteem which was beaten down. Whenever I became scared she would respond right away. I felt secure knowing she was right there for us. (As stated in client survey)

Background/Overview

A complex set of socio-cultural, psychological and economic factors have contributed to the rise in the number of children placed in substitute care (Pecora, Whittaker, and Maluccio, 1992; Wells and Biegal, 1992; Wells and Tracey, 1996). Current estimates (Clearinghouse on Child Abuse and Neglect, www.calib.com) indicate that the number of children placed in foster care at the close of 1999 averaged 568,000. During that year, it was estimated that 826,000 children were victims of child maltreatment nationwide. Approximately one-fifth of victims had received family preservation services within the previous five-year period, while more than five per cent had been reunited with their families during that same time period.

Intensive family preservation services, an innovation of psychologists David Haapala and Jill Kinney, in the 1970s (Nelson, 1997; Rossi, 1991; Wells and Biegal, 1992), were designed to stabilize at-risk families and avert out-of-home care. Kinney and Haapala theorized that out-of-home care could be prevented by the provision of intensive home-based services to families at imminent risk of child placement. This intensive service

known as the Homebuilders model provided a combination of counseling, psychoeducation, and concrete services to families in their homes for ten to twenty hours per week and for four to six weeks. The purpose of this intensive intervention was to stabilize families experiencing crisis, avert out-of-home care, and to reduce the amount of public funds devoted to the placement of children (Nelson, 1990; Rossi, 1991; Wells and Biegel, 1992). Studies have been conducted to measure the degree to which each of the foregoing goals was successfully accomplished (AuClaire and Schwartz, 1986; Bickman, 1990; Feldman, 1991; Fraser, 1991; Fraser, Pecora, and Haapala, 1991; Kinney, Haapala and Booth, 1991; McCroskey and Meezan, 1997; Pearson, 1990; Schuerman, Rzepnicki and Littell, 1994; Yuan, Wheeler, Struckman-Johnson and Rivest, 1990; Yuan, 1990).

Intensive family preservation services have been the focus of many outcome studies to determine the effectiveness of programs based on placement prevention (Pecora, Whittaker and Mallucio, 1992). In contrast, little intervention research has been conducted to examine the specific services and combination of family preservation services that are being provided to at risk families. Given the small component of social work practice research devoted to the study of intervention technology, this is not altogether surprising (Austin, 1998; Cheetham, 1992; Fortune, 2001; Thyer, 2001).

Several evaluations, which have explored the process of service provision, include descriptive intervention evaluations (Berry, 1995, 1992; Berry, Cash and Brook, 2000; Kinney, Haapala and Booth, 1991; Fraser, Pecora, and Lewis, 1991), experimental studies

(Feldman, 1991; Schuerman, Rzepnicki and Littell, 1994), and quantitative studies correlating (Berry, 1994 & 1995) services to placement and treatment outcomes. However, the number of studies describing patterns of service provision has been minimal in comparison to the number of studies conducted to evaluate placement prevention.

Delineating the specific interventions administered to families receiving intensive family preservation services should lead to a more profound understanding of how the variation in intervention composition influences child and family outcomes, as well as providing an opportunity to compare differing practice models and reconfigure practice, based on the identification of effective interventions (Berry, 1997; Pecora, Whittaker, Maluccio, Barth, and Plotnick, 1992; Rossi, 1991, 1992a; 1992b; Staff and Fein, 1994). In addition, defining specific service components of a particular model also responds to the demands for greater accountability in intervention management (Rossi, 1991). Finally, exploring the nature of interventions provided in intensive family preservation programs will assist in advancing clearer linkages between theory and practice (Rossi, 1992b; Wells and Biegel, 1991, 1992) and social work education.

Significance of the Study

Over the past two decades, the child welfare system has placed a high priority on reuniting families or keeping them intact through the provision of intensive family preservation services. Concomitantly, the child welfare system is committed to protecting

the safety and well being of children served by intensive family preservation programs. In light of the tension that exists between preserving families and protecting children, the subject of explicating, delineating, and discovering the specific interventions provided, is not only relevant, but also propitious. This dissertation study focuses on defining the interventions and services provided by Families First (FIP), an intensive family preservation program and the effect and effectiveness of the interventions on improving family functioning and preventing placement of at risk children and families.

The significance of studying service delivery in intensive family preservation practice is critical to the field of child welfare, as well as to the profession of social work for the following reasons. First, the efforts of practitioners to preserve families and of researchers to study the effectiveness of intensive family preservation services have demonstrated both contradictory and equivocal findings (Blythe, Salley and Jayarante, 1994; Fraser, Nelson and Rivard, 1997). To that end, to truly serve the best interests of vulnerable children and families, it is essential to discover what works, under what conditions, and with what types of families. Because family preservation continues to be a goal of the child welfare system, as evidenced by federal policy mandates of the Adoption and Safe Families Act, 1997, it is critical that we continue to improve our understanding of intervention components and their effectiveness in promoting family functioning and placement prevention. Second, the specific nature of intensive family preservation services has received less than adequate attention in the literature making intervention research the weakest aspect of intensive family preservation services research (Fraser,

Pecora and Haapala, 1991). What is more, the profession of social work is in compelling need of evidence that will account for the effectiveness of interventions (Fortune, 2001; Thyer, 2001). These gaps in theory and research, in the nature of intensive family preservation services, are a matter of importance to the profession and to those we serve.

Purpose and Goals of the Study

My interest in intensive family preservation practice has grown out of a combination of direct practice experiences in child welfare and family preservation, as well as, my experience as the director of an intensive family preservation program. Since there have been few empirical and theoretical examinations that address the details of intervention and service delivery in intensive family preservation, our understanding of practice process and efficacy is limited. For that reason, the purpose of the dissertation is to acquire a deeper understanding of the interventions delivered, in what combination, to whom, and the effects and effectiveness of interventions on the prevention of placement, family reunification, and family functioning.

The dissertation addresses the following research questions:

1. What are the interventions that are associated with positive outcomes for families participating in Families First?
2. Is there a specific constellation of interventions that intensive family preservation workers provide for various identified family problems?
3. Is there a relationship between improved family functioning and a pattern of services provided?

4. What types of interventions do families find to be the most and least helpful?
5. Does the intensive family preservation program under study demonstrate treatment fidelity congruent with the intensive family preservation program model?
6. What are the implications for social work education?

Overview of the Study

The research design will utilize “clinical data mining” (Epstein, 1995; 2000; 2001) as a strategy to explore the nature of service provision at Families First (FIP), an intensive family preservation program, located in rural New York State. Quantitative data will be obtained from client records pertaining to the range of services and interventions, demographic and referral information, psychosocial assessment and risk factors, and outcomes of service provision. The family’s assessment of service provision will be captured through a survey mailed to parents, guardians, and other adult family caregivers. Both the quantitative and qualitative findings of this intervention research have the potential to strengthen the relationship between practice and theoretical rationale, as well as, enhance practice, program planning, social work education, and research developments. Further, a review of the literature on intervention research in family preservation will document the sparse empirical examination of the profession’s knowledge about what works, under what circumstances, and with whom.

Chapter II

Literature Review

A FIP social worker is quoted:

The main strength this family has is their expression of love and support. They are a talented group and have intelligence, common sense, and the ability to work hard. (As stated by worker in case research)

Literature Review

The literature review section will be divided into four parts as follows: 1) Definitions of Family-Based Service Models; 2) The Evolution of the Credibility Dilemma in Intensive Family Preservation Practice; 3) Theories Related to Intensive Family Preservation Technology and 4) Intervention Research in Intensive Family Preservation Services. The first part will define and provide a brief overview of the various models that fall under the rubric of family preservation services, while the second part will provide an overview of the historical underpinnings of intensive family preservation service technology relative to service confusion and gaps in the research. The third part will address the theoretical approaches associated with intensive family preservation services. To conclude, the last part will review intervention research studies of intensive family preservation practice.

Definitions of Family-Based Services

Overview and Rationale

Within this broad framework of family-based services, there is enormous variation in the kinds of interventions, duration of services, size of caseloads, and the components that characterize programs. Perhaps this is inherent in all program innovations, but it is one reason why research findings of intensive family preservation have been confusing (Pecora, Fraser, Nelson, McCroskey, and Meezan, 1995). The programs themselves are often described as family preservation, family support, family-centered, home-based or placement prevention services. These terms may be used interchangeably for the same program, which has led to considerable confusion among service providers and researchers, alike. Efforts to gain a clearer understanding of services offered under each category are ongoing and are assisted by the deconstruction of practice knowledge and interventions utilized across the family-based spectrum. The Child Welfare League of America proposed a trichotomized typology of family-based programs illustrated by the following chart (Pecora, Whittaker, Maluccio, Barth, and Plotnick, 1992):

Table 1: Typology of Family-Based Services

	Family Support	Family-Centered	IFPS
Service Goals	Assist adults Support parental figures Protect	Stabilize Families Preserve families Protect	Preserve or reunify families Protect
Target Population	All families with children	Families with problems Stability is threatened	Families in crisis Imminent risk of placement Reunifying
Service Options	Prenatal Early-childhood Parent education Respite	Case management Counseling Skill building Advocacy	Intensive crisis counseling Advocacy Concrete services Support services
Service Setting	Office Classroom	Office Home	Home

Despite the plethora of programs identified as family-based services and the resultant intervention diversity, family-based services share some common features.

Common Philosophy and Features of Family-Based Programs

According to Farrow (1991), Nelson (1994), and Whittaker (1991), as well as other authors, family-based services and support programs represent a significant departure from more traditional services that place treatment within a narrow "person-centered" perspective and embrace a "child rescue" philosophy. Consequently, traditional services have given little attention to the family's needs in a holistic manner (Pecora et al. 1995). Whittaker (1991) identifies the following as common features that distinguish these alternative conceptions of child and family services:

1. Establishing a service continuum - from preclusive prevention to secure treatment - with expanded capacity for individualized case planning through flexible funding and service eligibility.
2. Promoting competence and meeting basic developmental needs of children and families in "normalized" settings by teaching practical life skills and by providing environmental supports as opposed to uncovering and treating underlying pathology.
3. Considering service as family supportive and family strengthening, not as "child saving" or rescuing.
4. Reestablishing a person-in-environment perspective in theory, empirical research, and clinical practice as a foundation for intervention design.
5. Providing services to families with a child "at imminent risk of placement". This decision is jointly undertaken by the responsible agencies. Placement is sought when danger to the well being of the child or any member of the family is obvious.
6. Intervening with services quickly following the substantiation of risk. Services are provided with as high a treatment dosage as needed in order to restore family stability. However, services are of limited duration and directed at all family/household members, not just an identified family member.
7. A moratorium on placement is in effect for the duration of service provision or until it is determined, that placement is necessary to insure the safety of all those involved (Brieland, 1987; Pecora, et al., 1995; Rossi, 1991; Whittaker and Tracy, 1990; Whittaker, Kinney, Tracy and Booth, 1990).

The problem of understanding and delineating interventions is common to all helping professions (Orlinsky and Howard, 1986; Pecora et al., 1995); however it is even more complicated because the structure and range of family preservation program models is so varied. Three approaches to the delivery of family preservation services have been described in the literature (Wells and Biegel, 1992). Although each model possesses some service characteristics that distinguish it from the others, considerable overlap does occur among the models.

Three Approaches to the Delivery of Family Preservation Services: Intensive Family Preservation or Crisis Intervention Model

The intensive family preservation model (IFPS), a prototype of the Homebuilders intensive family preservation design developed by Kinney and Haapala (Kinney, Haapala, and Booth, 1991), purports a family empowerment approach, encouraging family participation in goal setting, and developing solutions to avoid family dissolution. Central features of this model include: 1) a home-based intervention approach; 2) service intensity up to 20 hr. per week for no longer than 90 days; 3) round the clock worker availability for emergency visits; and 4) caseloads of no more than two families at any given time in order to insure intensive treatment (Wells and Biegel, 1992).

Services typically provided by intensive family preservation programs have been categorized as soft, hard/concrete, and enabling services. Soft services include such activities as providing psychoeducation, family counseling, and individual counseling. Concrete services encompass the provision of financial assistance, home repairs, transportation, and recreational activities that families generally cannot afford. Enabling services include activities provided on behalf of families, such as advocating with social service, legal, and educational systems, as well as, targeting families who require skill development in negotiating access to community support services (Berry, 1995; Rossi, 1991; Wells and Biegel, 1992; Wells and Tracey, 1996). The home-based model, which will be discussed in the following section, is similar in intent, but possesses a different method of delivering services to at-risk children and their families.

Home-Based Model

The goal of the home-based model of family preservation is to alter dysfunctional interactions within the family, as well as within the family's community. This model differs from intensive family preservation in several ways: 1) it is grounded in family systems theory, emphasizing assessment, counseling, case management; education, and skill building interventions; 2) services are provided from four to six months with less intensive weekly service provision; and 3) workers carry between six and ten cases, a considerable reduction in single case service intensity (Nelson, 1994). The third model of treatment to be discussed, the family treatment approach, shares a similar theoretical orientation as the home-based model, but differs again in its approach to preserving families.

Family Treatment Model

This model shares a similar theoretical orientation as the home-based model, however, service delivery differs in the following ways: 1) families are seen in the office, as well as their homes; 2) treatment is much less intensive with workers adhering to a more traditional service schedule of a once per week meeting, hence service tends to last for a longer period of time; 3) workers tend to carry more cases than either of the preceding models; and 4) a case manager from outside of the program is enlisted to coordinate concrete services. Similarly, an array of hard, soft, and enabling services are provided with more emphasis given to the provision of soft services which are provided by a

treatment specialist, while a case manager is assigned to the coordination of the concrete and enabling services (Nelson, 1997).

Summary

Regardless of the variation in the program models and interventions, family preservation programs share some underlying assumptions. One, improved family functioning is the focus for addressing problems. Two, home-based service provision, provided on an as needed basis, increases both the workers' understanding of the family and the likelihood that they can help the family to change. Three, an integrated response is applied to both the concrete and social-psychological problems. Four, a time-limited service conveys to families a belief in their own capabilities (Nelson, 1994, 1997; Wells, 1995).

Essentially, each family preservation program is its own model, using differing but multiple program goals, service delivery models, expected outcomes, and theoretical bases, depending on the style and resources of the agency. In the following section literature is reviewed as it pertains to the historical context and policy changes that may have contributed to the proliferation of program models, perceived to be inconsistent and undisciplined in their application to program paradigms. The proliferation of variations of intensive family preservation program models has made it difficult to systematically analyze and in turn, replicate intervention technology, thus the credibility of intensive family preservation practice has been questioned by researchers and child welfare experts.

alike (Karger and Stoesz, 1997; Gelles, 1996). This dilemma will be discussed in the next section.

Evolution of the Credibility Dilemma in Intensive Family Preservation Practice

Overview

Family preservation is a relatively new term, dating to the 1970s, yet the concepts and principles that underlie family preservation can be traced to actions of early relief workers at the turn of this century (Reed and Kirk, 1998). Throughout the 20th century, child welfare policy in the United States has strongly emphasized family preservation. Despite this long-standing policy aim, an unprecedented growth of the national foster care population, beginning in the 1960's, indicated that child placement was a major tactic in response to the child welfare problem (Pelton, 1993). Children in substitute care were found to lack clearly specified case plans resulting in unnecessarily long or unplanned placements, and moving repeatedly from one placement to the next, sometime referred to as "foster care drift" (Maas and Engler, 1959). Simultaneously, federal-funding policies encouraged maintenance of foster care placements and inadequately funded preventive or restorative family services. Notable exposes' of the shortcomings of child welfare services and of foster care, in particular, were widely publicized by both child welfare experts (Mass and Engler, 1959; Fanshel and Shinn, 1978) and investigative reporters (Pecora et al .. 1995) beginning in the 1950s. This recognized incidence of children in

care and the heavy costs to federal and state government incurred by providing for them generated a concern about the possible harmful effects of substitute care.

From the 1960s through the mid-1970s, child welfare experts across the country began to develop new program models for preventing the detrimental effects of foster care (Schuerman et al., 1994). Demonstration projects aimed at experimenting with various clinical and home-based approaches to prevent children from entering and remaining in foster care sprang up in New York, Oregon, Philadelphia, Washington, DC, and Wisconsin (Berry, 1997; Jones, Neuman and Shyne, 1976; Pecora et al., 1992).

A general recognition by the public and social workers of the importance of treating the family within their home environment, preserving the family and maintaining children in their homes as opposed to placement in foster care, and the necessity of making efforts to reunify families, developed in response to the discovery and recognition of "foster care drift" as a problem. An emerging research base in child welfare and increased political activity of social workers stimulated this new awareness. Thus, the stage was set for federal legislation to shift its emphasis from foster care as a remedy, to family preservation as a fundamental activity of child welfare (Berry, 1997; Pecora et al., 1992).

Emergence of Permanency Planning in Child Welfare

Following the demonstration projects of the 1970s, a general recognition and acceptance of new values and service directions emerged that emphasized the importance of treating the family within their own environment, maintaining children in their own homes as opposed to placement in foster care, and making efforts to reunify affected families (Berry, 1997). These values helped to give shape to the concept of permanency planning. Maluccio, Fein, and Olmstead (1986) define permanency planning as the "systematic process of carrying out, within a brief time-limited period, a set of goal directed activities designed to help children live in families that offer continuity of relationships with nurturing parents or caregivers and the opportunity to establish life-time relationships (p.102)." This philosophy triggered a shift in federal legislation, which emphasized the benefits of placement prevention over the benefits of foster care (Berry, 1997). The Adoption Assistance and Child Welfare Act of 1980 had as its primary philosophy the importance of preserving families. This Act was established as the federal government's effort to promote permanency planning through federal legislation as it advanced the family preservation movement.

Adoption Assistance and Child Welfare Act of 1980

The Adoption Assistance and Child Welfare Act of 1980 (PL 96-272) established permanency planning as a guiding philosophy and mandated that a series of reforms be implemented by state child welfare agencies in an attempt to quell the tide of children being placed and languishing in out-of-home care. This legislation sought to keep

children in their homes by mandating agencies to make "reasonable efforts" to keep children and families safely together before out-of-home placement became a considered option. In the event that placement became a necessity, reunification of children with families was expected to occur as expediently as possible.

This act intended to broaden the scope of child welfare services to include prevention of family breakup, as well as, the unnecessary separation of children from their families (Maluccio, Fein and Olmstead, 1986). However, the full potential of permanency planning was not attained nor was the requirement of reasonable efforts extended to all eligible families according to this legislation (Berry, 1997). A variety of circumstances contributed to the Act's limited success: the reforms and requirements established in the 1980 legislation did not receive the designated funding, nor were funds distributed as the legislation intended (Kammerman and Kahn, 1990); 2) the child welfare system experienced dramatic increases in the number of families mandated for service provision; 3) agencies were faced with increased service needs, in the absence of corresponding funding increases for family preservation services; 4) foster care remained the service of choice, which resulted in a rise in the foster care population in the early 1980's; 5) reunification efforts rose during the second half of the decade, but to families who were not adequately prepared or supported; and 6) children in care at the close of the 1980's were more apt to come from families with substance abuse related difficulties (Hawkins and Catalano, 1990; Maluccio, Abrameczyk, and Thomlison, 1996; Nelson, 1990), to be HIV affected; to have emotional and /or behavioral problems or to be

medically fragile or physically handicapped (Maluccio, et al., 1996) . In recognition of the highly individualized needs of this new population of children and families, the system began to respond with a variety of specialized family preservation service options. Intensive family preservation services, and its vast range of intervention models and modalities, multiplied throughout the 1980's and into the 1990's in order to embody reasonable efforts (Berry, 1997).

The Promotion of Intensive Family Preservation Services

Despite the dichotomous philosophical tension that surrounded intensive family preservation, of preserving families and protecting children, permanency planning was diversely implemented from state to state (Kammerman and Kahn, 1990) with varied support from key policymakers and advocates. As mentioned earlier, federal funding for PL 96-272 was weak, allowing non-governmental organizations to take the lead in financing intensive family preservation strategies (Adams, 1994). The Edna McConnell Clark Foundation was one such group that successfully stepped into the vacuum left by the federal government (Adams, 1994) and "marketed" the Homebuilders model of family preservation. The Clark funding was key to selling the intensive family preservation model to legislators and child welfare professionals across the country (Adams, 1994; Costin, Karger and Stoesz, 1996; Lindsey, 1994; Pelton, 1997). Most of the influential national organizations concerned with child welfare received substantial funding from the Clark Foundation for the development of intensive family preservation services development (Adams, 1994).

Spurred by the foundation's funding, intensive family preservation services (IFPS), modeled after Homebuilders, proliferated (Pelton, 1997). The rapid growth of and high expectations for the family preservation movement to remedy the foster care crisis generated many family preservation service models throughout the country (Cimmarusti, 1992). Enthusiasm amongst child welfare professionals grew as program evaluations reported monetary savings and sharply reduced placement rates (Hartman, 1993).

The thrust of the Clark Foundation's investment was to support the replication and monitoring of the Homebuilders model of family preservation (Adams, 1994). While child welfare organizations accepted the Clark Foundation's funding, it was discovered that many organizations subverted the program model by treating families for whom placement was not imminent, by not supplying concrete services, or by providing services for longer time periods. Additionally, in order to take advantage of the funding offered by the Clark Foundation, many states implemented services in a knowledge vacuum. It became more important for programs to concentrate their effort and resources on program development rather than assuring logical program underpinnings, particularly as funding was relatively lucrative (Adams, 1994; Dylla and Berry, 1998). As the selling of family preservation took hold, agencies seemed to accept funding blindly resulting in programs that were implemented reactively and inconsistently with an absence of training, education, technical assistance, clearly defined program parameters, and theoretical linkages (Adams, 1994). Throwing money at the problem did not ensure faithful program replication.

Summary

The erratic development of intensive family preservation program services, coupled with the service philosophy of "doing whatever it takes" (Berry, 1997, p.37) to keep families together has contributed to the nebulous descriptions of interventions in the field of intensive family preservation practice. Hence, both researchers and practitioners alike (Rossi, 1991, 1992a; Karger et al., 1996) have raised the question of program and method credibility. Additionally, intensive family preservation programs have received much criticism for the absence of a clear theoretical foundation that is coherently integrated with program content (Dylla and Berry, 1998; Rossi, 1992a; 1992b; Wells, 1994). The subsequent section will address the theoretical perspectives that have gained prominence in the field of intensive of family preservation.

Conceptual Framework Underlying Intensive Family Preservation Services

Overview

Wells and Biegel (1992) contend that family preservation programs and research studies of family preservation programs are not grounded in theory:

Families and children are not conceptualized in ways that are tied to theoretical assumptions underlying the program model; the theoretical assumptions regarding what works and why are not well tested; and the outcomes that are related logically to assumptions underlying family preservation service programs have not been evaluated. The failure to conceptualize research in more theoretical terms makes it difficult to understand the way in which programs work, and ultimately, to enhance the effectiveness of programs and to allocate resources wisely (p.19).

The rapid and erratic development of intervention technology (Dylla and Berry, 1998; Rossi, 1992a; Wells and Biegel, 1992) in intensive family preservation services has been blamed for the atheoretical nature of program development and subsequent research. Yet, intensive family preservation services do purport theoretical foci (Berry, 1997) ranging from a structural family therapy approach, a social learning approach to an ecological approach. This diversity in application of theory influences how services are provided and has contributed to the confusion in theoretical application.

Chen and Rossi (1987) argue that program evaluation, has been characterized by adherence to a predetermined step by step research method, "usually undertaken without concern for the theoretical applications of program content, setting, participants, implementing organization, and so on (Chen, 1990, p.18)." In an attempt to not only avoid this problem, but also to better clarify the connections between the program operations and its effects, this discussion will specifically focus on the program theory that drives services.

According to Chen (1990), "A social or intervention program is the purposive and organized effort to intervene in an ongoing social process for the purpose of solving a problem or providing a service. The questions of how to structure the organized efforts appropriately and why the organized efforts lead to the desired outcomes imply that the program operates under some theory (p.39)." Scientific theory or "descriptive" theory is usually defined as a set of interrelated propositions intended to explain and predict a phenomenon. For this program study, the term "theory" will broadly refer to a set of

interrelated assumptions, principles and/or propositions intended to both explain and guide social actions (Chen, 1990). This type of evaluative theory is referred to as "prescriptive theory" as it prescribes what ought to be done or how to get something done better. This "prescriptive theory", also known as program theory (Bickman, 1987; Chen, 1990), is action oriented, focusing on how treatment is constructed and implemented: identifying the program resources, activities, intended outcomes, and specifying a chain of causal assumptions linking program resources, activities, intermediate outcomes and ultimate goals (Chen, 1990). It is in this way that it differs from the traditional input-output assessment of a program evaluation.

Although there are many variations of the intensive family preservation model, the Homebuilders model of intensive family preservation is the most widely emulated (Berry, 1997). The beliefs, values, concepts, and practice principles of the Homebuilders model of intensive family preservation practice has provided the rationale and technology for the development and diffusion of a variety of program designs that go by the name of family preservation. The following section will provide a brief overview of the program theory that underlies intensive family preservation, followed by a brief overview of the Homebuilders model.

Philosophical Tenets of Family Preservation Practice

Family integrity and the primacy of the parent-child attachment are among the strongest values in our society (Whittaker, Kinney, Tracey and Booth, 1990). Family preservation programs maintain their primary purpose as the aversion of any unnecessary placement while enabling the child to remain safely at home. The child's need for continuity and stability, and the need to protect the parent-child bond from unnecessary state intervention have been recurring themes in the development of intensive family preservation services. Other principles that form a foundation underlying service delivery include the significance of the biological tie to the child's identity and the impact of a separation on the parent and child relationship (Goldstein, Freud, and Solnit, 1979).

The design and delivery of intensive home-based service considers the environment (the immediate home environment, extended family and community) as the source and solution to family problems. As client competencies and environments are considered, this perspective views the family as a unit of service, focuses on developing parenting competencies and skills, while removing or reducing obstacles that interfere with the family's coping (Maluccio, Fein and Olmstead, 1986). Family preservation services are designed to build supportive, nurturant environments for clients through various forms of environmental helping aimed at increasing social support, and improving clients' competence through teaching specific life skills (Whittaker, Schinke, and Gilchrist, 1986). At the heart of this approach is the view that clients are colleagues in all stages of service delivery including problem definition and problem solving. This approach to, and

respect of, clients contributes to the high level of client engagement said to exist in such programs (Berry, 1997). In addition, family preservation utilizes a holistic approach of providing service to the entire family unit, in their home and community setting.

Practice Principles and Intervention Technology of the Homebuilders Model

Homebuilders, the first intensive family preservation program to achieve national recognition, represented a shift in the out-of-home child placement paradigm, from protecting the child through removal from the family, to changing the family dynamics to nurture the child (Gershenson, 1991). There are a number of program characteristics that distinguish the Homebuilders model from other types of home-based services. Four principles collectively constitute the content characteristics that define family preservation practice and serve as a foundation for service delivery-1) family centeredness; 2) in-home intensive services; 3) a generic and integrated response to multiple family problems; and 4) time-limited service duration.

The entry point for service eligibility is a child's risk of imminent placement. Intervention commences when at least one family member expresses a desire to maintain the family unit (Kinney, Madsen, Fleming and Haapala, 1977). Rapid response to referrals is a significant service element. It is hypothesized that families experiencing crisis are more likely to accept and utilize this window of opportunity to promote change, affording them motivation to try new ways of coping (Kinney et al. 1990). Clients are viewed as colleagues and partners in the process of goal setting, which is a crucial empowering

element of this practice (Berry, 1997; Nelson, 1990). It is said that family performance is enhanced in part because clients are involved in their own treatment design; treatment is individualized to meet the unique strengths and needs of each family, while continuously conveying a respect and belief in each family's capacities for growth and change (Berry, 1997).

A second distinguishing characteristic of the Homebuilders model is the in-home locus of service delivery. Families and children are served in their homes because it is assumed that clients are better served in the environment in which the problem occurs (Berry, 1997). Additionally, it is believed that serving the family in their home environment permits more effective understanding of the context, pattern, and nature of the family's problems, a better understanding of the family stresses because the worker can immediately process and promote problem solving behaviors, and identification and linkage of the family to appropriate informal and community supports (Nelson, 1990).

The Homebuilders model was designed and reserved for families in need of crisis intervention. Intensive family preservation programs are predicated on the assumption that family functioning is impaired by a multiplicity of interacting problems. A third distinctive feature of this model is the multi-problem orientation, which charges practitioners with the responsibility for recognizing and responding to a broad range of needs and difficulties simultaneously. This objective entails an integrated range of responses including practical problem solving; instructional assistance to address family

conflicts, behaviors, and communication; multi-modal counseling; linking families to other resources for continued treatment needs; and providing concrete services (Berry, 1997). Such an integrated approach is critical to effectively restoring the family's capacity to care for their children (Nelson, 1990), provides the practitioner opportunities to model skills and coping strategies, and demonstrates the program's commitment to the family's improvement. (Berry, 1997).

A final distinguishing characteristic of the Homebuilders model lies in the nature and duration of the worker-family relationships (Nelson, 1990). Typically, families are provided with services for four to eight weeks, based on the expectation that change can occur rapidly. The intensity of the practitioner's involvement with the family (10-20 hr. per week), the ready availability of the worker to the family (being on call as needed), and flexibility of scheduling (workers carry only two clients at a time) allows the practitioner to tailor services and observe the family process in action. The Homebuilders model emphasizes the importance of spending large amounts of time with the family during the aftermath of the crisis and subsequent referral. The worker's ready availability during the most difficult periods of the family's day serves to demonstrate commitment to the family, the belief that change can occur, and the opportunity to practice skills in incremental steps (Berry, 1997).

The Homebuilders model maintains a set of beliefs and attitudes that are congruent with social work knowledge, values and skills. Kinney, Haapala, Booth and Leavitt (1990)

identify the following as significant to the design of intensive family preservation delivery systems: 1) workers should strive toward a compassionate view of a family's problems; 2) families are valued for their diversity and uniqueness; 3) families are experts on their own lives and family preservation is a partnership involving the worker, the family, and larger community agencies, informal helpers, networks and state agencies; 4) families are self-determining and can become self-sufficient . clients should have as much power as possible; clients are treated as colleagues; 5) the workers' job is to instill hope and not assume ahead of time if a situation is hopeless. Beyond this basic framework, services are intended to be flexibly tailored to the specific and individual needs and strengths of each family (Berry, 1997; Kinney et al, 1990; Nelson, 1990).

Summary

Like many innovations, this service was developed in response to a need, a need for a change in how services were being delivered to children and families who were identified as at risk of family dissolution. Core helping skills that are common to family systems, social learning, and crisis intervention theories complement and inform social workers, program administrators, and researchers, as practice approaches are designed and implemented (Barth, 1997).

As early research results reported that family preservation programs were successful in preventing a large number of imminent placements, replication was both rapid and frequent. However, replication often proceeded in the absence of a clear and careful

delineation of program and service components. Additionally, agency administrators tended to implement the intensive family preservation model with a less than adequate understanding of the beliefs and values which guide practice decisions (Berry, 1997). This combination of flexibility of practice and blending of program features has contributed to "model drift", a loss of program integrity (Bath and Haapala, 1994), and a corresponding difficulty in "unpacking" interventions (Nelson, 1997). The faithful implementation of program models, known in the literature as treatment fidelity (Bickman, 1990), has been identified as a critical missing element in the implementation and evaluation of intensive family preservation programs. The following section will review intervention research of intensive family preservation programs.

A Review: Intervention Research in Family Preservation Programs

A parent is quoted as saying:

When we were short on money they gave us money for heat and cooking gas. They gave us gift certificates at Christmas time. Anytime I needed help they always came through for me. My experience with our worker was extremely positive for both my family and me. She was always willing to offer support, advocacy, and to listen to all of us. (As stated in client survey)

Overview

The value of social work interventions has been a matter of controversy and concern since the beginning of the twentieth century (Mullen and Dumpson, 1973; Reynolds, 1942). During the last several decades, we have seen increasing pressure brought to bear on practitioners to be "accountable" for what they do in practice (Corcoran and Fishcer,

2000). The process of clearly delineating services and interventions is a priority, essential to knowing what interventions to repeat, modify, or avoid. The establishment of relationships between intervention and outcome is a huge challenge for the social work researcher because of the complex nature of the social work task (Cheetham, 1992). The field of family preservation is no exception when it comes to the paucity of intervention and practice research given that process variables are amongst the most difficult to measure, yet the most clearly associated with service outcomes (Spaid, Lewis and Pecora, 1991).

The evaluative research of family preservation services has focused overwhelmingly on outcomes (Craig Van-Grack, 1997), with most reporting the placement prevention rate as their primary criterion of success (AuClaire and Schwartz, 1986; Berry, 1997; Feldman, 1991; Fraser, Pecora, and Haapala, 1991; McCroskey and Meezan, 1997; Schuerman, Rzepenicki and Littell, 1994; Yuan, McDonald, and Wheeler; Struckman-Johnson and Rivest, 1991). A few evaluations have addressed other effects on the reduction of risk behaviors, such as child behavior and family functioning (AuClaire and Schwartz, 1986; Feldman, 1990; Fraser et al, 1991; Landsman, 1985; Meezan and McCroskey, 1996; McCroskey and Meezan, 1997; Wells and Whittington, 1993). Still fewer studies evaluated family preservation service elements, characteristics, and compositions, in detail. Studies evaluating service components have typically focused on the "hard" or concrete services delivered to families, while a surprisingly small portion of studies attempt to disassemble the vast array of helping services that are routinely provided to

high-risk families. The following review of intervention research considers studies of both intensive family preservation services and those programs with a family preservation philosophy.

Intensive Family Preservation Service Studies of Intervention Technology

The earliest comprehensive studies conducted of intensive family preservation programs devoted a portion of the research to delineating service provision, as well as program implementation patterns. A descriptive overview of the Homebuilders program in Washington (Kinney, Haapala, and Booth, 1991) revealed that of 86 families served, 56 percent had been provided transportation, but decreasing proportions were provided other concrete services, such as, job hunting (21 percent), recreational activities (19 percent), help in obtaining transportation (17 percent), help with housework (17 percent), and financial assistance (16 percent).

Fraser, Pecora, and Haapala (1991) conducted an evaluation of two intensive family preservation treatment program sites in Utah and four sites in Washington. The characteristics of services, including types of clinical and concrete services, intensity and duration of treatment, and use of ancillary services were examined in relation to client demographics and placement prevention. A quasi-experimental design, one group pretest-posttest, with a partial twelve-month follow-up, was employed to collect service data of families that received intensive family preservation services. A detailed service analysis of four hundred and fifty-three case records utilizing the Concrete Services Checklist and

the Clinical Services Checklist (Fraser, Pecora, and Haapala, 1991; Fraser, Pecora and Lewis, 1991; Lewis, 1991a) found that three-fourths of the families studied received some form of concrete services. Transportation was the only concrete service utilized by more than half of all families served and the provision of recreational activities was provided almost as often. Other common activities provided were helping a client find a job, doing housework with them, arranging and securing financial assistance, and organizing recreational activities. Of the seventy-five clinical techniques delineated in the Clinical Services Checklist (Fraser, Pecora, and Haapala, 1991; Lewis, 1991a), thirty-three interventions were most commonly provided. These interventions focused on the development of the treatment relationship, improving parenting effectiveness, modifying problem behaviors, teaching child development, building self-esteem, and consulting with other service providers.

In general, therapists reported providing high levels of the entire range of clinical activities or techniques, with 31.8 different clinical activities utilized with each client family, suggesting not only the eclectic nature, but also the tailoring of services to fit family needs. Using a bivariate analysis, Fraser, Pecora, and Lewis (1991) reported that the overall time spent providing concrete services was significantly associated with reduced risk of placement. However, teaching time and money management was the only clinical service associated with program success. Utilizing a multivariate analysis it was determined that the provision of concrete services remained critically important in lowering the risk of placement (Lewis, 1991b). Lewis describes the role of concrete

service as helping families to improve their living conditions while, helping workers to build relationships with families.

Leonard Feldman's (1991) evaluation of the Homebuilders program model in New Jersey compared and contrasted the experiences of clients receiving intensive services with a similar group of clients receiving traditional preventive services for service types and amounts. Designed as a true experiment, this study involved random assignment of eligible families to an intensive family preservation program or to a traditional community service. Using the Client Clinical Services Checklist and Concrete Services Rating Sheet (Kinney, Haapala, and Booth, 1991), Feldman found that the most common services provided concerned teaching child management skills (54 %), providing basic clinical skills such as relationship building and building hope (54 %), teaching emotional management (49 %), and advocating for the client (45 %). Less common were coaching in interpersonal skills (36 %) and other services such as, money management, time management, and increasing formal support (21%). Only nine percent of the families in this program used concrete services, including, assisting clients in securing transportation, food, clothing, and housing. Overall, families had proportionately fewer children enter placement than those families receiving traditional preventive services.

Berry's (1992) evaluation of a Northern California program was designed to examine the correlation of hard and soft services with case outcomes, namely placement prevention, risk reduction, and treatment goal attainment. Of the 327 cases in this study, 116 were

selected for closer examination of service provision. Family preservation workers completed standardized logs at case opening and closing, reporting such information as, time spent with the family, treatment site, and focus of service. This model, like those previously discussed emphasized parenting education and family interaction skill building. Caseworkers commonly provided concrete services, such as budgeting assistance, home safety, and locating housing daycare and employment, to name a few. Services routinely provided included assessment, parent education, supplemental parenting, and teaching family care.

Parents showed the most signs of improvement in skill development relative to discipline, childcare, and acquisition of resources. The concrete and enabling services were associated with better outcomes for families, in general. Families most likely to remain intact were those receiving services included parenting skills, family care education, and securing food and medical assistance. The softer or clinical services, such as counseling and assessment, were not associated with better outcomes. In fact, it was found that when counseling and crisis intervention services were provided in large amounts, a child was subsequently more likely to be placed.

Berry (1995) examined the services of an intensive family preservation program in Fort Worth, Texas, as part of a larger study to determine the degree of treatment fidelity and the relationship of services to program outcomes, particularly placement prevention. The evaluation utilized a one-group pre-test post- test design. The sample consisted of all

cases opened between May 1, 1992 and October 31, 1992. This six-month period provided a sample of 40 families with 97 children. Berry utilized monthly contact sheets to track both the site of services and the amount of time service was provided to families. Workers completed the Checklist of Services provided at case closing which assisted in enumerating hard, soft, and enabling services provided during the treatment period.

Results indicated that the most common services provided were soft services, namely, case planning, assessment, parenting and family care education, crisis intervention, and counseling. Other services that were commonly provided included referral and support groups. Counseling was associated with subsequent family stability, with 40% of families receiving counseling. Of the concrete services, transportation was most commonly provided, while only 10% of families served received household maintenance assistance. On the average, families received in home services for approximately seventeen weeks and 14.7 hours per week. The mean time spent in direct contact with the family was 52.5 hours, with some matching of services to family risk factors identified at intake. The findings reported decreases of 15 % in the proportion of families with parenting and discipline problems.

A utilization-focused outcome evaluation was conducted by Berry, Cash, and Brook (2000) to examine the association of service characteristics of an intensive family preservation program to child and family outcomes. The state management information system was utilized to obtain client and service characteristics as well as case outcomes.

Case records that were reviewed were opened in May 1996 and closed by August 31, 1997, resulting in 53 cases in the sample. Service characteristics were gathered from the client contact log, the concrete services log, and the clinical services log, all developed for this study. Demographic information included household composition, age and sex of each family member, nature and severity of the presenting problem, family stressors, and family resources. Additionally, the study tracked placement during or after service provision.

Analyses of service characteristics were associated with some improvements. Families who remained intact had received almost twice as many days of service as those whose children were placed. Likewise, a higher intensity of service was associated with improvements in family communication and harmony, attention to the needs of children, improved marital relationship, ability to access support from formal and informal services, and a child's acceptance of discipline. Gains in certain skills seemed to be associated to a significant degree ($p < .001$) with the provision of specific services. As an example, concrete services such as help with paying bills, cleaning the house, moving a residence and providing recreational activities were respectively associated with improvements in preparing nutritious meals, improvements in family and child relationships, improvement in budgeting. Improved employment stability was directly associated with the provision of transportation. Surprisingly, specific clinical techniques thought to be associated with client improvement were not associated with any specific client improvements.

Family Preservation Studies of Intervention Technology

The Family First evaluation, an experimental design (Schuerman, Rzepnicki, and Littell, 1994), is one of the most extensive studies conducted to determine effectiveness of family preservation services. Several sub-studies have been derived from this experiment. This research project began in 1990, in conjunction with Chapin Hall Center for Children at the University of Chicago to assess the effects of family preservation programs as compared to services families would ordinarily receive relative to placement prevention. Eligible families were randomly assigned to the Family First Program or to regular services (control group). Random assignment continued for two years from December 1, 1988 through December 31, 1992 and involved 6,522 families.

Data on the amount and type of services provided came from service summaries completed by Family First workers, interviews with workers responsible for providing regular services and interviews with parents in the experimental sites. Caseworkers reported types of services provided by selecting from a checklist of 30 services on the service summary form. In order to obtain a more comprehensive picture of the approaches workers used with families, workers selected from a list of 50 items and 5 techniques they used most often.

Although Family First was designed to be short term and time-limited, families were served for relatively longer periods. The median length of service time provided to 60% of families was 108 days. Family First social workers reported an average of 91 hours of

service provision in the first 90 days of family contact. It was documented that 89% of families received at least one concrete service (food, clothing, and financial assistance), while 93% of Family First cases received at least one counseling service (verbal and behavioral therapies aimed at altering client functioning). The data suggests that workers most often focused on the psychological functioning of their client (58%) while employing a problem-solving approach. Skills building (48%) were commonly listed as a focus, as were structured problem solving interventions. Focus on the family unit was a major emphasis in treatment for only about one-third (32%) of the families. Teaching child management skills (24%), building structure and routine (23%), examining current behavior (28%), and accompanying client to other agencies (35%) were techniques dispensed most often by Family First workers.

Service characteristics appeared to have no affect on placement outcome. It was concluded by these researchers that the duration of family preservation services, intensity of contact with workers, and the number of concrete services provided did not have significant overall impact on placement or subsequent maltreatment at case closing. It is plausible that "model drift" is accountable for the lack of program success.

Qualitative Studies of Intensive Family Preservation and Family Preservation Programs

No significant stand alone qualitative studies have been conducted of intensive family preservation services. However, the following studies shed light on the family's experience with service provision.

Pecora, Bartlome, Magana and Sperry (1991) conducted a consumer satisfaction survey, utilizing open-ended questions, that focused specifically on what clients thought were the most important treatment goals, what was most helpful about services, comparisons of family functioning before and after services were provided, and the level of consumer satisfaction. Primary caretakers of 290 families in Washington and 106 families in Utah involved in the FIP program were interviewed in person or by telephone. From the perspective of caretakers, the services improved family relationships, anger management, the child's behavior and family communication skills. Generally, services were rated as helpful with the exception of some criticism regarding length of intervention and types of interventions used by therapists.

In a qualitative study conducted by Rzepnicki, Schuerman, Littell, Chak and Lopez (1994), as part of the Family First experiment, researchers engaged in in-person interviews with 144 randomly selected families in both the Family First program and regular services groups. Forty-eight interviews were conducted at three months after

program involvement and again nine months later. The purpose of this survey was to determine whether Family First benefited clients in ways intended over time.

A portion of this study focused specifically on the views of parents and guardians relative to services received. Questions specifically asked of parents concerned whether they had received services from the list of concrete and counseling services. Concrete services most often reported by Family First parents were the provision of furniture or other household goods, food, clothing, transportation, and financial assistance. Counseling services commonly received included drug or alcohol treatment, family counseling, and individual counseling.

Coleman and Collins (1997) conducted a qualitative analysis of parents' and primary caretakers' views of services provided by a family preservation program modeled after the Homebuilder's design. This substudy was part of more comprehensive study, which utilized both quantitative and qualitative methods to learn how families made changes after a family preservation program and to obtain their views on service provision. Face to face, field interviews were conducted with parents and caretakers who had received services between six months and three and a half years previously. Families were selected by referral source; specifically families referred because of abuse or behavior problems. One hundred and four families agreed to be interviewed, 51 from the abuse group and 53 from the behavior problem group. Caretakers were asked three open-ended questions to explore their perception of services and the existence of problems following treatment: 1)

what did families with children who had been abused and those with behavior problems find to be most the helpful in their counseling? 2) What did families find did not help or dislike about counseling? 3) After family preservation services, what happened with respect to the problems for which the family was initially referred?

Clients reported the intervention they valued most to be the non-traditional counseling approach in terms of site and scheduling, the amount of time and support that the worker provided, the dignity and respect with which they were treated, parenting education, conflict resolution, the worker's presence during a crisis, their availability and accessibility, the family focus, and the workers' ability to listen. Aspects of service that clients identified as detrimental were the short length of service and lack of follow-up services.

Meta-Analysis of Intervention Research in Family Preservation

Blythe, Salley, and Jayaratne (1994) conducted a comprehensive meta-analysis of family preservation outcome research. The authors examined previously completed studies focusing on areas that were not fully explored, in particular, characteristics of treatment variables and the effect size across selected studies. Blythe, Salley, and Jayaratne examined both program evaluation efforts and quasi-experimental and experimental studies. Twelve studies were included in this review, which was conducted between 1990 and 1993. The research concluded that most programs appeared to be less intensive than the Homebuilders model. Additionally, studies failed to report enough information about

the nature and type of interventions. The authors concluded that in most cases, because we do not know the exact nature of the intensive family preservation services or the reliability with which they were delivered, rigorous evaluation of mature family preservation programs is needed.

In yet another survey of previously conducted evaluations, Fraser, Nelson and Rivard (1997) reviewed twelve published and unpublished studies of family preservation programs since 1985. The only investigations considered were those programs in which workers carried small caseloads and provided services for no longer than twenty weeks. A variety of outcomes were examined, such as, placement, reunification, arrest, incarceration, as well as service provision within the arenas of mental health, juvenile justice and child welfare. A portion of their discussion was devoted to service characteristics. Although not present in every program design, the authors of this study identified a constellation of core elements that characterize innovative family based services:

- *In vivo focus: Services are present focused and delivered in the home or community setting. They are action oriented, culturally sensitive, and address problems by working collaboratively with family member.*
- *Empowerment: Family members assist in or set services goals and are viewed as colleagues in defining a service plan.*
- *Crisis Intervention- Supportive or backup services available 24 hours a day.*
- *Skill building- Communication, problem solving, parenting, household management, management of peer influences, and use of medications, agency - level advocacy, and other skills are taught based on the individual needs of the family members.*

- *Marital and family intervention- Where needed services are provided to de-escalate parent-child or marital conflict.*
- *Collateral services- Workers make referrals to and coordinate community resources. They build partnerships with collateral services by developing family plans regarding school and friends actively engaging resources in the school and community.*
- *Concrete services- Workers help family members meet food, housing, clothing, financial assistance, transportation, health care and other needs.*

The construction of exemplary services for children and families is dependent on continued research endeavors, particularly research that rigorously analyzes interventions and their impacts. The following table graphically depicts intervention research studies that have been conducted in the field of family preservation.

Table 2: Evaluation of Services by Design, Program Model and Author

Research Design	IFPS Intensive Family Preservation Services	FPS Family Preservation Services
Descriptive	Kinney, Haapala & Booth (1991) Lewis (1991) Berry (1994) Berry, Cash & Brook (2000)	
Quasi-experimental	Fraser, Pecora & Haapala (1991) Lewis (1991) Berry (1995)	
Experimental	Feldman (1991)	Schuerman, Rzepnicki & Littell (1994)
Qualitative	Coleman & Collins (1997)	Reznicki, Schuerman, Littell, & Lopez (1994)
Meta-analysis		Blythe, Salley & Jayarante (1994) Fraser, Nelson & Rivard (1997)

Summary

The overriding goal in the aforementioned studies is in understanding the impact of intensive family preservation services and determining its worth as a service approach to prevent placement. As noted, a wide variation of services and models of family preservation exist. However, there seems to be a consensus that concrete and enabling services are more highly correlated with family gains than soft services. Considered as vital to relationship building, ongoing family treatment, and service success, the provision of concrete services demonstrates to the family that the worker is there to help and not just talk. The development of rapport between worker and family is propelled through the provision of immediate intervention and service. Solving crises as quickly as possible, helps to engage the family, which is critically important in short-term interventions (Fraser, Pecora and Haapala, 1991). In addition, the amount of time spent, and more specifically, time spent in the home, made a difference in placement prevention.

Regarding softer services, a broad range of services from psychotherapeutic techniques to cognitive behavioral techniques were identified, but the majority were educational in nature. The educational techniques primarily involved modeling parenting and family care skills, which were associated with greater gains for families and a greater likelihood that they would not experience a placement.

The preceding literature review highlights studies as well as portions of studies devoted to the examination of interventions. In addition to answering the questions of which

interventions work with which clients to produce which outcomes. this study is interested in determining whether this particular program is consistent with the intensive family preservation program model. The next chapter will describe the combination of quantitative and qualitative methodologies utilized to examine intensive family preservation interventions and treatment fidelity (Bickman. 1990).

Chapter III

Methodology

Rationale/Goals of the Study

Since relatively few empirical studies have been undertaken to describe in detail the nature of social work interventions, in general, and even fewer of these have addressed intensive family preservation services, limited information about service delivery and treatment fidelity (Bickman, 1990) exists. In light of these gaps in practice knowledge, the one purpose of this study is to learn more about the service delivery process in intensive family preservation. This knowledge is intended to inform and enhance practice and program development for intensive family-focused placement prevention programs. The guiding proposition in this study is that intensive family based services/interventions, a combination of soft, concrete, and enabling services, are utilized in varying combinations by practitioners and are effective in preventing the placement of at-risk children.

Setting

The setting of this dissertation study was Families First (for the purpose of this study, the agency will be referred to as FIP) an intensive family based program located in Kingston, New York, a relatively rural community. FIP, one of several prevention programs managed by St. Agatha's Foundling Home, a multi-service prevention center, is highly respected within the mental health and child welfare community. Since its inception in

1992, the mission of FIP has been to protect children from any immediate or short-term danger of abuse or neglect; to help parents build on family strengths and resources in order to reduce the risk of abuse or neglect; to ensure the child's safety and ultimately to prevent the placement of children into substitute care.

Consistent with intensive family preservation program theory, FIP is a voluntary program that selects families for treatment based on their willingness to participate in intensive services. Tailored to accommodate individual family needs while building on family strengths, FIP provides a continuum of hard, soft, and enabling (Berry, 1996) services, including counseling, information and referral, budgeting and money management, health care, nutrition, parenting and communication skill development. FIP receives referrals from the Division of Social Services, Child Protective Services unit, specifically through either the mandated prevention unit; the foster care unit, the intake/investigation child protection service workers, family court, mental health services, or families themselves. Families served by FIP are referred because it is assessed by the referral source and confirmed by the Director of FIP that they are at imminent risk of having a child removed from the home. An initial intake and planning meeting is held between the worker and the family, followed by a conference between the FIP worker and the director. The director and the worker then assess the family's suitability for intensive services based on the following criteria: the family is willing and able to participate in services; at least one child is at risk of removal; and intensive services are likely to protect the children from any immediate or short-term harm.

Intensive family preservation services are provided from four to eight weeks, meetings are scheduled at least four times per week for as many as fifteen hours per week in the family's home, and workers are on call to their caseload of two families, twenty-four hours per day. Three Masters level (M.S.W.) social workers; two Masters level psychologists, and one Bachelors level psychologist, staff the program.

In 1999 I conducted an exploratory pilot study of services FIP provided to at-risk families. Delineation of interventions was accomplished by reviewing all family case records for 1995, the year with the least amount of placement since the Program's inception. Fifty-four case records were systematically reviewed and a detailed inventory of potential variables including independent variables (interventions), intervening variables (demographics, risk factors, resiliency factors) and dependent variables (placement prevention, improved family functioning) (Epstein, 2001) were gathered by this researcher. These data included documentation from daily progress notes, case summaries, intake and discharge summaries, psychological and medical reports, and court reports. From this initial subset of data, preliminary data extraction forms were developed. FIP does not maintain any standardized reports, allowing for the quantification of data such as, family income, race, household composition, diagnosis, levels of abuse or neglect at intake and discharge, or placement and reunification information. Nor were standardized records kept of service provision and time spent with family. As a result, all information accumulated on each family came directly from the written case notes, as well as written inter and intra agency documentation.

From the beginning of this pilot project and throughout the dissertation project, formal and informal meetings were held with program staff and the program director. Agency staff was continuously involved in framing the research questions, checking for agreement on intervention variables, and discussing the culture of the program. At the conclusion of the pilot study, it was clear that FIP consistently modeled intensive family preservation program theory and program elements, specifically, the Homebuilders model. Therefore, FIP appeared to be a prime site for research for the following reasons: 1) it made possible an examination of treatment fidelity with the original intensive family preservation model (Homebuilders); 2) client records contained much detailed intervention information allowing for extensive comparative intervention research with prior studies cited in the literature review; and 3) the agency at large was receptive to an evaluative study of its own service and intervention elements.

Sample

The sample of this study is comprised of all families who were served by FIP. The sampling frame that was applied to this study was the two-year period from January 1, 2000 through December 31, 2001 and resulted in 116 case records. This particular sample frame was selected because many of the current workers were employed during this two-year period. It was hoped that practitioner knowledge of program theory and service provision would yield a more comprehensive understanding of intervention technology.

Overview of the Research Procedure and Design

While most evaluations in the field of family preservation have focused on participants in treatment and their case outcomes, few studies, as previously noted, have focused on service and intervention characteristics that would constitute best practice in these service models (Berry, Cash and Brook, 2000). This study then is essentially a case study of a single intensive family preservation agency. In addition, it is a feasibility study intended to determine whether the “clinical data-mining” method (Epstein, 2001) can be successfully applied to intervention research of family preservation services. Case study as a research strategy has been described as follows:

The essence of a case study, the central tendency among all types of study, is that it tries to illuminate a decision or set of decisions: why they were taken, how they were implemented, and with what result (Yin, 1989, p. 22 in Schramm, 1971).

Yin (1989) described the case study:

“A case study is an empirical inquiry that *investigates a contemporary phenomenon within in its real life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used* (p. 23).”

The research objectives of this dissertation study were to: 1) determine fidelity (Bickman, 1989, 1990) to the intensive family preservation program model endorsed by the agency via descriptive statistics regarding individual interventions; 2) to identify clusters of interventions and determine whether they are consistent with intervention categories in the literature; 3) to determine whether client demographics and presenting problems are correlated with client outcomes; 4) to compare these findings with previous studies of

comparable intensive family preservation programs and 5) to assess the feasibility of utilizing clinical-data mining as a method for studying family preservation programs retrospectively and still produce results that are valid, reliable, and comparable to previous prospective studies. A triangulated approach combining "clinical data mining"(Epstein, 2001) and survey research was employed to describe intensive family preservation interventions and to correlate these with program outcomes. Finally, a survey of client perspectives on these services provides qualitative data concerning consumers' perspectives on family preservation.

Quantitative Design

Strengths and Limitations in the Use of "Clinical Data-Mining":

Strengths

The exploratory pilot study provided a beginning understanding about the types and manner in which intensive family preservation services were delivered to families. The findings from this pilot study generated new questions about the patterns of service delivery relative to outcomes and treatment fidelity. In order to capture the depth and breadth of the programs' offerings and impact, a quantitative design seemed called for which would then provide systematic data regarding not only service provision and outcomes, but also family demographics.

In this study, a retrospective approach that utilized available clinical information obtained from existing client records (Epstein, 2001) of the FIP program was intentionally chosen

as the primary research method to describe the nature of family preservation practice and the outcomes of the interventions. Dorbrof, Dolinko, Lichtiger, Uribarri, and Epstein (2001) indicate that the utilization of available clinical data that is routinely available in medical and social service settings can be representative and reflective of the process of service delivery since it was generated from actual documentation extracted from case records.

Reaching into case records and disentangling the array of practice techniques and tacit knowledge which often goes unacknowledged in experimental studies, may lead to a greater understanding of what is being done, why, and how it affects families. "Available clinical information brings with it the possibility of providing rich descriptive, quantitative accounts (Epstein, 2001, p.22)" of the variety of social work interventions provided by FIP, family risks, case outcomes, and an approximate effect of the interventions. Epstein, Zilberfein and Snyder (1997) present a compelling argument for the utilization of available agency data by pointing out that, "In comparison with studies based on original data generation, available information studies are likely to raise fewer ethical problems, are faster and less costly to complete, are less disruptive to existing staff and patient care routines, and makes use of compliance and outcome indicators that are more likely to be agency- and practice-relevant (p. 225)." It was for these reasons that the retrospective approach of "clinical-data mining" was chosen as a means for describing intensive family preservation practice.

However, the aforementioned advantages that “clinical data mining” affords both the researcher and the practitioner have not escaped the scrutiny of “gold standard” researchers (Epstein, 2001) particularly critical of the validity and reliability of available clinical information.

Limitations of "Clinical -Data Mining": Problems of Validity and Reliability

Whenever research is based on an analysis of data that already exist, the researcher is confronted with obvious limitations to what can be retrieved from the data (Rubin and Babbi, 2001). The caveat to utilizing available clinical information is that all data are based on worker report and their judgments, not intended for research purposes.

Therefore, there is the potential problem of measurements not being valid representations of the variables and concepts under investigation. The absence of a standardized data set results in not only the variability of information from record to record, but differences in how the same or similar interventions are described and named, and ultimately the absence of information. Therefore the reliability of the original data is open to question (Nilsson, 2001). As with all secondary analysis studies there is an inability to infer causality within the data. Finally, since this study did not utilize a control group and is based on a population of limited size, the ability to generalize beyond the population is restricted (Epstein, 2001; Nilsson, 2001).

Operational Definitions:**Predictors/Independent Variables Defined**

Generally, intervention or service is activity provided by the worker to bring about a systemic change. Johnson and Yanca (2001) define intervention as a specific action provided by a worker in relation to human systems in order to induce change. The purpose of social work activity (intervention or service) is to promote or restore a mutually beneficial interaction between individuals and society in order to improve the overall quality of life. Social workers focus on the interaction between the person and their environment (home, neighborhood, workplace, community) in order to help people: develop their competence, obtain resources, encourage organizations to be responsive, facilitate interaction between individuals and their environment, and influence interaction between organizations and institutions. In this study, intervention, service, and activity are used as interchangeable terms to explain any action provided by workers to cultivate change in the family system.

For the purpose of this study, intensive family preservation practice will interchangeably be referred to as intervention or service. Since intensive family preservation services are intended to be responsive to the needs of the family, they naturally vary from family to family (Berry, 1997). This diversity of interventions delivered to families has been categorized as "hard" or concrete (transportation, financial resources or material good), "soft" or clinical (counseling and parent education), and "enabling"(establishing linkages to both formal and informal supports) (Berry, 1997). A complete inventory of

interventions and services, Inventory of Demographics and Services, which comprise the independent variable, can be found in Appendix 1.

Intervening Variables-Presenting Problems and Demographic Variables

Creating innovative solutions to family needs, a hallmark of intensive family preservation services, entails a thorough understanding of the family. Intake data is important in identifying gains the family has made at termination, as well as the constellation of services that proved to be effective in preventing placement. This includes family constellation, number of children, age of identified child, incidence of parental mental illness and childhood emotional disturbance (see Appendix 1).

Outcomes/Dependent Variables Defined

Effectiveness of service can be described in terms of a variety of outcomes including maintenance of the child in their home, reunification of the child with their family, and the reduction in family violence (Berry, 1997). In this case study, the funding source is most concerned with the demonstration of non-placement as an indicator of program effectiveness, including the reunification of a child with the family. The following section will discuss how this information was collected and organized.

Instrumentation

Initial Review of Records

The review of records was guided and informed by the pilot study, family preservation practice concepts and theory, and clinical practice wisdom. As stated earlier, the two most recent years of service delivery were selected for case record review because the program had maintained all but one of the same staff during the two years. This period afforded greater access to practitioner wisdom, corroboration of information, and potential interpretation of interventions and services.

During the pilot study, standardized instruments for "mining" data from the records were not utilized. Each of the 54 cases was reviewed for service and demographic information, which was then extracted. The review of case records, revealed a pattern of available information, such as, referral source, reason for referral, ages of children, and case outcome, to name a few. Interventions varied from family to family, however, a cadre of services and interventions were routinely provided. After reading approximately five cases, a data-extracting instrument was developed, which consisted of demographics, interventions, and outcomes found in the records. The continual "data mining" process, allowed for the creation of more categories and broadened the document search to include not only progress notes and intake and discharge summaries, but to also court documents and psychological and hospital reports. At the completion of the pilot project, 19 demographic and outcome variables and 69 services and interventions were "mined" and inventoried from the existing available data.

Thus, the initial review of records revealed information that was available in the client records for the development of an inventory of this information. This review was also used to determine what information needed to be excluded from the study because it was not consistently available in the case records. For instance, income status and ethnic or racial background were inconsistently documented in the case records.

Development of the Research Instrument

Guided by this pilot review of client records, an original research instrument, the "Inventory of Demographics and Services" (Appendix 1), was designed to retrieve and record available data from client records. This inventory reflected salient program theory and concepts derived from a variety of sources including: 1) the literature review of family preservation practice; 2) practice wisdom that resulted from the investigator's experience as an intensive family preservation program director and practitioner; 3) the pilot study; and 4) three instruments for analyzing interventions, the Concrete Service Checklist and the Clinical Services Checklist (Fraser, Pecora & Haapala, 1991), the Major Techniques Checklist (Schuerman, Rzepnicki and Littell, 1994) and the Therapeutic Interventions and Concrete Services Inventory (Pecora, Fraser, Nelson, McCroskey and Meezan, 1995). These instruments (Appendix 2), although designed for a prospective, quasi-experimental study of intensive family preservation services and outcomes, informed the development of the present "data mining" instrument as it reflected many of the services that FIP provided to families and program theory.

The selection and development of variables pertaining to service provision and outcomes were guided by these questions: What were the specific services and interventions provided to families? How long did services last? Who referred the family for services? Why was the family referred for services? Were children placed in substitute care during service provision? Was the identified child reunified with their family following services? What were the individual and family stresses that could be associated with the risk of out-of-home placement for the children?

The development of the inventory of variables was an ongoing process requiring a number of revisions. Variables were eliminated when it appeared that the information varied from record to record. As interventions were discovered in the case record, they were added to the inventory of variables. Numerous revisions were made in an effort to achieve as much intervention and service clarity and consistency and to eliminate the overlapping or "lumping" of interventions together. Operational definitions were developed for all of the variables, utilizing the review of the literature, as well as practice knowledge, in order to insure that each intervention was mutually exclusive, simple to understand and, exhaustive (Appendix 3).

The process of identifying, coding, and revising the variables led to the development of the final version of the "Inventory of Demographics and Services"(Appendix 1), which was used to extract data from the existing clinical records. This inventory included three

categories as follows: client characteristics at intake, service provision, and outcomes (Table 3).

Table 3: Elements of Data Collected at Intake, During Service, and at Case Closure

Client Characteristics	Service Provisions	Case Outcomes
1. Demographics	1. Service time	1. Child placement
2. Referral sources	2. Types of services	2. Reunification
3. Nature of abuse		3. Reduction in stressors - family violence
4. Family stressors: - family violence - substance abuse - mental illness - environmental stressors		

Adapted from Berry, Cash, and Brook, 2000

Validity of the “Data Mining” Research Instrument

A measuring instrument is valid when it measures what it is intended to measure (Epstein and Tripodi, 1977). For the purpose of this study, both content and face validity and the questions addressed by each were used as guides in addressing the validity of the instrument.

Face validity refers to what an instrument “appears to” measure rather than what it actually measures. As a result, some researchers argue it is not a true form of validation. However, it is a desirable characteristic for a measuring instrument because it asks the question: does the measuring instrument “appear” to measure the subject matter under consideration (Grinnell, 1997; Rubin and Babbi, 2001)? Whether a measure has face

validity is determined by the subjective assessments made by the researcher and other experts (Rubin and Babbi, 2001).

Content validity includes elements of face validity, but is considered a technically more legitimate type of validity. Content validity asks the question, does the measuring instrument adequately measure the major dimensions of the variable under consideration (Grinnell, 1997)? The term, content validity, refers to the degree to which a measure covers the range of meanings included within the concept. Therefore, content validation is largely a judgmental process and relies on the skill and judgment of the person who constructs it (Rubin and Babbi, 2001). In an effort to establish both face and content validity for the research instrument, Inventory of Demographics and Services, the investigator utilized "practice wisdom" derived from both clinical and administrative experience in the field of family preservation and verified through the literature review of existing inventories of interventions (Berry, 1992, 1997; Berry, Cash and Brook, 2000; Fraser, Nelson and Rivard, 1997; Fraser, Pecora and Haapala, 1991; Lewis, 1991). In addition, the FIP practitioners provided interpretations of services and interventions.

Reliability of the "Data Mining" Research Instrument

A measuring instrument is reliable to the extent that independent applications of the same instrument will consistently yield the same result. Dependability, stability, reproducibility are all synonyms for reliability (Grinnell, 1997). The reliability of the Inventory of Demographics and Services was not established prior to the initiation of the study, but

was assessed both within the study and in relation to existing literature (Berry, 1992; Berry, et al., 2000; Fraser, et al., 1991; Lewis, 1991).

Due to the confidential nature of information contained in the charts, the agency prohibited anyone other than this investigator to review client records. Therefore, in order to establish intra-rater reliability, the researcher recoded ten randomly chosen charts. A reliability coefficient of .80, or higher was obtained in all except three of the 137 variables when the records were recoded. Inconsistent ratings were found in the following three service related variables: #19, providing reinforcement had a reliability coefficient of .60, #21, teaching cognitive self-control had a reliability coefficient of .70, and #43, teaching self-management skills had a reliability coefficient of .60. After a thorough review of the operational definitions, it was apparent that overlap existed in the operationalizing of these service variables. In order to increase the distinctiveness of each intervention and to eliminate the possibility of services being counted twice, the decision was made to delete the aforementioned variables. Therefore, variables with a reliability coefficient of .70 or below were deleted.

Based on service descriptions of Berry (1995, 1997), Fraser et al. (1997), and Lewis (1991), services were combined and collapsed into two summated scales. Berry's, which consisted of hard, soft, and enabling services, and in addition, a category referred to as strengths assessment services (Berry, et al, 2000). Fraser's scale defined six categories of service: empowerment, skill building, collateral, marital and family, crisis, and concrete

services. A variable reliability analysis was conducted on both Berry's services categories and Fraser et al's categories. Reliability was very good, ranging from .8105-.8624 for all of the summated scales.

Data Analysis

"Mined Data"

SPSS was used to analyze the quantitative data. Each variable from the "Inventory Demographics and Services" was assigned a code in SPSS in order to expedite entering the data. With the assistance of a student worker, all of the data from the 116 cases was entered from the code sheets. After the initial frequencies of services and interventions were obtained, these variables were collapsed into groupings based on the literature and subsequently recoded. Cross tabulations permitted analysis of possible associations between the dependent variables, whether a child was placed or not, and the independent variables, services. Further analysis was conducted to determine the possibility of associations between family demographics and risk factors, interventions, and outcomes. A t- test was computed to determine if any relationship existed between the level of family violence before and after service provision.

Profile of the Sample

All records that were closed during the two-year period, January 1, 2000 and December 31, 2001 were included in the sample. The data was "mined" by thoroughly reviewing each case record and recording the data from the records onto the "Inventory of Demographics and Services" code sheet (Appendix 1). Data collection took place from November 2001 through May 2002.

The sample of 116 families who received intensive family preservation services included 296 children. An almost equal number of families had one (23.3%), two (30.2%), or three children (32.8%). Single-mother headed families, 42.2%, far outweighed families with two biological parents, 22.4%, or blended (step/common-law/homosexual), 25 %. A relatively small number of families lived in other family arrangements, such as, single father, grandparent, extended family members, or foster families, 9.5%.

The child identified as being at risk of placement and most in need of services was male, 61.2% of the time. Although the ages of the identified child ranged from prenatal (0) to 17 years, 14 and 15 year olds were identified as equally at-risk, at 19.9% respectively, followed by 14.7% at 13 years of age. The referral source requested intensive services primarily due to the unmanageability/behavior problems, such as, truancy, running away, mental health issues, and family violence (45.7%), followed by reunification of child with their family (18.1%), child neglect (13.8%), and child abuse (10.3%). Almost three-fourths of families, 74.1%, were referred by Mandated Prevention Services, followed by

21.6% of the referrals being made directly from Child Protective Services. The remainder of referrals came from a variety of sources.

The data mining process revealed a core of risk factors typically influencing families that received services. Approximately half (53.4%) of the 116 identified children were diagnosed with an emotional disturbance. The most common diagnoses were bi-polar disorder (15.5%) and post-traumatic stress disorder (12.1%). The remainder of the children bore diagnoses such as, childhood schizophrenia, oppositional disorder, and depression. Families also reported that 28.4% of children served suffered from suicidal or homicidal ideations. It was discovered that 14.7% of the total number of children served had previously experienced an out-of-home placement, while 4.3% were adoptees. There were a small proportion of parents diagnosed with a mental illness, 19.8%, and almost half (45.6%) of all parents and or caretakers were identified as experiencing substance abuse problems. Table 4 depicts the characteristics of this sample.

Table 4: Profile of Families (N=116)

Family Composition	%
Single Mother	42.2
Two Parents-Bio	22.4
Blended	25.0
Other family member, single father, foster family	9.5
Identified child	
Male	61.2
Female	38.8
Age of Identified Child	
0 yrs	.9
1 yr	1.7
2 yrs	5.2
4 yrs	1.7
5 yrs	.9
6 yrs	1.7
7 yrs	.9
8 yrs	.9
10 yrs	1.7
11 yrs	6.9
12 yrs	7.8
13 yrs	14.7
14 yrs	19.9
15 yrs	19.9
16 yrs	3.4
17 yrs	6.0
Reasons for referral	
Unmanageability	45.7
Reunification	18.1
Neglect	13.8
Abuse	10.3
Other	13.4
Referral Source	
Mandated prevention	74.1
Child protective services	21.6
Foster care	0.9
Family court	1.7
Other	1.7
Family risk factors	
Emotional disturbance	53.4
PINS Petition/Juvenile court involvement	48.3

Substance abuse	42.2
Suicidal/homicidal	28.4
Domestic violence	19.8
Parental mental illness	19.8
Previously placed in care	14.7
Victim of sexual abuse	14.7
Homelessness	7.8

Client Survey

This research is cross-sectional and uses a survey design to gain a better understanding of how service recipients assessed the type and quality of treatment they received. There are several advantages to using a survey design. The principal advantage of this approach is that the necessary data can be collected quickly and inexpensively. While the self-administered questionnaire provides a great sense of anonymity and confidentiality, it also reduces the possibility of researcher bias. The written questionnaire permits participants to respond at their own pace. Since the survey usually has a restricted range of response categories for a given question, respondents only have a limited range of options from which to choose (Grinell, 1997; Rubin and Babbi, 2001).

Although survey research has the above advantages, it also has its weaknesses. The survey relies on the memory of the respondent and in the case of a self-administered questionnaire; subjects must have relatively good reading skills. The fact that the questionnaire is self-administered can be a disadvantage. Respondents who do not understand a question cannot readily obtain clarification. Relative to reading skills and memory is the fact that often it is difficult to obtain in-depth and open-ended responses

from participants. More specifically, the following methodological limitations are associated with consumer satisfaction and outcome research including: 1) people may respond positively to everything they are asked; 2) clients may not respond honestly for fear future services may be withheld or sanctions of some kind may be imposed; 3) surveys rarely take into account the influence of the agency, client backgrounds, and other "intervening variables" upon client responses (Fraser, et al., 1991).

Obtaining the client's perspective in assessing the process and outcome of service delivery in human services has been emphasized by a number of program evaluation experts (Fraser et al., 1991). Rapp and Poertner (1987) argue that the "centerpiece of agency performance is the benefits accrued by clients as a result of our efforts (p.23)."

A few studies of family-based service provision have attempted to determine client satisfaction through mail and telephone surveys. Hayes and Joseph (1985) conducted a client satisfaction survey using both mail and telephone in which they found that the majority of clients were positive about service. The following section will address the development of the survey used for this study and attempts to address the foregoing issues.

Development of the Self-Administered Questionnaire; Reliability and Validity of Instrument

The most crucial considerations in the construction of a measuring instrument are in ensuring the validity and reliability (Grinell, 1997). In reviewing the literature, there were no standardized instruments that specifically addressed type and quality of service provision from the recipient's perspective. In an attempt to attain a maximum response rate from the self-administered questionnaire, practice wisdom, the family preservation literature, and input from FIP practitioners, all were utilized in its construction.

To maximize the external validity of the instrument several steps were taken. A cover letter from the FIP program director (Appendix 4) accompanied the letter (from the study's investigator), which explained the study and the importance of the family's participation in assisting improved program design (Appendix 5). The letter from the study's investigator followed with a clear and simple explanation of the study's purpose, as well as the importance of the family's' participation to improved program planning. Queries were intended to minimize invasiveness and maximize relevance to the study's focus of service provision and satisfaction. Questions were organized in order of content, while the wording was designed to be as uncomplicated as possible, in order to maximize the response rate. In an effort to maximize internal validity, every attempt was made to convey a clear meaning, to keep questions and responses short, and to provide a range of response options. All but four questions on the survey were close-ended.

The four open-ended questions pertained specifically to family goal achievement and satisfaction with the family's service provider. Open-ended questions can take more time for respondents to complete and some people may have more difficulty expressing themselves in writing, which can lead to a lower response rate and decreases external validity. Therefore, only four open-ended questions were included in the survey. Internal validity is a consideration with respect to open-ended questions because an element of subjectivity is introduced when coding the responses (Grinnell, 1997). In order to increase the internal validity, responses must be coded into meaningful categories. Such coding permits more objective analysis of the data.

The self-administered questionnaire included two scaled checklists and four open-ended questions (Appendix 6). The questionnaire was developed for the express purpose of understanding what services families believed they received, how useful the services were to families, and if the program model was consistent with the program theory. The questionnaire was designed to be completed by parents, guardians, and caretakers of children receiving services.

The first checklist of services asks clients to rate their satisfaction with the service they received. The categories of service in the checklist are considered to be practically, philosophically and theoretically tied to family preservation service provision. The second checklist asks clients to identify the types of services and interventions they received by Families First. The four open-ended questions addressed the client –worker relationship

and family outcomes relative to goal attainment and overall satisfaction with the program. My dissertation committee chair (Dr. I. Epstein), the Director of Families First, and the Executive Director of St. Agatha's Foundling Home, reviewed the questionnaire. Some minor revisions were made to the language of the open-ended questions.

The questionnaire was pre-tested with two families who had been served by FIP, who were known to the investigator, but were not a part of this sample frame. The purpose of pre-testing the instrument is to assess whether questions measure what was intended to be measured, whether the questions were understood and similarly interpreted by the individuals, whether the questionnaire created a positive impression, and whether the participants felt there was any suggestion of bias in the wording. Both parents who pre-tested the questionnaire described it as easy to read, covering the important aspects of treatment and encouraging their input. This feedback was particularly valuable to the investigator in designing the final instrument (Appendix 6).

Survey Sample Selection

This sample is a combination of purposive and convenience samples. Convenience sampling relies on the closest and most available subjects to constitute the sample; therefore the same sampling frame that was utilized to "mine" the existing clinical records was utilized as the sampling frame for the survey (January 2000 through December 2001), as it constituted the most recent group of recipients. The purposive aspect is that this researcher was hopeful that it would be easier to locate recent recipients

of service. In addition, it was felt that families most recently receiving services were more likely to respond because their service experience was relatively recent and hopefully fresh in their minds.

Grinnell (1997) states that the larger the sample the more confident the researcher can be of the results. In an effort to reduce nonsampling sources of error and obtain the highest response yield, the entire population served from January 1, 2000 through December 31, 2001 (n=116) was included in the mailing. Still in all, the opportunity to generalize findings to families that received intensive family preservation services from similar programs is limited.

Data Collection

Prior to mailing questionnaires to the 116 parents and/or guardians, the research protocol was submitted for approval to the Protection of Human Subjects from Research Risks, Institutional Review Board at the City University of New York, Hunter College. The research protocol included the packet each family would receive. The following items were reviewed by the IRB: 1) the letter from the Director of Families First providing an explanation of the research project (Appendix 4); 2) the letter from the researcher describing the nature of the research study, how their confidentiality and anonymity was to be protected, how they would be remunerated if they decided to participate, the Informed Consent form (Appendix 5); the questionnaire (Appendix 6) and the follow-up postcard reminder (Appendix 7).

Family addresses were obtained from the closed case records. Each family received the agency cover letter, the cover letter from the researcher explaining the study, the consent form, the questionnaire, and an addressed and stamped envelope for participants to return the questionnaire. This initial packet was sent from the agency on agency stationery, at the agency's request. Affixed to each questionnaire was a code number, which corresponded to the code number affixed to the Informed Consent Form. Participants were to return the coded informed consent and coded questionnaire together. Upon receipt of the informed consent form and questionnaire and within one week, the researcher mailed a check to the respondent, for \$10.00. This monetary incentive was intended to maximize questionnaire returns, as well as to show appreciation for their participation. A log of case numbers and transaction activity was recorded.

The first yield of returns totaled 9 questionnaires. Therefore, two weeks after the first mailing, the postcard was sent to remind families of the importance of their participation and the remuneration, if they agreed to participate. This mailing yielded another 12 surveys for a total of 21 returned questionnaires. Although this yield is only 5.5% of the total number of mailed questionnaires (N=116), this investigator felt that this was a valuable source of information.

The close-ended responses were coded and entered into SPSS for later analysis. In the content analysis of the open-ended responses, steps outlined by Grinnell (1997) were closely followed. referents to each question and response, and categories of analysis were

established. For instance, Question #4 asks the respondent to: Describe the kinds of goals you focused on, which included such categories as anger management, communication improvement, and linkage to services. Thus, the unit of analysis was the identified goals and the correlating categories included anger management, communication improvements and linkage to services, to name a few. These categories reflected corresponding problems that the family was experiencing. A significant piece of intensive family preservation program theory concerns how the worker tailors services to meet the family's needs. Questions # 6 and #7 attempt to address the family's experience of individualized service provision. Again, the unit of analysis is defined and categories were established. For instance in question # 6, "Is there anything your worker should have done differently," the unit of analysis is activities the worker should have offered the family. The categories included nothing, spent a longer period of time, linkage to services, and yes. A tally sheet was developed to record and code the data extracted from the four open-ended questions. For instance, the types and kinds of goals identified were tallied and totaled; this is referred to by Grinnell (1997) as coding manifest content.

Beyond the manifest content of communications, we are also interested in the content that is present, but not evident or active, known as latent content. Latent content is an indicator of underlying meaning of what is communicated and tends to be more difficult to code because it represents the meaning, depth, and intensity of a communication (Grinnell, 1997). Latent content was indicated in this study, specifically in question #4, "Please describe what changed in your family as a result of accomplishing these goals"

and #6. "Is there anything your worker could have done differently." Both of these question stimulated personal expressions of feelings. For instance the unit of analysis in #4 is family changes, however, some of the recurring themes identified were feelings expressed due to the lack of goal accomplishment. An identified category of latent content was feelings experienced by families including anger with services and satisfaction with services. Likewise, in question #6, the unit of analysis for the manifest content is activities or services. However, the unit of analysis for latent content was identified as feelings toward the worker. The categories included satisfaction with the worker's commitment or dissatisfaction with the worker for not being sensitive enough to the family's needs and predicament. Each of the responses was analyzed, coded, and tallied for latent content. Content analysis is utilized in this study to discern the effects of intensive family preservation services with families served. Interrater reliability was achieved by enlisting two independent raters in (Grinell, 1997) coding the responses. Each of the raters had experience with and understanding of intensive family preservation services, child welfare, and family therapy.

Cross-Checking Data

Weiss (1998) discusses the importance of cross-checking data gathered through different modes of inquiry as a means of corroborating the information gathered from various sources. "If interviews, observations and documents agree, the evaluator gains confidence that the information is right" (Weiss, 1998, p.263). Over the course of this study, on-going contact with the agency director, Walter Chrisman, as well as FIP practitioners has

been very important to understanding the how services were delivered and the underlying program philosophy. In order to gain a clearer understanding of the program and outcomes, as well as to increase confidence in the findings, the FIP Director met with the researcher at the conclusion of this study. This type of data cross-checking hopefully will lead to a richer and stronger story of how this intensive family preservation agency provides services to families at risk. In addition, the discussion of findings, particularly contradictions and inconsistencies aimed to shed new light on the outcomes.

Limitations of the Study

While “mining clinical data” from client records provided a unique and rich source of data, which was also easily accessible, there was undeniable variation as to what was contained in the case records. Some findings were affected by how clinicians varied in their documentation of interventions and the types of family facts they highlighted. Another disadvantage in collecting the family profile was the absence of a standardized demographic inventory, which might have permitted more referred correlations between service provision and family makeup. However, the richness of this data lies in the worker’s formulation of family history and dynamics, service delivery, family strengths, struggles in treatment, and accomplishments. This information is easily lost in scaled documents and inventories of activities.

The major limitation to the mailed questionnaire was the meager rate of respondents and responses to the open-ended questions. However, this unobtrusive survey method, which is also economical and time-efficient, permitted a window into the families’ experience of FIP. Unfortunately, findings cannot be generalized from either research strategy. Instead,

modest speculations on the likely applicability of findings to other situations under similar, but not identical conditions can be extrapolated from the findings (Patton, 1990). As noted in the previous section, the response rate to the mailed questionnaire was very small. The illustrative quotes from the client surveys are incorporated at the beginning of the chapters. In addition, the results of the 21 surveys will be discussed in Chapter V.

Chapter IV

Who Were The Families and Children Served?

A recipient of services is quoted in the client survey as saying:

I have only positive things to say about our worker. She made herself available to us day or night. My experience was extremely positive for both me and my family. She was always willing to offer support, advocacy, and to listen to all of us. (As stated in the client survey)

The Findings

Goals and Operational Definitions

The primary objectives of this portion of the "clinical data mining" were to describe the nature and characteristics of the families and children served. Of primary importance in drawing conclusions, is to compare these findings with previous studies of comparable family preservation programs and assess the feasibility of employing this methodology in conducting intervention and program research.

As discussed in Chapter III, the ultimate dependent variable in this study is placement outcomes. The independent or predictor variables include all services and interventions as operationally defined in Appendix 2. The intervening variables, which may affect the relationships between interventions and outcomes, include family demographics psychosocial risk factors as "mined" from the case records. This chapter will focus on family demographics and the differential assessment of family and child risk factors.

Overview of the Findings

The quantitative findings presented in this chapter include a descriptive or univariate analysis of all the demographic variables. Explanation and discussion of descriptive findings is presented in two sections: Family Characteristics and Risks followed by Characteristics and Risks of Children. In the section titled Family Characteristics and Risks, the following aspects will be described and discussed: family composition, referral source, reason for referral, incidence of homelessness, substance abuse, and family violence. The next section, Characteristics and Risks of Children, provides descriptive analysis of the children at-risk of placement by age, gender, involvement with the juvenile justice system, and incidence of mental health problems. Tables are provided in each section to display frequencies.

Family Characteristics and Risks

Data was collected on a variety of family characteristics from the 116 cases in the sample. The outcomes, which appear in Table 4, were gathered from intake reports, daily process notes, three and six week summaries, and discharge notes. It is felt by a number of family preservation researchers (Besharov and Bachler, 1992; Fraser et al., 1991; Scannapieco, 1993; Wells and Biegel, 1991, 1992) that client characteristics, such as demographic information, presenting problems, and family strengths should routinely be measured in order that a baseline of family skills and resources is developed. The development of such a baseline could then serve as an indicator of services that should be offered to enhance the existing strengths of families and to prevent case reopening

(Berry, 1997). To date, the family preservation literature has been incomplete and inconsistent in reporting this information (Berry, 1997), primarily because program success has routinely been measured in terms of placement and non-placement outcomes.

FIP does not utilize a standardized questionnaire for gathering demographic information or risk assessments; as a result, the investigator had to carefully “mine” each record with the goal of revealing the nature of families requiring intensive family preservation services. Moreover, it should be noted that some of the family characteristics discussed in this study, are not addressed in the literature, but are pertinent to this study and possibly beyond.

Family Composition

In this sample of families, parenting was provided by birthparents, stepparents, relatives, and other care taking adults who were unrelated to children identified as at risk of placement. Approximately 44% of families were headed by a single parent (single parents by divorce, separation, or single and never-married parents), while 22.4% of the homes were headed by both birthparents, and 24% were headed by a blended family unit (divorced and remarried couples or co-habiting adults), in almost half of the families (42.2%) the primary caretaker was a single female. The high percentage of single parent headed families in this study is consistent with findings from other studies (Berry et al., 2000; Fraser et al., 1991).

Referral Source

Intensive family preservation services have been considered a last resort for families who were at risk of having children removed from their homes. Although FIP served children across the full range of ages and presenting problems, they tended to be slightly older. More children were referred for truancy, demonstration of incorrigible behavior at home and at school, and who were receiving mental health services or had been hospitalized in an inpatient mental health facility. The FIP program director identified that the referral trend has shifted from ten years ago and presently older children with behavior and mental health problems are more likely to be referred. The statistics reflect this trend.

Higher levels of economic, social, and/or emotional deprivation, combined with a dearth of resources to deal with those stressors, results in maladaptive coping strategies, which might include drug use, physical abuse, or child neglect (Berry, 1997). FIP accepts referrals from all community agencies, as well as individual citizens. The greater proportions of their referrals were received from one of the many programs under the auspices of the New York State Division of Social Services. The specific units include Mandated Prevention Unit, Child Protective Services Unit (CPS), and the Foster Care Unit. Table 5 illustrates source of referrals to FIP by frequency and percentage.

Table 5: Source of FIP Referral (N=116)

Referral Source	N	%
Mandated Prevention	86	74.1
CPS	25	21.6
Family Court	2	1.7
Self-referred	2	1.7
Foster Care	1	.9
Total	116	100.0

In 74.1% of cases, the referral source was the Mandated Prevention Unit, which screens families for more intensive clinical services specifically related to problems such as, child non-compliance, truancy, and delinquency. CPS is responsible for assessing all reports of abuse and/or neglect; in 21.6% of cases there was a CPS referral. Foster care, family court, schools, mental health, or self-referred individuals comprise the remaining 5% of cases. More families were referred by Mandated Prevention (74.1%) than any other referral source. This is in contrast to the study conducted by Fraser et al (1991), which reported that 59% of referrals came from CPS in Utah, while 24.6% came directly from juvenile court. Hence referral sources seem to vary widely from program to program. Since reason for referral is closely linked to referral source, the following section will describe why families were referred for services.

Reason for Referral

The intake application completed by the referral source indicates the presenting problems placing the child at risk of placement. The following table illustrates the reason families were referred for FIP services, as documented at intake.

Table 6: Reason for Referral

Reason for Referral	N	%
Unmanageability /court referred	53	45.7
Reunification	21	18.1
Child Neglect	16	13.8
Child Abuse	12	10.3
Domestic violence	6	5.2
Mental Health Risk	5	4.3
Other	3	2.6
Total	116	100

In 45.7 % of the sample, families were referred because a child was unmanageable, including such behaviors as running away, truancy, exhibiting behavior problems at school, non-compliance with curfews, physical violence towards self and others, and substance use or abuse. In 18.1% of cases, the reason for referral was identified as reunification following a placement in foster care, shelter, or a psychiatric facility. In 13.8% of cases, the reason for referral was child neglect, indicated when a

family failed to provide adequate food, shelter, clothing, health care and/or supervision. In 10.3% of families, a referral was initiated when child abuse was suspected or reported.

These results varied greatly from the study conducted by Berry, Cash and Brook (2000), where 44% and 34% of families were identified as demonstrating problems with physical abuse and neglect, respectively. Berry (1995) reported that 58% of families were referred for physical abuse and 25% were referred for physical neglect. Likewise, Fraser and Pecora (1991) reported that in Utah, 59% of referrals came from CPS. The next section will address parental mental health as a presenting problem.

Parental Mental Health

The incidence of parental mental illness, an important variable "mined" from the case records, provides a window into the complexity of family life for parents and their children.

In 19% of families, parents were involved in mental health services and had a DSM-IV diagnosis of bi-polar illness, schizophrenia, post-traumatic stress disorder, or major depression. Additionally, 28.4% of the families served by FIP had one family member demonstrate suicidal or homicidal ideations and or behaviors. A discussion of the

association between parental mental illness and placement prevention in this study can be found in the next chapter.

Homelessness

Although FIP keeps no formal records of family financial or educational status, case notes revealed that many families in this sample struggled financially. These families typically survived on time-limited public assistance, social security benefits, such as SSI, and/or minimum wage salaries. Moreover, in 7.8% of families served by FIP, families either were homeless at the time of referral or became homeless during treatment.

Substance Abuse

Substance abuse was an impairing condition in over half (53%) of the 116 FIP families in the sample frame. At least one primary caretaker was engaging in drug or alcohol abuse, or both. Primary substances used were alcohol, crack-cocaine, heroin, and marijuana. These results are consistent with Berry's findings (1995) in an examination of 40 families, where approximately 50% of caretakers abused substances. The relationship between substance abuse and placement will be further addressed in Chapter V.

Discussion

The referral "orbit" of FIP is diverse and not limited to a specific genre of family problems. Family preservation programs have been criticized for receiving referrals

"from only one of the "stages" of child welfare cases: the investigative stage"(Schuerman, et al., 1994, p. 238). As noted in Table 5 many more families (74.1) were referred from Mandated Prevention than from the investigative CPS unit, in fact indicating an older population of children was in need of intensive services. The frequency of families referred due to problems of unmanageable behavior and/or court involvement (45.7%) exceeded the frequency of families referred for problems of child abuse (10.3%) and child neglect (13.8%). The foregoing descriptive data suggests: 1) parents were not equipped with the skills to deal with their child's emotional disturbance and the resultant behavior problems manifested at home, at school and in the community; 2) the social service system, lacking necessary coordination with other community agencies, such as mental health services, failed families by not identifying children at risk and providing them and their families with preventive services; and 3) the complex challenges that multi-problem families are faced with- poverty, family violence, mental health issues, and substance abuse, often in isolation.

In light of the preceding information, serious attention must be given to the nature of family problems, the knowledge and skill required of those delivering services, and the necessity for ongoing staff training. The following section will address the children in this sample.

Characteristics and Risks of Children

Family preservation programs have the ultimate goal of preserving families, while ensuring the safety of children. This goal is often approached from a holistic and systemic perspective. Application of this perspective results in service provision to not only the identified child, but to all children residing in the home. Two hundred and ninety-six children received services from FIP. The mean number of children per family unit was 2.55 (SD = 1.43). In 32% of families, there were 3 children, 30.2% had 2 children, 23.3% had only one child, and in 12.6% of families, there were 4 to 8 children.

Families referred for services are usually experiencing one of two crises: 1) the family is not providing adequate childcare and supervision according to CPS and removal is imminent, or 2) a parent was refusing to allow a child to remain at home, or the child was refusing to remain at home (Kinney, Haapala and Booth, 1991). The child or children in these cases were on the verge of being placed in out-of-home care, thus they were considered "at risk" of placement. In each family, the referral agent indicated that the family situation necessitated intensive services to prevent placement. This occurred when: 1) immediate safety of children could not be ensured due to abuse, neglect, or family violence; 2) parent(s) or child (ren) had serious physical or emotional problems which impeded the safety and well-being of children; and 3) a child, parent or both had developmental disabilities requiring specialized parenting training.

The child at imminent risk of being placed in substitute care is referred to as the "identified child", the child who is in physical and/or emotional danger in terms of personal safety at home, at school, or in the community. For the purpose of this study, one child per family was considered the "identified child", the child most in danger of placement, totaling 116 children at risk of out-of-home care.

Age and Gender

The age of the identified children in the sampling frame ranged from infancy to seventeen years. The mean age of the identified child was 12.10 years. Thirteen year-old children were identified as being potentially at-risk of placement 14.7% of the time, 19.8% of the time the age of the identified child was 14 years and 15 years, respectively. In 61% of the cases (N=116) the identified child was male (See Table 3).

Juvenile Offenders- Status Offense

Of the 116 children identified as at risk of placement, 48% (56) had committed a status offense (an offense which would not be considered a crime if committed by an adult e.g. running away, truancy, unmanageable behavior). The court can adjudicate a child as delinquent by filing a PINS petition (Person in Need of Supervision) and assigning a probation officer.

Mental Health

A discovery made during the data mining process, was that 53.4% of children served by FIP were diagnosed with an emotional disturbance and received either outpatient or inpatient mental health services prior to or during FIP's involvement.

In the review of these cases it became apparent that these children were suffering from major mental disorders for many years and many had already been hospitalized in psychiatric facilities on numerous occasions.

The following table shows the frequency with which children were diagnosed with an emotional disturbance according to the DSM- IV.

Table 7: Children by DSM-IV Diagnosis

Diagnosis	N	%
None	57	49.1
Bi-Polar Disorder	18	15.5
Post-traumatic Stress Disorder	14	12.1
OCD/ Schizoaffective	9	7.8
Depression	8	6.9
ADHD	6	5.2
Schizophrenia	3	2.6
Oppositional	1	.9
Total	116	100.0

A study conducted by Fraser and Pecora (1991), reported similarly, that over two-thirds of children identified as at-risk had been involved with outpatient mental health counseling or had been placed in inpatient mental health facilities. In addition, relative to mental health status, 14.7 % (17) of the identified children were victims of sexual abuse, 14.7 % (17) had experienced at least 1 previous placement in substitute care, and 4.3 % (5) were adopted.

Discussion

This chapter attempted to describe the sample of families in terms of their demographic characteristics and their presenting problems. As stated previously, a multifaceted view of families was somewhat limited due to the lack of certain information that was not collected by the program, such as, age of parent/caretaker, race/ ethnicity, educational level and socioeconomic status.

The families, although referred by a variety of sources, were primarily referred by the Mandated Prevention Unit which serves children demonstrating unmanageable behaviors, who are generally ten years of age and above.

In terms of identified problems, there were many, but generally, the referral source identified one outstanding reason to account for the referral to FIP indicating an assessment that the child was at imminent risk of placement.

The material extracted from the case records indicates that the family landscape was both diverse and riddled with significant problems. For instance, approximately 50% of all families in the sample (N=116) were headed by a single mother. Of the 116 families in the sample, substance abuse plagued over half of all families, as did emotional disturbance of a child, juvenile delinquency (indicated by the filing of a PINS petition), as well as involvement with juvenile court system. The volatile nature of families was similarly revealed in the case record through worker's documentation, orders of protection, and reports from psychiatric hospitals, indicating family violence. Approximately 20% of families had each problems of domestic violence and parental mental illness. In 15% of families it was found that a child had been a victim of sexual abuse, while another 15% of families were found to have had at least one child who had previously been placed in care.

From the data presented, a number of conclusions can be drawn regarding families receiving services. First, they were diverse in terms of marital status, living arrangements, and living conditions. Although formal data was not collected on socioeconomic status, it was apparent from the case notes, that many families were living in poverty and had been struggling with their problems in isolation for a long time. This diversity suggests that a standard approach to family treatment would probably not work or be effective.

Second, the data suggests that families had a wide array of personal and family problems, particularly mental health issues and drug and alcohol involvement. Furthermore, many

families faced environmental and contextual problems (McCroskey and Meezan, 1997), including housing problems, homelessness, employment issues, and children facing problems at home and in the community. Third, many of the caregivers were victims of domestic violence presently and in the past. These life experiences undoubtedly affected parents' child-rearing abilities. Finally, the sample represents a full range of child maltreatment issues in varying amounts. Sometimes multiple allegations of abuse, neglect, and unmanageability were brought by the referral source.

Practice experience suggests that personal characteristics of parents and children, as well as demographic information, are important in determining treatment success. The somewhat intrusive and intense nature of this service demands that a worker enter a family armed with finely tuned relationship skills and the utmost sensitivity in hopes of forming a therapeutic connection aimed at improving family functioning and preventing placement. In order for families, such as these, mired in personal and systemic problems, to use help, they must be able to form a trusting relationship with a worker. Clearly, the personal and family characteristics in interaction with the worker's practice strategies and service delivery style, influences the success or failure of services.

Fraser et al (1997) reflects on future research directions, "And what is the differential contribution of elements of services-skills training, concrete problem solving, and empowerment to outcomes? To sort promise from compromise, a program of rigorous

intervention research is urgently needed (p. 150)." Chapter V will discuss the findings relative to services, service compositions, and placement outcomes.

Chapter V

Looking Inside the Black Box of Intensive Family Preservation Services

A FIP service provider is quoted during a conversation with the researcher:

We work with the whole family, on their turf, on their time frame. Sometimes they don't want us there, but we encourage their strengths, their growth, and their family culture, and then they let us in. It is not easy work, but it is rewarding-for all concerned, hopefully (summarized from a conversation between researcher and FIP practitioner)

The Findings

Goals and Operational Definitions

The primary objectives of the "clinical data mining" portion of this study were to describe the types of services provided to at-risk families and to determine fidelity to the program model; to identify clusters of interventions and to determine if they are consistent with intervention categorizations in the literature, and finally to determine whether client demographics and presenting problems are associated with client outcomes. Of primary importance in drawing conclusions, is to compare these findings with previous studies of comparable family preservation programs and assess the feasibility of employing this methodology in conducting intervention research.

As discussed in Chapter IV, the ultimate dependent variable in this study is placement outcomes. The independent or predictor variables include all services and interventions as operationally defined in Appendix 2. The intervening variables, which may affect the

relationships between interventions and outcomes, include family demographics psychosocial risk factors as "mined" from the case records.

Overview of Findings

The quantitative findings presented in this chapter include a descriptive or univariate analysis of all the service variables, a bivariate analysis of the relationships between the dependent variable (outcome of service) and the intervening variables, family characteristics and independent variables, services, and a multivariate analysis comparing categorizations of interventions, family characteristics, and placement outcomes. The analysis and discussion of findings is organized as follows: Family Demographics and Characteristics Relative to Placement, Characteristics of Children Relative to Placement, Duration of Service Time, Typologies of Services, Concrete Services, Enabling Services, Soft Services, Skill Building Services, Empowering Interventions, Crisis Interventions, Creative Therapies, Core Elements of Intensive Family Preservation Practice followed by a discussion of the client survey results, Parents View of Services.

In Family Demographics and Characteristics Relative to Placement, the association between family risks and placement prevention will be discussed. Likewise, the following section, Characteristics of Children Relative to Placement, will illustrate and discuss the association between children at risk and placement outcomes. What is considered the "black box" of services including length of service time and types of services and interventions provided associations between family characteristics, services

and placement outcomes. Additionally, throughout this chapter, clusters of services relative to findings in the literature will be discussed. Tables are provided in each section to display frequencies and associations between independent and dependent variables, where appropriate. Descriptions of salient bivariate and multivariate relationships are provided.

Throughout the empirical analysis, $p < .05$ level of statistical significance will be used for treating findings as “facts”. However, given the sample size, trend level findings will be reported at $p < .09$ level, as the trend level findings suggest potentially important information on the correlates of intensive family preservation treatment outcomes.

Family Demographics and Characteristics Relative to Placement Outcomes

Clearly, many factors affect intensive family preservation service outcomes. Spaid, Lewis and Pecora (1991) categorize these factors into three groupings: client variables, problem variables, and service variables. Client variables include demographic characteristic of parents and children, previous placements, and adoptive status. Problem variables include a range of factors including supervision of children, knowledge of childcare, types of problems experienced by the child and substance abuse. Service variables include types of services, intensity, and length of service.

Research studies of family factors associated with child placement have been unequivocal and contradictory. In still other studies, treatment success or failure has

clearly been associated with family characteristics (Spaid, et al, 1991), yet few studies have measured parental mental illness, emotional problems, and supervision of children relative to placement. Yet, Berry's evaluation of the Northern California Program Emergency Family Care (1992) found that family preservation was most frequent when the presenting problem was health, mental health, or single parenthood, and much less likely amongst families experiencing difficulties such as child neglect or parental developmental disability. The following section will review family factors as associated with placement outcomes.

Family Composition and Problems Relative to Outcomes

A chi-square analysis was utilized to ascertain whether family composition was predictive of placement. Children residing with birthparents and living in a blended family unit were defined as a "dual" parent family, while all other families were defined as single parent family units. A statistically significant relationship was not found between these two variables ($\chi^2=2.66$, $df=1$, $p= N.S.$); therefore one can infer that family composition had no bearing on placement outcome in this study. Previous studies have found marital status was correlated with negative outcomes (AuClaire and Schwartz, 1986). Likewise, in families where homelessness was a problem, the chi-square test indicated that homelessness was not predictive of out-of-home placement.

Referral Source/ Reason by Placement Prevention

A statistically significant relationship was not found between referral source and placement outcomes; however, referral source was a significant predictor of placement prevention when services were specified. The findings will be illustrated as categories of services are discussed throughout this chapter.

When reason for referral and placement outcomes were analyzed, no significant relationships were found. However, the reason for referral was a significant predictor of placement prevention when particular family preservation interventions were specified. These findings will be illustrated and discussed later in this chapter.

Parental Mental Health

A few studies have found that parental impairment due to mental illness was associated with child placement (Spaid et al, 1991). In a study of the Homebuilders program (Bath, Richey, and Haapala, 1992), case records of 1,056 families served by Homebuilders of Washington were examined from 1985 to 1988. Among parent characteristics, only parental mental health problems and low family income were associated with child removal. Another evaluation of a Homebuilders model program (Theiman and Dail, 1992) found associations between placement prevention, a family psychiatric history, and having a single caregiver in the home. Interestingly, the present study found that there were no children placed when parental mental illness was reported as a family problem. The following table shows these findings.

Table 8: Placement by Parental Mental Illness

	<u>Parental Mental Illness</u>					
	No		Yes			
	N	%	N	%	N	%
Placement Prevented	79	84.9	23	100.0	102	87.9
Placement Occurred	14	15.1	-	-	14	12.1
Total	93	100.0	23	100.0	116	100.0

($\chi^2 = 3.938$, $df = 1$, $p < .05$)

In 85% (84.9) of families who had no parental mental illness, placement was prevented as compared to 100% of families who had parental mental illness. Surprisingly, these findings indicate that a positive association exists between placement prevention and presence of parental mental illness.

These findings may suggest that the FIP workers were skilled in establishing a working rapport with mentally ill parents and their children, thus permitting and encouraging families to engage in intensive family services in order to prevent family dissolution. FIP's program director further clarified that he believed the success with this population could be attributed to a number of factors: FIP workers were skilled in case management, family work, and relationship development, the willingness of formal and informal service providers to coordinate services with FIP, and the motivation demonstrated by the family to maintain their family unit. An evaluation of a Northern California intensive family preservation program (Berry, 1992) found that family preservation was most

frequent when the family's presenting problem was one of health and mental health, which appears to be consistent with placement outcomes for FIP when there was a diagnosis of parental mental illness. It could be assumed that the FIP workers possessed knowledge, experience, well-developed case management skills, and sensitivity to adults with mental illness, thus increasing the chances of successful engagement and treatment outcomes.

Substance Abuse

The deleterious effect of drug and alcohol abuse on families is common knowledge. Substance abuse was not mined and analyzed separately for children because information in the case record was not always clear about whether the identified child used substances. The following table reports placement rates as associated with substance abuse.

Table 9: Placement by Substance Abuse

	<u>Substance Use</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	64	95.5	38	77.6	102	87.9
Placement Occurred	3	4.5	11	22.4	14	12.1
Total	63	100.0	53	100.0	116	100.0

($\chi^2 = 8.613$, $df = 1$, $p < .01$)

In approximately 95% of FIP families who did not have substance abuse problems, placement was prevented as compared 78% (77.6) of families where substance abuse was present. The enhanced placement prevention rate for families where substance abuse was absent was consistent with Berry's findings (1995). Furthermore, these findings echoed other studies (Fraser et al., 1991, Nelson, Landsman and Deutelbaum, 1990), which found that placement prevention was greater and therefore treatment was more effective with families where substance problems were absent. Yet, the larger percentage of families with substance abuse problems remained intact, which could imply that the program was somewhat effective.

The short term and intense treatment period may not be conducive to working with serious substance abuse issues. As a result, many intensive family preservation programs have created a separate program for families struggling with substance abuse problems, which entails a longer treatment period, but with the same amount of intensity (ex. Family Intensive Program, St. Johnsbury, VT). Again, consistent contact, worker knowledge and expertise in the area of substance abuse, coupled with speedy linkage to ancillary services, may have influenced the treatment outcomes for these families.

Family Violence

Circumstances that may contribute to family violence include stress, emotional disturbance of a child, marital problems, differences in parenting style, financial and housing problems, poverty, mental illness and family substance abuse. Family

functioning assessment scales were not utilized by FIP to document baseline information. However, the level of family violence was assessed by the referral source at the time of referral. Family violence was assessed by using a 4- point scale (4, high level of family violence; 3, moderate level; 2, low level; 1, no family violence). Each category was defined as follows (per referral agent): 1) high level- often physically or verbally threatening, physically abuses others and damages property; 2) moderate level-has angry outbursts, verbally abusive, may be destructive to property, but not people; 3) low level- occasionally has verbal outbursts and 4) no family violence. At case closure, the FIP worker provided a narrative description of improvement, which the researcher interpreted and subsequently assigned a numerical rating, using the aforementioned definitions and scale.

A paired samples t-test indicated that there was a reduction in the level of family violence following the provision of services. At intake the mean family violence score was $M = 3.03$ ($SD = 1.11$) and at discharge, $M = 2.42$ ($SD = 1.23$). These means were significantly different, $t(115) = 6.117$, $p < .01$. The before and after differences between the two means scores is statistically significant at a .000 level, indicating that there was a meaningful reduction in family violence.

The level of violence was significantly reduced for families where placement was prevented. At intake the mean family violence score was $M = 3.00$ ($SD = 1.13$) and at discharge, $M = 2.32$ ($SD = 1.22$). These means were significantly different.

$t = (101) = 6.312, p = .000$. For children who were placed in substitute care; the level of violence was not significantly reduced. At intake the mean family violence score was $M = 3.29$ ($SD = .91$) and at discharge, $M = 3.14$ ($SD = 1.10$). The mean difference in the scores is not significantly different, $t = (13) = .563, p = N. S.$, indicating that for families where children experienced placement, family violence was not significantly reduced.

In 5.2% of the sample ($N=116$), a family member felt their safety was physically and/or emotionally threatened by another member of their household, filed for protection from the court, and were subsequently issued an order of protection. When the association between placement outcomes and family violence relative to the issuance of a protective order was analyzed, there was no significant relationship ($\chi^2 = .868, df = 1, p = N.S.$). Family violence was further analyzed before and after services by reason for referral, gender of identified child, family composition, substance abuse, commitment of a status offense and emotional disturbance. A paired samples t-test indicated that a reduction in family violence occurred after service provision when the reason for referral was indicated as unmanageability, domestic violence and reunification. When the reason for referral was unmanageability at intake, the mean family violence score was $M = 3.04$ ($SD = .94$) and at discharge $M = 2.40$ ($SD = 1.18$). These means were significantly different, $t = (52) = 4.204, p = .000$. When the reason for referral was domestic violence, at intake the mean family violence score at intake was $M = 3.83$ ($SD = .41$) and at discharge $M = 2.50$ ($SD = 1.38$). These means were significantly different, $t = (5) = 2.390, p = .062$. In both instances, family violence at intake was assessed at a moderate level and following

services; the level of violence was reduced to a low level. When reunification was the reason for referral, at intake the means family violence score was $M = 2.67$ ($SD = 1.43$) and at discharge $M = 2.00$ ($SD = 1.26$). These means were statistically different, $t = (20) = 2.870$, $p = .009$.

A paired samples t-test indicated that there was a reduction in the level of violence after service provision in families where the identified child was male. At intake, the mean family violence score was $M = 3.04$ ($SD = 1.10$) and at discharge $M = 2.49$ ($SD = .15$). These means were significantly different, $t (70) = 4.236$, $p = .000$. These before and after differences, statistically significantly at a .000 level, indicated that there was a meaningful reduction in family violence. Similarly, when the identified child was female, the mean family violence score at intake was $M = 3.02$ ($SD = .17$) and at discharge $M = 2.31$ ($SD = .17$). Again there was a statistically significant difference, $t (44) = 4.509$, $p = .000$, indicating a meaningful reduction in family violence occurred for families where the identified child was female. Additionally, this analysis confirms that no matter the child's gender, family violence was significantly reduced at the termination of services.

In both single parent and dual parented families, the level of violence was significantly reduced by case closing. At intake, the mean violence score in single parent families was $M = 3.02$ ($SD = .13$) and at discharge $M = 2.17$ ($SD = .14$). Again, these means were significantly different, $t (64) = 5.738$, $p = .000$. While in dual parented families, at intake $M = 3.06$ ($SD = 1.61$) and at discharge $M = 2.75$ ($SD = 1.31$). Statistical significance was

reported, $t(50) = 2.679$, $p = .01$. This analysis confirms that a meaningful reduction in family violence occurred after service provision in both single and dual parented families. In analyzing the level of violence before and after services in families where substance among caregivers was a problem, those families who had substance abuse problems showed a meaningful reduction in violence. At intake the mean violence score was $M = 3.22$ ($SD = .14$) and at discharge, $M = 2.59$ ($SD = .16$). The mean scores were statistically significant, $t(49) = 4.280$, $p = .000$ and it appears that a significant reduction in violence occurred following services. For families where substance abuse was not a problem, at intake the mean violence score was $M = 2.90$ ($SD = .14$) and at discharge, $M = 2.30$ ($SD = .16$). These scores were statistically significant, $t(66) = 4.381$, $p = .000$. In as much as these findings do not show a great reduction in family violence when substance abuse was not a problem. This analysis confirms that for all families, those with substance abuse issues and those with none, a meaningful reduction in family violence occurred.

An analysis of family violence before and after services was conducted relative to children who had committed a status offense, as well as for those who had not committed a status offense. As in the case of substance abuse, those families where a child had committed a status offense showed a more significant reduction in family violence following services. At intake the mean violence score for families where a child had committed a status offense was, $M = 3.16$ ($SD = .14$) and at discharge, $M = 2.34$ ($SD = .15$). These scores were statistically significant, $t(55) = 5.440$, $p = .000$. These findings show that a meaningful reduction in family violence occurred following services. For

families where the identified child had not committed a status offense, at intake, the mean violence score was $M = 2.92$ ($SD = .15$) while at discharge, $M = 2.50$ ($SD = .17$). These scores were statistically significant, $t(59) = 3.239$, $p = .002$. Although for families where a status offense had not been committed, reported a much smaller reduction in family violence, there is still a meaningful reduction in family violence.

A final analysis of a diagnosis of emotional disturbance relative to family violence showed a meaningful reduction in family violence following service provision. For families where the identified child had a diagnosis of emotional disturbance at intake, the mean violence score was $M = 3.03$ ($SD = 1.23$) while at discharge, $M = 2.42$ ($SD = 1.11$). These results were statistically significant $t(115) = 6.117$, $p = .000$.

In analyzing the reduction of family violence following services, it was encouraging to find that overall, family violence decreased following services. Additionally, there appeared to be a significant reduction in violence when:

1) families were referred for unmanageability, domestic violence and reunification; 2) the identified child was male; 3) when substance abuse was identified as a problem for parent/ caretaker; 4) when a child committed a status offense; and 5) when a child was emotionally disturbed. Although family violence was reduced in both dual and single parent families, there was a more significant reduction of family violence for single parent families. In contrast to the present study, Theiman and Dail (1992) conducted a statewide evaluation of a Homebuilder's model program in Iowa. It was found that

families showing the least improvement in family functioning were those referred for parental dysfunction and/or family violence. These findings are suggestive of intensive family preservation services having had a positive impact on child and family functioning.

Characteristics of Children Relative to Placement

Evaluations of intensive family preservation services have been incomplete and inconsistent in reporting client characteristics (Berry, 1996). The next section of this study will describe the 116 children at imminent risk of placement.

Age and Gender

Fraser, Pecora, and Lewis (1991) found that children over the age of 12 were more likely to be placed during or after service provision. The present study found that approximately 65% of the sample of children (N=116), identified as at risk of placement, ranged in age from 12 to 16. The question arises as to why older children are more likely to be placed. To account for this occurrence, consideration needs to be given to the possibility that the older the child the more extensive the history of problems and failed service provision.

An independent t-test was conducted to determine if an association existed between age and placement prevention.. The following table illustrates the findings.

Table 10: Placement by Age of Identified Child

	M	SD	t	p
Placement Prevented	11.90	4.27	1.445	.151
Placement Occurred	13.57	1.55		

The mean age of children who had placement prevented was 11.90 as compared to those 13.57, the age of children who were placed. A statistically significant association was not found between age of identified child and placement outcomes.

Descriptive statistics in Chapter III indicated that far more males (61.2), than females were represented in this study and identified as at risk of placement. The following table illustrates how gender of identified child and placement are associated in this study.

Table 11: Placement by Gender of Identified Child

	Male		Female		Total	
	N	%	N	%	N	%
Placement Prevented	61	85.9	41	91.1	102	87.9
Placement Occurred	10	14.1	4	8.9	14	12.1
Total	71	100.0	45	100.0	116	100.0

($\chi^2 = .701$, $df = 1$, $p = N.S.$)

In families where the identified child was male, placement was prevented 86% of the time as compared to 91% of families where the identified child was female. A statistically significant relationship was not found between gender and placement outcomes ($\chi^2 = .701$, $df = 1$, $p = N.S.$). It appears that females and males fared equally well in the FIP program. These findings are consistent with the study conducted by Fraser, Pecora and Lewis (1991).

Juvenile Offenders- Status Offense

Although assessing the improvement in child functioning is an implicit goal of intensive family preservation programs, little attention has been paid to this aspect of research (McCroskey and Meezan, 1997). In eliciting caretaker's responses as to why children were placed, Fraser, Pecora, Haapala and Bennett (1991) note that the most often cited reason for placement was because a child would not obey, committed a crime or delinquent act, was involved with drug or alcohol abuse, and was physically violent or out of control. Of the 116 children in this sample, 45.7% were referred because of unmanageable behaviors and 48.3% committed a status offense. Table 12 illustrates the association between placement prevention and whether the identified child had committed a status offense.

Table 12: Placement by Status Offense

	<u>Status Offense</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	56	93.3	46	82.1	102	87.9
Placement Occurred	4	6.7	10	17.9	14	12.1
Total	60	100.0	56	100.0	116	100.0

($\chi^2 = 3.418$, $df = 1$, $p < .07$)

In 93.3% of families whose children had not committed a status offense, placement was prevented as compared to 82.1 % of children who had committed a status offense. These results indicate that services were more effective with children who had not committed a status offense. However, it is important to note that of the 56 children who committed a status offense, only 10 were placed. Therefore, it does seem to indicate that services contributed to improved child functioning. These findings concur with those of other studies where it was found that children with extensive behavior problems at home and school were more likely to experience placement and as a result, more likely to be adjudicated delinquent or a person in need of supervision (Kagan and Scholsoger, 1988).

The FIP program director reflected that it is more likely for children who have been involved with the juvenile justice system to experience placement. He felt that after offering children a number of chances to rectify their behavior, the judicial system becomes impatient and possibly fearful- placement becomes the key to protection when

they have run out of chances. As well, service providers may find it more hopeful to put their time and energy into children who have not yet turned 16.

Emotional Disturbance

Feldman (1990) reported that families referred because of a combined problem of emotional disturbance or behavior problems and poor parenting were more likely to experience placement. In a similar vein, Fraser, Pecora, and Lewis (1991) found that children who had mental health histories had a greater risk of placement than those children with no prior mental health history. An analysis of the association of placement outcomes by emotional disturbance ($\chi^2 = 2.012$, $df = 1$, $p = N. S.$) produced no significant findings. Despite this non-significant outcome, as mentioned in the previous section, the level of family violence decreased following services to families where children were diagnosed with an emotional disturbance.

Service Time

Berry (1994), Berry, Cash and Brook (2000) and Fraser, Pecora and Lewis (1991) all consistently theorize that the more time spent in direct contact with families the more likely the family will achieve a positive family outcome.

The mean number of days spent in providing services to a family was approximately 46 days (45.62) or 6.5 weeks. Consistent with the intensive family preservation model, which emphasizes short-term intensive treatment (4-8 weeks), close to half (41.3%) of

all cases were closed between 46 and 57 days, or 8 weeks of treatment time. Although FIP does not record hours spent in the home, the "data mining" process revealed that workers generally met with families daily and depending on their specific needs, might meet with them more than once per day. To determine if there was any association between duration of services and placement outcomes, independent samples test was run. Table 13 illustrates the duration of services relative to placement.

Table 13: Placement by Days of Service Time

	M	SD	t	p
Placement Prevented	47.5	12.25	3.21	.000
Placement Occurred	32.2	17.2		

The number of days that a case was open was predictive of placement prevention. In cases where a child was placed, on the average, the family received 15 days of treatment time less than those children who were not placed. Children who did not experience placement were provided services for an average of 47 (47.6) days, while children who were placed in out-of-home care received an average of 32 (32.2) days of service. The difference between the two scores was statistically significant at a .000 level.

"Data mining" revealed that families continued the treatment process until their FIP worker made final recommendations to terminate services. Treatment time may have

been "cut short" when placement appeared to be both imminent and appropriate. In families where a child experienced a placement, none prematurely terminated treatment on their own. The shorter length of service to families where a child was placed, in most cases, was a function of the child experiencing a placement, rather than the termination of services by the family or worker due to lack of interest or cooperation. Since FIP does not require workers to maintain logs of actual time spent at each face-to-face contact, there is no information on the number of hours spent in the delivery of service per family.

Site of Service Delivery

Consistent with the intensive family preservation program model and with findings of other studies (Berry, 1997; Berry et al., 2000; Fraser, et al., 1997; Haapala, 1991) the "clinical data mining" process revealed that the home was the primary site of treatment.

FIP workers might meet with a family member or the family as a whole, in a collaborative meeting at another agency, or at an alternative site, such as a diner or restaurant, in a park, or even in the car, when necessary. In a very few instances, meetings were held at the FIP office. Such meetings might occur because the family was homeless, it was not possible to achieve a confidential atmosphere in the home, it was not safe to discuss information at home, or the family had administrative business that necessitated meeting with their worker on the agency premises. The incidence of home-based contacts was not tallied for this study, nor was a comparison drawn between the frequency of office contacts and home visits, as office visits were infrequent.

Summary

"Clinical data mining" revealed the following program design and practice characteristics of intensive family preservation services: 1) services were family-centered- the family was the focus of treatment (FIP workers met with the whole family); 2) services were provided in the home, where family crisis occurred (the record revealed that the worker met in the family home at least 4 times per week); 3) services were flexibly provided- workers were present, on-site in an effort to mitigate the risk to children and others (workers notes revealed that they would visit families at varied hours depending on their work and school schedules and were available for crisis intervention); 4) workers assumed a multi-problem orientation- the integrated approach to problem-solving allowed them to respond to a range of presenting needs (case notes discussed the person in environment approach to problem solving and partializing when necessary); and 5) intensity and short duration of service delivery reinforces an emphasis on the family's ability to function independently (cases were open from 4 to 8 weeks and workers met with families at least 4 times per week, as documented in the case record).

Treatment success might logically be assumed based on the following findings:

1) a reduction in family violence when families were referred for unmanageability, domestic violence and reunification, when the identified child was male, when substance abuse was identified as a problem for parent/ caretaker, when a child committed a status offense, when a child was emotionally disturbed and for both dual and single parent families; 2) placement was prevented when the duration of service time was extended:

and 3) there were no children placed when parental mental illness was reported as a family problem. The effectiveness of intensive family preservation services will be further discussed relative to specific services and placement prevention in the following section.

Service Typologies

In this section, a description of types and combinations of services provided by FIP will be discussed. As noted in previous sections, one of the most compelling gaps in family preservation evaluations is the delineation of program elements, specifically service provision (Staff and Fein, 1994; Wells and Biegel, 1990). It is the provision of services that is of utmost importance to an understanding of the effectiveness of family preservation services because “without an appreciation of how services are provided and thus how a program is implemented, all information about the outcomes of an intervention becomes ephemeral, tied to a particular program or service setting, and not amenable to generalization” (Staff and Fein, 1994, p.195).

Information on what is considered the “black box” of services (Bickman, 1991; Staff and Fein, 1994) was gathered from the 116 case records in this sample. Data “mined” from the records included length of service time, concrete services provided, enabling services, and clinical skills provided. As stated earlier, there have been few studies conducted describing intensive family preservation intervention technology. Berry (1995, 1997), Berry et al. (2000), Fraser, et al and Lewis (1991) and Fraser, Nelson and Rivard (1997),

have conducted the major studies of service provision in intensive family preservation and from their research delineated specific service categories. This study utilized both Berry's (1997) typology of services and Fraser et al. (1997) scale of services.

Berry (1997) discusses the components of service provided by intensive family preservation services as ranging from softer services, such as counseling and family assessment, to enabling services devoted to building formal and informal social supports, to the harder or concrete services of household maintenance help, provisions of furniture, car repairs, or other basic needs (Fraser, Pecora, and Lewis, 1991).

Fraser et al (1997) describes a set of core service elements which include empowerment activities (families assist in setting goals and are viewed as colleagues in treatment), crisis intervention (24 hour a day support services), skill building activities (education provided in parenting, communication, problem-solving etc.), marital and family intervention (services provided to de-escalate parent-child or marital conflict), collateral services (coordination of resources), and concrete services (provision of services to meet basic survival needs). These two typologies are very similar; however, Fraser's typology subdivides the larger groupings of Berry's soft and enabling services into more specific categories. This present study utilizes both Berry's continuum of services and Fraser et al's core service elements when discussing service implementation. See Appendix 4 for service scales by author. The following section will analyze placement outcomes relative to a specific service provision followed by a multivariate analysis of placement outcome,

service, and family or child characteristic. The reader should note that in a number of cases, a significant association did not appear to exist until a service was specified. This outcome will be addressed in the discussion section of this chapter.

All Service Categories

The final "Inventory of Variables" identified 112 types of interventions provided to families in varying proportions. Of the 112 interventions, 82% were identified as clinical or soft services, 11% of interventions were identified as enabling activities and 7% were identified as concrete activities. An average of 57 different interventions were provided per family unit. Since during the pilot study it proved too time consuming to tally the cumulative number of times a particular service was provided per family, in this study, a service was counted only once on the "Inventory of Variables" when received by the family.

Concrete Service Characteristics

The provision of concrete services, such as household goods, financial assistance, food, and transportation, is an important component in intensive family based programs (Berry, 1996). The centrality of the provision of hard services is addressed extensively in the literature (Berry, 1995, 1997; Berry et al., 2000; Fraser et al. 1991; Lewis, 1991; Kinney et al., 1991). The application of a direct solution to a concrete problem early in the intervention (Kinney et al., 1991) helps the caseworker to engage the family in the treatment process more readily. Additionally, families may not find it possible to address

emotional/communication problems if their day-to-day living condition is precarious. Lindsey (1991) and Pelton (1989), contend that it is vital that the worker address the family's economic stability and the physical condition of the home as soon as possible because these aspects may influence a placement decision.

Every family in the FIP sample received at least one concrete service, with approximately 75% of families receiving an average of 3.1 concrete services. This finding is consistent with that of Fraser, Pecora, and Haapala (1991) and Lewis (1991), where 74.2% of 453 families received some type of concrete service and an average of 2.54 concrete services was provided for the entire study sample. Lewis (1991) suggests that this could indicate that services were individually tailored to meet family needs. Transportation and recreational services were provided to 89.7% of families, the most frequently provided concrete services. Contrary to other studies (Fraser et al, 1991; Lewis, 1991; Berry et al., 2000), FIP workers provided transportation more often. This finding is consistent with the environmental conditions and constraints of rural Ulster County, which covers a large geographic area and public transportation does not run to the outer reaches.

The provision of financial assistance for rent, furniture, home repairs, food, and utility connections, was the next most frequently provided concrete service and was provided to 56.9% of the total FIP sample. Other concrete services provided in less frequent amounts included recognizing special family events through celebration (37.9%), modeling and participating in home management activities, such as cleaning, shopping, and daily

chores (37%), helping to arrange for daycare or respite (30.2%) helping families to move or find housing (19%), and helping children with home work (6.9%). Utilizing the service scales of both Berry (1997) and Fraser et al. (1997), approximately 89 % (89.7 and 88.8 respectively) of the sample received from two to five concrete services. Table 14 illustrates the frequency of concrete service provision.

Table 14: Frequency of Concrete Service Provision (N=116)

Concrete Service	N	%	M	SD
Transportation	104	89.7	0.96	0.31
Financial assistance	66	56.9	0.57	0.50
Celebrating family events and "family-nights"	44	37.9	0.29	0.46
Participating in home management activities	33	28.4	0.28	0.45
Arranging for daycare or respite	35	30.2	0.30	0.46
Chores	10	8.6	0.86	0.28
Helping with homework	8	6.9	0.69	0.25

Of the aforementioned services, providing resources (financial assistance for rent, down payments, food, utilities payments, and furniture and car repairs) was significantly associated with placement prevention for specific populations. The following table illustrates the relationship between the provision of financial resources, placement outcome, and children who committed a status offense.

Table 15: Placement by Financial Resources by Status Offense

<u>Status Offense was not Committed</u>						
<u>Financial Resources</u>						
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	17	81.0	39	100.0	56	93.3
Placement Occurred	4	19.0	-	-	4	6.7
Total	21	100.0	39	100.0	60	100.0

($\chi^2 = 7.959$, $df = 1$ $p < .05$)

For families where a status offense had not been committed, in 81 % of families who did not receive financial assistance, placement was prevented as compared to 100% who received this service. For those families where a child committed a status offense, 86.2% who had not received the service, placement was prevented compared to 78 %(77.8) that received financial assistance. The above results show that financial assistance was associated with placement prevention, but only in the case of those children who had not committed a status offense. The association between the provision of financial assistance, a child diagnosed with an emotional disturbance, and placement is illustrated in the following tables.

Table 16: Placement by Financial Assistance by Emotional Disturbance

	<u>Emotional Disturbance is Absent</u>					
	<u>Financial Assistance</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	15	71.4	30	90.9	45	83.3
Placement Occurred	6	28.6	3	9.1	9	16.7
Total	21	100.0	33	100.0	54	100.0

($\chi^2 = 3.506$, $df = 1$, $p < .07$)

For 71.4% of families who did not receive financial assistance and did not have children with a diagnosed emotional disturbance, placement was prevented, as compared to 91 % (90.9) who received this service. In families where a child was emotionally disturbed, 93.1% who were not provided with financial assistance had placement prevented, as compared to 91 % (90.9) of families who received financial assistance. Consequently, financial assistance seems to appear to be a function of placement prevention but only where an emotional disturbance is absent. However, financial assistance does appear to have a positive effect on families. Finally, a one-tailed independent sample t-test was conducted between the summated scale of concrete services. Berry (1997) and Fraser et al. (1997). The following tables illustrate the findings.

Table 17: Placement by Berry's Summated Scale of Concrete Services

	M	SD	t	p
Placement Prevented	3.25	1.25	1.500	.068
Placement Occurred	2.71	1.14		

In families where placement was prevented, a mean score of 3.25 was received for concrete services as compared to families where placement occurred who received a mean score of 2.71. The findings were statistically significant at $p < .07$, indicating that concrete services, per Berry (1997), were predictive of placement prevention.

Table 18: Placement by Fraser et al's Summated Scale of Concrete Services

	M	SD	t	p
Placement Prevented	3.27	1.34	.918	.180
Placement Occurred	2.93	1.21		

In families where placement was prevented a means score of 3.27 was received for concrete services as compared to a mean score of 2.93 in families where placement occurred. The findings were not statically significant, indicating that the provision of concrete services, per Fraser's typology, was not predictive of placement prevention.

Summary

Intensive family preservation model of service delivery builds in the provision of concrete services as a means of demonstrating the workers' commitment to the family, tailoring of services to meet individual family needs, and demonstrating "teachable" moments whereby the worker can model skills (Berry, 1997). The intensive family preservation literature indicates that the objective of providing concrete services is to reduce familial and environmental stress by improving the impoverished circumstance of families, so that the psychosocial nature of family problems can then be addressed. The preceding results indicate that providing "at-risk" families with concrete services, particularly the provision of financial support, is associated with placement prevention. Although very few studies have evaluated correlates of service provision in detail, Fraser et al. (1991) found transportation and recreation to be most highly associated with placement prevention, while Berry (1994) found that families who received home management care, as well as securing food and medical help, were the most likely to remain intact.

Statistical significance between service and placement prevention was only achieved when the identified problem was absent. One can speculate that children with emotional disturbance and those who committed a status offense were in greater need of the softer or enabling services to actually prevent placement. Although these specific services did not appear to have an impact on placement prevention, the provision of financial assistance appears to have played a role in creating stability in the lives of families.

In an attempt to understand why concrete services were associated with placement prevention in other studies (Berry, 1992, 1995; Berry, Cash and Brook, 2000; Lewis, 1991), but not in the present study, ideas from the director of FIP were elicited. His feeling is that many clients do not take advantage of the transportation because they do not want to attend the school meetings, go to the counseling services, or fill out applications at the Division of Social Services- they would rather be doing other things. Transportation is an appendage of the FIP service and sometimes the service is a nuisance, an intrusion in the family.

Enabling Services

Enabling services facilitate access to both the external soft and concrete services by helping the family to establish community linkages. Fraser et al. (1997) refers to these services as collateral services. Utilizing Berry's scale of enabling services, approximately 9.5% of all FIP service activities fell under this rubric. Every family was provided with at least one enabling service, while on the average, families received 7 enabling services over the course of treatment.

Those enabling services provided with the most frequency included, advocating on behalf of the family (94%), accompanying clients to agencies (91.4%), providing information and referral linkages (85.3%), providing information on various resources (84.5%) and providing case management service (73.3%). The following services, although provided less frequently, aimed to decrease the social isolation of families, as well as provide them

with a supportive relationship: testifying and attending court with clients (62.1%); teaching clients how to access services and modeling how to negotiate services (44%); assisting in building informal community supports (41.4%); and teaching clients how to use leisure time (38.8%).

A crucial element of intensive family based services is the linkage of families with services. The great majority of the families (85%) were referred to other services upon termination, such as, outpatient mental health services, substance abuse counseling programs, private counseling services, or intensive/longer term treatment options, such as Coordinated Children's Services. Berry's study (1997) supports the contention that enabling services are associated with better family outcomes, including making the greatest gains in skills. Table 19 illustrates the frequency with which families received enabling services.

Table 19: Frequency of the Provision of Enabling Services (N=116)

Enabling Activity	N	%	M	SD
Advocating on behalf of families	109	94.0	.94	.24
Accompanying clients to agencies	106	91.4	.91	.28
Providing information and referral	99	85.3	.85	.36
Providing information on resources	98	84.5	.84	.36
Providing case management services	85	73.3	.73	.44
Testifying and attending court	72	62.1	.62	.49
Teaching how to negotiate local services	44	37.9	.44	.50
Assist in building informal supports	48	41.4	.41	.49
Teaching clients to use leisure time	45	38.8	.39	.49

Families typically received an array of enabling services. Specific services that were found to be associated with placement prevention include, providing information on resources, teaching clients how to negotiate local service systems, and accompanying clients to other services. The following tables will illustrate the association between placement prevention and the provision of specific enabling activities.

Table 20: Placement by Provides Information

	<u>Provides Information on Resources</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	13	72.2	89	90.9	102	87.9
Placement Occurred	5	27.8	9	9.2	14	12.1
Total	18	100.0	98	100.0	116	100.0

($\chi^2 = 4.954$, $df = 1$, $p < .05$)

Table 20 illustrates that approximately 72% (72.2) of families who did not receive information on available resources had placement prevented as compared to 91% (90.9) of families who received this service ($p < .05$). Providing information on available resources then is related to placement prevention.

When substance abuse, parental mental illness, and committing a status offense were analyzed for covariation with receipt of this service, significant levels of association were indicated for single parent families, families where parents were diagnosed with a mental illness, and families where substance abuse was not a problem. This indicates the conditions under which this service served to prevent placement. The following tables illustrate our findings.

Table 21 : Placement by Provides Information by Substance Abuse

	<u>Substance Abuse is not a Problem</u>					
	<u>Provides Information on Resources</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	10	76.9	54	100.0	64	95.5
Placement Occurred	3	21.3	-	-	3	21.3
Total	13	100.0	54	100.0	67	100.0

($\chi^2 = 13.046$, $df = 1$, $p < .01$)

In families for where substance abuse was not a problem, 77% who were not provided with information on resources had placement prevented as compared to 100% who received the service. On the other hand, when substance abuse was a problem, a statistically significant relationship was not found between provides information on resources and placement prevention. The provision of information on resources is associated with placement prevention but only for those families where substance abuse was not an issue ($p < .01$). In other words, if family members are abusing substances, merely providing information may not be enough to prevent the placement of their child. When analyzing the relationship between placement prevention, family composition and providing information on resources, a significant relationship between placement prevention and service provision to single parent families was indicated. Table 22 illustrates the findings.

Table 22: Placement by Provides Information by Single Parent

Single Parent Family

Provides Information on Resources

	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	5	55.6	37	88.1	42	82.4
Placement Occurred	4	44.4	5	11.9	9	17.6
Total	9	100.0	42	100.0	51	100.0

($\chi^2 = 5.400$, $df = 1$, $p < .05$)

For single parents 56% (55.6) of families who did not receive information on resources had placement prevented as compared to 88% of families who did receive the service. The findings indicate that for single parent families the provision of information about resources is associated with placement prevention. In dual parent families, 90% (89.9) who were not provided with information on available resources, placement was prevented, as compared to 92% who did receive the service. Hence, for these families the provision of information on resources does not predict placement prevention. Nonetheless, the vast majority of these families (92%) did receive this service.

In the case of families referred for reunification, when analyzed relative to provides information on resources, a statically significant relationship was discovered between these two variables ($\chi^2 = 9.975$, $df = 1$, $p < .01$). Therefore, one can infer that

reunification was a predictor of placement prevention, yet the cell numbers were too small to report findings.

The social worker accompanying the client to meet other service providers also appeared to have significant influence on placement prevention as the following table illustrates.

However, that association did not achieve statistical significance at the .05 level.

Table 23: Placement by Accompanied Client

	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	7	70.0	95	89.6	102	87.9
Placement Occurred	3	10.4	11	10.4	14	12.1
Total	10	100.0	106	100.0	116	100.0

($\chi^2 = 3.316$, $df = 1$, $p < .07$)

Nonetheless, 90% of those who received this service had placement prevented as compared to 70% who did not. Further specifying this relationship by family risk factors indicated a significant association between children who had committed status offenses, family composition, and children diagnosed with an emotional disturbance relative to placement prevention. Table 24 illustrates these findings.

Table 24: Placement by Accompanied Clients by No Status Offense

Child Did Not Commit Status Offense

Accompanied Clients to Other Services

	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	3	60.0	53	96.4	56	93.3
Placement Occurred	2	40.0	2	3.6	4	6.7
Total	5	100.0	55	100.0	60	100.0

($\chi^2 = 9.740$, $df = 1$, $p < .01$)

In families where a child had not committed a status offense, 60% who were not accompanied to other agencies, appointments, and services, placement was prevented as compared to 96% of families who received this service. The support of a worker accompanying a client to meet with other service providers can be most empowering; in addition, it provides an opportunity for social skill mastery. The results suggest that this type of client advocacy, which is an essential component of intensive family preservation services, appears to support placement prevention.

On the other hand, in families where a child had committed a status offense, there was no association with placement prevention. It seemed curious that this service was more fruitful with families where children had not committed a status offense.

In discussing this with the Director of FIP, he suggested that children who have committed status offenses are reluctant to attend services of any sort. They are more

likely to not only refuse accompaniment to service meetings such as mental health, counseling, substance abuse assessment, or school meetings, they might refuse to go at all. The next set of tables shows the relationship between family composition, service and placement.

Table 25: Placement by Accompanied Client by Dual Parent Family

	<u>Dual Parent Family</u>					
	<u>Accompanies Client to Other Services</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	3	60.0	57	95.0	60	92.3
Placement Occurred	2	40.0	3	5.0	5	7.7
Total	5	100.0	60	100.0	65	100.0

($\chi^2 = 7.962$, $df = 1$, $p < .01$)

For dual parent families, 60% who were not accompanied to other services by their worker, placement was prevented as compared to 95% of families who received the service. On the other hand, for single parent families, accompanying clients to other services had no association with placement prevention. Placement prevention thus appears to be more sensitive to this intervention in dual parent families, than single parent families. Similar to the child that committed a status offense, a single parent may be less likely to attend meeting with outside service providers because it may interfere with their job security, and income. "Service becomes a pain, particularly filling out forms" (as

quoted by the FIP Director). The next set of tables will illustrate the relationship between this service, a diagnosis of emotional disturbance, and placement prevention.

Table 26: Placement by Accompanied Client by No Emotional Disturbance

Diagnosis of Emotional Disturbance is Absent

Accompanied Client to Other Services

	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	5	83.3	52	92.9	57	91.9
Placement Occurred	1	16.7	4	7.1	5	8.1
Total	6	100.0	56	100.0	62	100.0

$(\chi^2 = 3.456, df = 1, p < .07)$

For families that did not have a child with a diagnosis of emotional disturbance, 83% (83.3) who were not accompanied to services had placement prevented, as compared to 93% (92.9) who received the service. However, this relationship did not achieve statistical significance at .05 level. In contrast, in families where there was a diagnosis of emotional disturbance, there was no relationship found between accompanying clients to other services and placement prevention. Therefore, this service appears to have more influence with families who do not have an emotionally disturbed child to care for. The last enabling service, teaching clients how to negotiate and access local service systems, was also associated with placement prevention. Practitioners provide this service

by modeling for clients how to effectively communicate with service providers, as well as rehearsing how to handle a new and/or difficult experience with a service provider.

Table 27: Placement by Teaches Clients How to Negotiate Services

	<u>Teaches How to Negotiate Local Service Systems</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	53	81.5	49	96.1	102	87.9
Placement Occurred	12	18.5	2	3.9	14	12.1
Total	65	100.0	51	100.0	116	100.0

($\chi^2 = 5.693$, $df = 1$, $p < .05$)

Table 27 illustrates that 81.5% of families who were not taught to negotiate local service systems, had placement prevented as compared to 96% of families who received this service. The following tables will illustrate the provision of this service relative to family composition and risks as associated to placement prevention.

Table 28: Placement by Teaches to Negotiate by Mandated Prevention

	<u>Mandated Prevention</u>					
	<u>Teaches to Negotiate Local Services</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	39	81.3	36	94.7	75	87.2
Placement Occurred	9	18.8	2	5.3	11	12.8
Total	48	100.0	38	100.0	86	100.0

($\chi^2 = 3.459$, $df = 1$, $p < .07$)

In families referred by Mandated Prevention, 81.3% who were not taught to negotiate with local services had placement prevented, as compared to 95% (94.7) of families who received skills to help them to negotiate local services.

Table 29-a: Placement by Teaches to Negotiate Services by Dual Parent

	<u>Dual Parent Family</u>					
	<u>Teaches to Negotiate Local Services</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	34	87.2	26	100.0	60	92.3
Placement Occurred	5	12.8	-	-	5	7.7
Total	39	100.0	26	100.0	65	100.0

($\chi^2 = 3.611$, $df = 1$, $p < .06$)

The preceding table illustrates that for dual parent families 87% who were not taught to negotiate service systems, placement was prevented as compared to 100% of families who were taught. However, this relationship fell just shy of achieving statistical significance

Table 29-b: Placement by Teaches to Negotiate by Single Parent

	<u>Single Parent Families</u>					
	<u>Teaches to Negotiate Service Systems</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	19	73.1	23	92.0	42	82.4
Placement Occurred	7	26.9	2	8.0	9	17.6
Total	26	100.0	25	100.0	51	100.0

($\chi^2 = 3.140$, $df = 1$, $p < .08$)

Similarly, for single parent families 73% who were not taught to negotiate service systems avoided placement as compared to 92% who were taught how to negotiate for themselves. These findings support the influence this enabling service had on placement prevention, but were not statistically significant. The next set of tables report findings when substance abuse is a risk.

Table 30: Placement by Teaches to Negotiate by Substance Abuse

	<u>Substance Abuse is a Problem</u>					
	<u>Teaches to Negotiate Service Systems</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	20	66.7	18	94.7	64	95.5
Placement Occurred	10	33.3	1	5.3	11	22.4
Total	30	100.0	19	100.0	75	100.0

($\chi^2 = 5.265$, $df = 1$, $p < .05$)

In substance abusing families 67% (66.7) who were not taught how to negotiate service systems placement was prevented, as compared to 95% (94.7) who were taught how to negotiate service systems. The significance of this relationship suggests the importance of being taught these day-to-day living skills for substance abusing families and their role in placement prevention. Alternatively, in families in which substance abuse was not a problem, no relationship appears to exist between being taught to negotiate service systems and placement prevention. The next table illustrates the relationship between the receipt of this service in families where a child had committed a status offense.

Table 31-a: Placement by Teaches to Negotiate by No Status Offense

Status Offense Was Not Committed

Teaches to Negotiate Service Systems

	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	28	87.5	28	100.0	56	93.3
Placement Occurred	4	12.5	-	-	4	6.7
Total	32	100.0	23	100.0	56	100.0

($\chi^2 = 3.750$, $df = 1$, $p < .06$)

In families where a child had not committed a status offense, 88% (87.5) who were not taught how to negotiate service systems had placement prevented as compared to 100% of who received the service. Teaching to negotiate service systems appears to promote placement prevention with families where a child had not committed a status offense.

Table 31-b: Placement by Teaches to Negotiate by Status Offense

Status Offense Was Committed

Teaches to Negotiate Service Systems

	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	25	75.8	21	91.3	46	82.1
Placement Occurred	8	24.2	2	8.7	10	17.9
Total	33	100.0	23	100.0	56	100.0

($\chi^2 = 2.233$, $df = 1$, $p = N.S.$)

In the case of families where a child had committed a status offense, 76 % (75.8) who had not been taught to negotiate the service systems had avoided placement as compared to 91 % (91.3) who were taught to negotiate service systems. This relationship came close, but did not achieve statistical significance. The following tables illustrate findings when emotional disturbance is specified.

Table 32-a: Placement by Teaches to Negotiate by No Emotional Disturbance

<u>Diagnosis of Emotional Disturbance is Absent</u>						
<u>Teaches to Negotiate Service Systems</u>						
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	19	73.1	26	92.9	45	83.3
Placement Occurred	7	26.9	2	7.1	9	16.7
Total	26	100.0	28	100.0	54	100.0

($\chi^2 = 3.798$, $df = 1$, $p < .06$)

In those families where a child did not have a diagnosis of emotional disturbance, 73% (73.1) who were not taught how to negotiate service systems had placement prevented as compared to 93% who received the services.

Table 32-b: Placement by Teaches to Negotiate by Emotional Disturbance

Diagnosis of Emotional Disturbance is Present

Teaches to Negotiate Local Service Systems

	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	34	87.2	23	100.0	57	91.9
Placement Occurred	5	12.8	0	0	5	8.1
Total	39	100.0	23	100.0	62	100.0

($\chi^2=3.207$, $df=1$, $p<.08$)

Families in which a child had a diagnosis of emotional disturbance, 87 % (87.2) who were not taught how to negotiate service systems had placement prevented as compared to 100% of families who received the service. In both instances, emotional disturbance seems to be sensitive to families being taught to advocate for themselves. However, neither of these contingent relationships achieved statistical significance. The last table in this section will illustrate the relationship between families being taught to negotiate service systems, when a parent was diagnosed with a mental illness.

Table 33: Placement by Teaches to Negotiate by No Parental Mental Illness

	<u>Parental Mental Illness is Absent</u>					
	<u>Teaches to Negotiate Service System</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	47	79.7	32	94.1	79	84.9
Placement Occurred	12	20.3	2	5.9	14	15.1
Total	59	100.0	34	100.0	93	100.0

($\chi^2 = 3.525$, $df = 1$, $p < .06$)

In families where parental mental illness was not a risk factor, 80% who were not taught to negotiate local social service systems had placement prevented as compared to 94% of families who were taught to negotiate for themselves. However, this finding fell just below the .05 level of significance. On the other hand, for families with a mentally ill parent, being taught to negotiate services had no differential impact. Placement was prevented for 50% of each service group.

In an attempt to further analyze whether an association existed between the provision of enabling services and placement outcomes, a one-tailed independent samples t-test was conducted using the scales based on both Berry (1997) and Fraser et al (1997). The following tables will report the association between Berry's enabling services and Fraser's collateral services.

Table 34: Placement by Scale of Enabling Services by Berry

	M	SD	t	p
Placement Prevented	7.04	2.09	2.134	.017
Placement Occurred	5.79	1.85		

A mean score of 7.04 was received for enabling services received by families where placement was prevented as compared to a mean score of 5.79 for families where placement occurred. These findings were statically significant at $p < .05$ level suggesting that the receipt of enabling services was predictive of placement prevention. On the other hand, collateral services identified by Fraser et al. (1997), which are comparable to Berry's enabling scale, did not indicate an association with placement prevention, as the following table illustrates.

Table 35: Summated Scale of Collateral Services by Fraser et al

	M	SD	t	p
Placement Prevented	4.52	1.22	1.049	0.186
Placement Occurred	4.14	.867		

A mean score of 4.52 was computed for families who had placement prevented as compared to a mean score of 4.14 computed for families where placement occurred. There was no statistically significant relationship found between this scale of services and placement.

Summary

Enabling services documented in the aforementioned studies are associated with better outcomes for families. The enabling services are aimed at helping clients learn how to obtain help on their own. This method of empowerment is a core ingredient in the intensive family preservation model, which supports the teaching or pscho-educational approach of assisting clients (Haapala, Pecora and Fraser, 1991). Of the three enabling services that showed significant associations with placement prevention, teaching clients how to negotiate local service systems appears to have had the greatest impact on placement prevention when family problems are specified.

Characteristics of Soft or Clinical Services

An assumption underlying intensive family preservation services is that the flexibility of small caseloads coupled with the home-based approach allows workers to do “whatever it takes” to reduce the likelihood of maltreatment while trying to prevent the foster placement of child (ren)(Berry et al., 2000). Looking into the “black box” of interventions and services revealed a broad spectrum of clinical activities, from a variety of theoretical perspectives, guiding the application of services to the myriad of family problems. Utilizing Berry’s (1997) typology of soft services, 92 of the total interventions were categorized as service activities that tended to be used to establish and facilitate therapeutic relationships (listening, offering support, encouraging), those activities that provided structure for treatment (setting treatment goals, clarifying problems) and treatment techniques associated with behavioral change (reinforcements and

identification of logical consequences). The average number of soft services provided to families was approximately 47(46.73) services. Overall, the soft services were most commonly provided to families in this study. This finding is consistent with that of Berry (1994, 1995); Berry, et al. (2000); Fraser, Pecora and Haapala (1991); and Lewis (1991).

With the help of the Fraser et al. (1997) typology, soft services/clinical interventions were further delineated into subcategories as follows: family and marital interventions, skill building activities, empowerment interventions, and crisis interventions. In 100% of the 116 families served, at least 1 soft service was provided. In fact, it was discovered that more than half (52.4%) of families received between 27 and 32 clinical interventions.

Table 36: Mean Soft/Clinical Services Provided Per Family by Category

Category of soft service	M	SD
Marital and family interventions	27.10	5.49
Empowerment Interventions	11.94	2.26
Skill Building Interventions	8.22	3.92
Crisis Interventions	1.91	.84

The soft services that were found to significantly affect the prevention of placement were those that were considered marital and family interventions. The following section will discuss the category of marital and family interventions that were predictive of placement prevention including: couples counseling, reflecting and validating feelings, providing

encouragement, building in structure and daily routine, and discussing progress as termination of services approaches. The first set of tables will illustrate the association between the marital and family interventions and the prevention of placement.

Marital and Family Interventions - a function of placement prevention?

Table 37: Placement by Couples Counseling

	<u>Couples Counseling</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	62	82.7	40	97.6	102	87.9
Placement Occurred	13	17.3	1	2.4	14	12.1
Total	75	100.0	63	100.0	116	100.0

($\chi^2 = 5.541$, $df = 1$, $p < .05$)

In 98 % of families who received couples counseling, placement prevention was achieved, as compared to 83% of families who did not receive this service. The provision of counseling to the parental dyad appears to have had a global impact on family functioning. Moreover, couple counseling seems to be differentially associated with placement prevention when the variables referral source, substance abuse and parental mental illness were taken into consideration. The following tables illustrate these findings.

Table 38: Placement by Couples Counseling by Mandated Prevention

	<u>Mandated Prevention</u>					
	<u>Couples Counseling</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	44	81.5	31	96.9	75	87.2
Placement Occurred	10	18.5	1	3.1	11	12.8
Total	54	100.0	31	100.0	86	100.0

($\chi^2 = 4.268$, $df = 1$, $p < .05$)

In families referred by Mandated Prevention, 81.5% who did not receive couples counseling had placement prevented as compared to 97 % (96.9) of families who received the service.

Table 39-a: Placement by Couples Counseling by No Substance Abuse

	<u>Substance Abuse is Not a Problem</u>					
	<u>Couples Counseling</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	42	93.3	22	100.0	64	95.5
Placement Occurred	3	6.7	-	-	3	4.5
Total	45	100.0	22	100.0	67	100.0

($\chi^2 = 1.535$, $df = 1$, $p < .05$)

For families with no substance abuse problem, 93% of families who did not receive couples counseling had placement prevented as compared 100% who did receive couples counseling. The results indicate that couples counseling was predictive of placement prevention in families where substance abuse problems did not exist.

Table 39-b: Placement by Couples Counseling by Substance Abuse

	<u>Substance Abuse is a Problem</u>					
	<u>Couples Counseling</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	20	66.7	18	94.7	38	77.6
Placement Occurred	10	33.3	1	5.3	11	22.4
Total	30	100.0	19	100.0	49	100.0

($\chi^2 = 5.265$, $df = 1$, $p < .05$)

For families with substance abuse problems, 67% (66.7) of families who did not receive couples counseling had placement prevented as compared to 95%(94.7) of families who received couples counseling. For these couples, this type of counseling seems to have played a powerful role in placement prevention.

Table 40: Placement by Couples Counseling by No Parental Mental Illness

<u>Parental Mental Illness is Absent</u>						
<u>Couples Counseling</u>						
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	47	78.3	32	97.0	79	84.9
Placement Occurred	13	21.7	1	3.0	14	15.1
Total	60	100.0	33	100.0	93	100.0

($\chi^2 = 5.782$, $df = 1$, $p < .05$)

For families in which there was no diagnosed parental mental illness, 78 % (78.3) who did not receive couple counseling had placement prevented as compared to 97% who received couples counseling. However, since placement was prevented in all families involving parental mental illness, couples counseling was not differentially associated with this outcome. For families where a parent was diagnosed with a mental illness, 100% of families received no couples counseling and placement was prevented as compared to 100% of families who received couple counseling. The following table illustrates the prevention outcome for couples counseling when emotional disturbance is considered.

Table 41: Placement by Couples Counseling by Emotional Disturbance

	<u>Emotional Disturbance is Present</u>					
	<u>Couples Counseling</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	33	86.8	24	100.0	57	91.9
Placement Occurred	5	13.2	-	-	5	8.1
Total	38	100.0	24	100.0	62	100.0

($\chi^2 = 3.435$, $df = 1$, $p < .07$)

For families where the identified child was diagnosed with an emotional disturbance, 87 % (86.8) who did not receive couples counseling had placement prevented as compared to 100% who did receive couples counseling. This non-significant but discernible trend suggests that couples counseling is helpful in placement prevention when an emotional disturbance is present. In contrast, when emotional disturbance was absent, there was no association between this intervention and placement prevention.

The reflection and validation of feelings by the worker provides the client and/or family an opportunity to experience a sense of understanding and empathy, encourages expression of feelings, helps the client to distinguish between various feelings, and helps to control and manage feelings (Pillari, 2002). The following tables illustrate the association between receipt of this soft service, family risk factors, and placement outcomes.

Table 42: Placement by Reflect and Validate

	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	4	57.1	98	89.9	10	87.9
Placement Occurred	3	42.9	11	10.1	14	12.1
Total	7	100.0	109	100.0	11	100.0

($\chi^2 = 6.654$, $df = 1$, $p < .05$)

In 57% of families where the record did not indicate feelings reflected and validated, placement was prevented as compared to 90% (89.9) who received this intervention. The following table provides findings when this intervention is associated with the reason for referral as well as specific family risk factors.

Table 43: Placement by Reflect and Validate by Unmanageability

	<u>Unmanageability</u>					
	<u>Reflect and Validate Feelings</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	2	50.0	43	87.8	45	84.9
Placement Occurred	2	50.0	6	12.2	8	15.1
Total	4	100.0	49	100.0	53	100.0

($\chi^2 = 4.113$, $df = 1$, $p < .05$)

In families who were referred because the identified child demonstrated unmanageable behaviors, 50% who did not have feelings reflected and validated had placement prevented, as compared to 88 % (87.8) of families who received the service. It appears that for families with children who were incorrigible, having their feelings not only heard but validated, resulted in placement prevention.

Table 44-a: Placement by Reflect and Validate by No Substance Abuse

Substance Abuse is Not a Problem

Reflect and Validate Feelings

	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	3	75.0	61	96.8	64	95.5
Placement Occurred	1	25.0	2	3.2	3	4.5
Total	4	100.0	63	100.0	67	100.0

($\chi^2 = 4.189$, $df = 1$, $p < .05$)

Where substance abuse was not a problem, 75% of families who did not have feelings reflected and validated had placement prevented as compared to 97 % (96.8) who appeared to receive this intervention.

Table 44-b: Placement by Reflect and Validate by Substance Abuse

	<u>Substance Abuse is a Problem</u>					
	<u>Reflect and Validate Feelings</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	1	33.3	37	80.4	39	77.6
Placement Occurred	2	66.7	9	19.6	11	22.4
Total	3	100.0	46	100.0	49	100.0

($\chi^2 = 3.589$, $df = 1$, $p < .06$)

Likewise, where substance abuse was a problem, 33% of families who did not have feelings reflected and validated had placement prevented as compared to 80% of families who did receive the intervention. Between both types of families then, those who had substance problems and those who did not, the findings are suggestive that reflecting and validating feelings is a function of placement prevention. Another area of family risk and its association to reflect and validate feelings is illustrated in the following table.

Table 45-a: Placement by Reflect and Validate by No Status Offense

<u>Status Offense is not Committed</u>						
<u>Reflect and Validate Feelings</u>						
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	2	50.0	54	96.4	56	93.3
Placement Occurred	2	50.0	2	3.6	4	6.7
Total	4	100.0	56	100.0	60	100.0

($\chi^2 = 12.934$, $df = 1$, $p < .01$)

For families where a child had not committed a status offense, 50% of families who did not have feelings reflected and validated had placement prevented, as compared to 96 % (96.4) who had feelings reflected and validated.

Table 45-b: Placement by Reflect and Validate by Status Offense

Status Offense is Committed

Reflect and Validate Feelings

	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	2	66.7	44	83.0	46	82.1
Placement Occurred	1	33.3	9	17.0	10	17.9
Total	3	100.0	53	100.0	56	100.0

($\chi^2 = .518$, $df=1$, $p= N.S.$)

In families where a status offense was committed, 2/3 of families served who did not have feelings reflected and validated had placement prevented as compared to 83% of families who received this intervention. Table 46 will illustrate the relationship between reflection of feelings and parental mental illness.

Table 46: Placement by Reflect and Validate by Parental Mental Illness

Parental Mental Illness is Absent

Reflect and Validate Feelings

	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	3	50.0	76	87.4	79	84.9
Placement Occurred	3	50.0	11	12.6	14	15.1
Total	6	100.0	87	100.0	93	100.0

($\chi^2 = 6.125$, $df = 1$, $p < .05$)

Where parental mental illness was absent, 50% of families who did not have feelings reflected and validated avoided placement as compared to 87% (87.4) of families who received this intervention. For families where parental mental illness was a problem, 22 of the 23 families with mental illness received this intervention. And, because all of these had placement prevented there is no way to assess the differential impact of this intervention with these data.

Table 47: Placement by Reflect and Validate by No Emotional Disturbance

	<u>Emotional Disturbance is Absent</u>					
	<u>Reflect and Validate Feelings</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	2	40.0	43	87.8	45	83.3
Placement Occurred	3	60.0	6	12.2	9	16.7
Total	5	100.0	49	100.0	54	100.0

($\chi^2 = 7.450$, $df = 1$, $p < .01$)

For families where there was no diagnosis of emotional disturbance, 40% who did not have feelings reflected and validated had placement prevented as compared to 88% (87.8) who received the intervention. For families where an emotional disturbance was present, however, the high incidence of receipt of this service and of placement prevention made it impossible to assess its differential impact.

These results show statistical significance when there was no family problem of substance abuse, parental mental illness, emotional disturbance or unmanageability. The results suggest that reflecting and validating feelings was not an appropriate intervention, at this time. Families faced with such problems may not have been emotionally or physically prepared to utilize this soft service due to having more immediate survival needs.

Providing encouragement to families is a vital service. One can speculate that such families have little to no trust in outsiders. The following tables illustrate the influence of encouragement to families contributed to placement prevention.

Table 48: Placement by Provides Encouragement

	<u>Provides Encouragement</u>				Total	
	No		Yes			
	N	%	N	%	N	%
Placement Prevented	72	84.7	30	96.8	102	87.9
Placement Occurred	13	15.3	1	3.2	14	12.1
Total	85	100.0	31	100.0	116	100.0

($\chi^2 = 3.117$, $df = 1$, $p < .08$)

In 85 % (84.7) of families whose records indicated that they were not provided with encouragement, placement was prevented, as compared to 97% (96.8) who with encouragement, placement was prevented, as compared to 97% (96.8) who did appear to

receive the service. Although these findings were not statistically significant, the trend is consistent with those of Fraser et al. (1991), that providing encouragement to families has a positive impact on placement prevention. The following tables will illustrate the association between this intervention, other family risks, and placement prevention.

Table 49: Placement by Provides Encouragement by Substance Abuse

	<u>Substance Abuse is a Problem</u>					
	<u>Provides Encouragement</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	22	68.8	16	94.1	38	77.6
Placement Occurred	10	31.3	1	5.9	11	22.4
Total	32	100.0	17	100.0	49	100.0

($\chi^2 = 4.104$, $df = 1$, $p < .05$)

Where substance abuse presented as a family problem, 69% (68.8) of families who did not receive encouragement had placement prevented as compared to 94% (94.1) of families who were provided with encouragement. This suggests an important role of encouragement for substance abusing families. It is safe to assume, that where families have substance abuse problems, enlisting the support of others can be vital to helping people address their treatment needs, take stock of their lives, and identify their role in the family system. On the other hand, for families where substance abuse was not a problem, there was no relationship between the receipt of encouragement and placement

prevention. The following table will illustrate the association between providing encouragement when parental mental illness is a risk factor.

Table 50: Placement by Encouragement by No Parental Mental Illness

	<u>Parental Mental Illness is Absent</u>					
	<u>Provides Encouragement</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	55	80.9	24	96.0	79	84.9
Placement Occurred	13	19.1	1	4.0	14	15.1
Total	68	100.0	25	100.0	93	100.0

($\chi^2 = 3.267$, $df = 1$, $p < .08$)

For families in which parental mental illness was not a problem, 81% (80.9) who did not receive encouragement as an intervention placement prevented as compared to 96% of families who received this service. These findings did not achieve statistical significance however. On the other hand, since all families with parental mental illness had placement prevented there was no way to assess its impact with these families.

Families who are referred for intensive services present with an array of problems that contribute to the family and household confusion- poverty, mental illness, childhood emotional and developmental disabilities, as well as substance abuse. A significant role for the family preservation worker is to enhance family stability.

consistency, and predictability through the creation of family rules, structure, and routine. Although the association between building in structure and placement prevention did not produce significant findings, when family risks were considered, placement prevention appears to be sensitive to this, particularly in single parent families.

Table 51: Placement by Building in Structure by Single Parent

<u>Single Parent Families</u>						
<u>Provide Structure and Daily Routine</u>						
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	4	57.1	38	86.4	42	82.4
Placement Occurred	3	42.9	6	13.6	9	17.6
Total	7	100.0	44	100.0	51	100.0

($\chi^2 = 3.548$, $df = 1$, $p < .06$)

On the other hand, where a single parent was the head of the household, 57% who did not have structure and daily routine established had placement prevented, as compared to 86%(86.4) who received this service. Although this finding fell short of statistical significance, it suggests that for single parent families, providing structure and daily routine, appears to be associated with placement prevention. For dual parent families, building in structure and daily routine was not associated with placement prevention.

Table 52: Placement by Building in Structure by No Status Offense

Status Offense is not Committed

Building in Structure

	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	6	75.0	40	83.3	46	82.1
Placement Occurred	2	25.0	8	16.7	10	17.9
Total	8	100.0	48	100.0	56	100.0

($\chi^2 = 3.429$, $df = 1$, $p < .07$)

For families where a youth had not committed a status offense, 75% of families who were not provided with assistance in creating structure and daily routine had placement prevented as compared to 83% who received the service. This finding was not statistically significant, but it does suggest a trend. On the other hand, for those where a status offense was committed, no relationship appears between building structure and daily routine and placement prevention. Children and/or adolescents, who have committed status offenses, may be less amenable to the imposition of any type of family structure that will inhibit their freedom, which may account for the lack of association between this intervention and placement prevention.

Discussing family progress prior to and at the time of termination can be a powerful assessment and validation tool. Individuals and families, alike, reflect on what circumstances brought them to intensive family preservation services, what were their

goals and objectives for treatment, what progress was made, and what is left to be done., Although FIP workers review family progress continuously, approximately two weeks prior to termination a more formal review is conducted, giving families a chance to take advantage of the intensive support and guidance for the remaining two weeks.

Table 53: Placement by Discussed Progress

	<u>Discusses Family Progress at Termination</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	15	75.0	87	90.6	102	87.9
Placement Occurred	5	25.0	9	9.4	14	12.1
Total	20	100.0	96	100.0	116	100.0

($\chi^2 = 3.808$, $df = 1$, $p < .06$)

In 75% of families who did not discuss family progress at the time of termination from FIP, placement was prevented, as compared to 91 % (90.6) of families who did not have a termination discussion. Table 54 illustrates the association between this intervention and substance abuse.

Table 54-a: Placement by Discussed Progress by No Substance Abuse

Substance Abuse is not Problem

Discusses Progress at Termination

	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	12	85.7	52	98.1	64	95.5
Placement Occurred	2	14.3	1	1.9	3	4.5
Total	14	100.0	53	100.0	67	100.0

($\chi^2 = 3.981$, $df = 1$, $p < .05$)

For families in which substance abuse was not a problem, 86% (85.7) of families who did not discuss progress at termination had placement prevented as compared to 98% of families who received this service.

Table 54-b: Placement by Discussed Progress by Substance Abuse

Substance Abuse is a Problem

Discusses Progress at Termination

	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	3	50.0	35	81.4	38	77.6
Placement Occurred	3	50.0	8	18.6	11	22.4
Total	6	100.0	43	100.0	49	100.0

($\chi^2 = 2.981$, $df = 1$, $p < .09$)

For families who had substance abuse problems, 50% did not discuss progress at termination and placement was prevented as compared to 81% of families who received this service. The association between the service and substance abuse was greater with those families who did not have this problem. It appears then that discussing progress at termination is more likely to be associated with prevention for non-substance abusing families.

Table 55: Placement by Discussed Progress by No Emotional Disturbance

	<u>Emotional Disturbance is Absent</u>					
	<u>Discusses Progress at Termination</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	5	55.6	40	88.9	45	83.3
Placement Occurred	4	44.4	5	11.1	9	16.7
Total	9	100.0	45	100.0	54	100.0

($\chi^2 = 6.000$, $df = 1$, $p < .05$)

For families where there was no diagnosis of emotional disturbance, 56% (55.6) of the families that did not discuss progress at termination had placement prevented as compared 89% of families that received the service. However, for families where emotional disturbance was present, there was no relationship between these two variables. The following table will illustrate the service, gives advice or direction, in association to children who were referred for reasons of unmanageable behaviors.

Table 56: Placement by Gives Advice or Direction by Unmanageability

	<u>Unmanageability</u>					
	<u>Gives Advice or Direction</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	5	62.5	40	88.9	95	84.9
Placement Occurred	3	37.5	5	11.1	8	15.1
Total	8	100.0	45	100.0	53	100.0

($\chi^2 = 3.691$, $df = 1$, $p < .06$)

In families where the reason for referral was unmanageability, 63% (62.5) who were not provided with advice and direction had placement prevented as compared to 89% who received the service. In an attempt to further analyze whether an association existed between the provision of soft services and placement outcomes, a one-tailed independent samples t-test was conducted using the scales based on Berry's typology (1996) and Fraser et al's typology (1997). The following tables will report the associations found.

Table 57: Placement by Scale of Soft Services by Berry

	M	SD	t	p
Placement Prevented	47.41	8.69	2.189	0.016
Placement Occurred	41.79	11.28		

A mean score of 47.41 was received for soft services received by families where placement was prevented as compare to a mean score of 41.79 for families where placement occurred. These findings are statistically significant at $p < .05$ level indicating that the receipt of soft services was predictive of placement prevention. The results using Fraser et al's typology of marital and family interventions are shown below.

Table 58: Placement by Scale of Family Interventions by Fraser et al

	M	SD	t	P
Placement Prevented	27.44	5.35	1.807	0.037
Placement Occurred	24.64	6.02		

A mean score of 27.44 was found for marital and family interventions received by families where placement was prevented as compared to a mean score of 24.64 where placement occurred. These findings were statistically significant at $p < .05$ level, indicating that the receipt of marital and family interventions was not only predictive of placement prevention, but where placement was prevented, families were in receipt of more soft services.

Summary

Soft or clinical services typically, have not been found to be associated with placement prevention (Berry, 1997). However, in the present study, when specific soft services were specified relative to family risk factors and placement prevention, couples counseling, reflect and validate, and provide encouragement were predictive of placement prevention

when substance abuse was a problem. Couples counseling was also predictive of placement prevention when emotional disturbance was a risk, as building in structure and daily routine was similarly predictive of placement prevention when associated with single parent families.

More telling was the positive association found between the scale of soft services/marital and family interventions and placement prevention. These findings suggest that the services, couples counseling, reflect and validation of feelings, providing encouragement, and building in structure and daily routine have in common modeling and reinforcing positive family interaction, which in the long run may contribute to placement prevention. Additionally, with those children who were referred by the Mandated Prevention Unit, couples counseling was associated with placement prevention. Similarly, when children were referred for unmanageable behaviors, advice giving appears to be positively associated with placement prevention.

To illustrate the importance that FIP places on soft services, the director of FIP explained, "When we work with a family, we have an I-Thou relationship with the family, other service providers, and each other. We are in this relationship together and it is the importance of the relationship that allows us to be successful with multi-problem families. If there is a confrontation, we do whatever we can to bridge the relationship and build it back up. We do not judge families; it is about working together and showing

them that we truly care. Respecting each client and their integrity is the core philosophy of our program.”

Skill building Activities

Another dimension of the soft services is referred to as skill-building activities (Fraser et al., 1997) or "psycho educational" services. These services combine psychotherapeutic and social learning approaches in an effort to teach families new methods of handling day-to-day activities, parenting issues, and family problems (Kinney et al., 1991). These services constitute approximately 6.2% of the 112 clinical interventions or soft services, routinely provided by the FIP workers. An average of 8 (8.2) skill-building activities were provided per family. Table 59 illustrates the variety of skill-building interventions and the frequency with which they were provided.

Table 59: Frequency of Skill Building Activities (N=116)

Intervention	N	%	M	SD
Teaches parenting skills	101	87.1	0.87	0.34
Teaches social skills	93	80.2	0.20	0.40
Teaches token system	87	75.0	0.25	0.43
Teaches time out	86	74.1	0.26	0.44
Teaches communication skills	77	66.4	0.66	0.47
Provides information on child development	76	65.5	0.66	0.48
Teaches relaxation skills	75	64.7	0.35	0.48
Teaches anger management	74	63.8	0.64	0.48
Teaches child management skills	72	62.1	0.62	0.49
Teaches problem-solving skills	72	62.1	0.51	0.50
Provides literature	69	59.5	0.41	0.49
Teaches through role-playing	64	55.2	0.45	0.50
Behavioral rehearsal	47	40.5	0.45	0.50
Teaches use of leisure time	45	38.8	0.39	0.49
Teaches home management skills	33	28.4	0.28	0.45
Teaches assertiveness and advocacy	28	24.1	0.24	0.43
Teaches sex education	25	21.6	0.22	0.41

Consistent with findings of Fraser et al. (1991), skill building services which were predictive of placement prevention included teaching parenting skills, problem solving

skills, and teaching through role-play.. The following tables illustrate the possible impact of these skill-building activities on placement prevention.

Table 60: Placement by Teaches Problem-Solving

	<u>Teaches Problem-Solving</u>				Total	
	No		Yes		N	%
	N	%	N	%	N	%
Placement Prevented	46	80.7	56	94.9	102	87.9
Placement Occurred	11	19.3	3	5.1	14	12.1
Total	57	100.0	59	100.0	116	100.0

($\chi^2 = 5.519$, $df = 1$, $p < .05$)

In 81% (80.7) of families who did not receive teaches problem-solving skills training, placement was prevented as compared to 95% (94.9) of families who received this service. The following table illustrates the findings of this service as associated with parental mental illness.

Table 61: Placement by Teaches Problem-Solving by No Parental Mental Illness

Mental Illness is Absent

Teaches Problem-Solving Skills

	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	39	78.0	40	93.0	79	84.9
Placement Occurred	11	22.0	3	3.0	14	15.1
Total	59	100.0	43	100.0	93	100.0

($\chi^2 = 4.080$, $df = 1$, $p < .05$)

In families where parental mental illness was absent, for 78% who were not taught problem-solving skills has placement prevented, as compared to 93% families who were taught problem solving skills.

Table 62: Placement by Teaches Problem-Solving by Substance Abuse

Substance Abuse is Present

Teaches Problem-Solving

	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	13	61.9	25	89.3	38	77.6
Placement Occurred	8	38.1	3	10.7	11	22.4
Total	21	100.0	28	100.0	49	100.0

($\chi^2 = 5.168$, $df = 1$, $p < .05$)

For families where substance abuse was a problem, 62% of families who did not receive problem-solving skill training had placement prevented as compared to 89% who were taught problem-solving skills. In contrast, for families where substance abuse was not a problem, there was no significant association between skill training and placement prevention. The following table illustrates that problem solving was associated with placement prevention when the identified child was diagnosed with an emotional disturbance.

Table 63: Placement by Teaches Problem-Solving by Emotional Disturbance

	<u>Emotional Disturbance is Present</u>					
	<u>Teaches Problem Solving</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	25	83.3	32	100.0	57	91.9
Placement Occurred	5	16.7	-	-	5	8.1
Total	30	100.0	32	100.0	62	100.0

($\chi^2 = 5.801$, $df = 1$, $p < .05$)

For families where a child had an emotional disturbance, 83 % (83.3) who were not taught problem-solving skills had placement prevented as compared to 100% of those families who were taught problem solving skills. For families with a child who was not diagnosed with an emotional disturbance, 78% (77.8) who were not taught problem-solving skills had placement prevented as compared to 89%(88.9) who received the

intervention. This relationship was not statistically significant. The following tables shows findings when a child committed a status offense.

Table 64: Placement by Teaches Problem-Solving by Status Offense

	<u>Committed Status Offense</u>					
	<u>Teaches Problem Solving Skills</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	23	74.2	23	92.0	46	82.1
Placement Occurred	8	25.8	2	8.0	10	17.9
Total	31	100.0	25	100.0	56	100.0

($\chi^2 = 2.991$, $df = 1$, $p < .09$)

A non-significant trend worth noting was found for families in which there was a status offense committed by the identified child. In these families 74 % (74.2) of those who were not taught problem-solving skills had placement prevented as compared to 92% who were taught problem solving skills. On the other hand, for families with a child who had not committed a status offense, 89% of those who did not receive problem-solving skills had placement prevented, as compared to 97% who received problem-solving skills. This relationship was not statistically significant, however. A similar differential response was identified when receipt of problem solving training was analyzed by family composition. The following tables will illustrate the findings.

Table 65-a: Placement by Teaches Problem-Solving by Dual Parent

	<u>Dual Parent</u>					
	<u>Problem Solving Skills Taught</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	28	87.5	32	97.0	60	92.3
Placement Occurred	4	12.5	1	3.0	5	7.7
Total	32	100.0	33	100.0	65	100.0

($\chi^2 = 2.052$, $df = 1$, $p = N.S.$)

In two parent families, 88% (87.5) who were not taught problem-solving skills had placement prevented as compared to 97% who received the service. This difference was not statistically significant.

Table 65-b: Placement by Teaches Problem-Solving by Single Parent

	<u>Single Parent</u>					
	<u>Problem Solving Skills Taught</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	18	72.0	24	92.3	42	82.4
Placement Occurred	7	28.0	2	7.7	9	17.6
Total	25	100.0	26	100.0	51	100.0

($\chi^2 = 3.617$, $df = 1$, $p < .06$)

By contrast, a stronger trend was shown in single-parent households. This table shows that for 72% of single parent families who were not taught problem solving skills had placement prevented, as compared to 92% who were in receipt of this intervention. This finding fell just short of statistical significance. Teaching problem-solving skills appears to be associated with placement prevention when correlated to family risks, especially, single parent families, substance abuse, commitment of a status offense, and the emotional disturbance of a child. These family problems which are complicated by families living on the edge of poverty, as many of these families are; who have less familial and other informal supports; and who admittedly have fewer skills in understanding emotional illness or family substance abuse. These results are promising and speak to the skill of the FIP worker, as well as the family's commitment to preserving their family system.

The teaching of parenting skills and child development, which includes teaching age appropriate care, expectations, and nurturance, is another activity, which intensive family preservation workers concentrate on with families. Although, in general, the association between teaching parenting skills and placement prevention is not significant, when the intervention is associated with family composition and commitment of a status offense, there does appear to be an association.

Table 66: Placement by Teaches Parenting Skills by Dual Parent

	<u>Dual Parent Family</u>					
	<u>Teaches Parenting Skills</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	7	77.8	53	94.6	60	92.3
Placement Occurred	2	22.2	3	5.4	5	7.7
Total	9	100.0	56	100.0	65	100.0

($\chi^2 = 3.106$, $df = 1$, $p < .08$)

This table shows that where two parents head families, 78 % (77.8) who were not taught parenting skills had placement prevented as compared to 95 % (94.6) who were taught parenting skills. This trend does not achieve the .05 level of significance though it is worth noting. In single parent families, there was no association between being taught parenting skills and placement prevention. The following tables illustrate parenting skill training and its association with placement prevention with commitment of a status offense.

Table 67: Placement by Teaching Parenting Skills by No Status Offense

	<u>Status Offense not Committed</u>					
	<u>Teaches Parenting Skills</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	8	72.7	48	98.0	56	93.3
Placement Occurred	3	27.3	1	2.0	4	6.7
Total	11	100.0	49	100.0	60	100.0

($\chi^2 = 9.192$, $df = 1$, $p < .01$)

For families where a status offense was not committed, 73 % (72.7) of those who were not taught parenting skills, placement was prevented as compared to 98% who were taught these skills. The next table will illustrate the results for families where a child had committed a status offense. For families where a status offense was committed, parenting skill training does not appear to be significantly associated with placement prevention when a child has committed a status offense.

The last skill-building intervention that appears to have an association to placement prevention will be discussed in the following tables. In teaching families through role-play the worker and parents may practice through acting out such day to day issues as, how to discipline, set limits with children or praise them, and how to model appropriate responses. In addition, teens may role-play how to respond to peer pressure and couples

may role-play how to discuss a stressful subject, all with the intent of trying out new and improved behaviors. In the case of substance abuse, family composition and status offenses, this intervention was associated with placement prevention. The following tables illustrate these findings.

Table 68: Placement by Teaches Through Role-Play

	<u>Teaches through Role-Play</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	53	82.8	49	94.2	102	87.9
Placement Occurred	11	17.2	3	5.8	14	12.1
Total	64	100.0	52	100.0	116	100.0

($\chi^2 = 3.525$, $df=1$, $p < .07$)

In 83 % (82.8) of families who did not receive instruction through role-play, placement was prevented as compared to 94 % (94.2) who were taught through role-playing activities. However, this trend was not statistically significant. The following table will illustrate findings when substance abuse is a problem.

Table 69: Placement by Teaches Through Role-Play by Substance Abuse

	<u>Substance Abuse is a Problem</u>					
	<u>Teaches Through Role-Play</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	17	65.4	21	91.3	38	77.6
Placement occurred	9	34.6	2	8.7	11	22.4
Total	26	100.0	23	100.0	49	100.0

($\chi^2 = 4.710$, $df = 1$, $p < .05$)

In families with substance abuse problems, 65 % (65.4) who were not taught through role-play had placement prevented as compared to 91% who received this intervention. This suggests that teaching through role-play is especially effective with substance abusing families. However, for families with no substance abuse problems, a relationship did not exist between taught through role-play and placement prevention. The following table will illustrate findings when this service is associated with the commitment of a status offense.

Table 70: Placement by Teaches Through Role-Play by Status Offense

	<u>Status Offense Committed</u>					
	<u>Teaches Through Role-Play</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	25	73.5	21	95.5	46	82.1
Placement Occurred	9	26.5	1	4.5	10	17.9
Total	34	100.0	22	100.0	56	100.0

($\chi^2 = 4.377$, $df = 1$, $p < .05$)

For families with children who committed a status offense, 74% (73.5) of those who had not been taught new behaviors through the use of role-play had placement prevented as compared to 96% (95.5) who had received this intervention. On the other hand, in families where there was no status offense committed, there was no relationship between being taught through role-play and placement prevention. Education through role-play also had significant results in single parent families as will be illustrated in the following tables.

Table 71: Placement by Teaches Through Role-Play by Single Parent

	<u>Single Parent</u>					
	<u>Teaches through Role-Play</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	18	72.0	24	92.3	42	100.0
Placement Occurred	7	28.0	2	7.7	9	17.6
Total	25	100.0	26	100.0	51	100.0

($\chi^2 = 3.617$, $df = 1$, $p < .06$)

In single parent families, 72% of those who were not taught through role-play had placement prevented as compared to 92 % (92.3) of single parent families who were taught through role-play. This trend falls just shy of statistical significance. By contrast, for dual parented families, teaching through role-play had no association with placement prevention.

There are a number of skill building activities that are provided to families. The analysis of these services relative to family risk and placement prevention indicate that teaching problem solving skills, parenting skills, and teaching through role-play are important in placement prevention. To further analyze if skill-building activities might be associated with placement prevention, a one-tailed independent sample t-test was conducted using Fraser et al (1997) typology of services. Table 72 illustrates the findings.

Table 72: Placement by Skill Building Scale by Fraser et al

	M	SD	t	P
Placement Prevented	8.51	3.86	.220	.014
Placement Occurred	6.07	3.83		

A mean score of 8.51 was found for skill-building services received by families who had placement prevented as compared to a mean score of 6.07 for families where placement occurred. These findings were statistically significant at $p < .05$ level, indicating that the receipt of skill-building services was predictive of placement prevention.

These findings strongly support the value of skill-building activities as a means to assisting families in the mastery of day to day activities, in achieving greater emotional and behavioral self-control and management, in improving social and communication skills, in gaining a more comprehensive understanding of child development needs, as well as child management and problem solving. Additionally, the association between skill-building activities and placement prevention are consistent with those of Fraser, Pecora, and Haapala (1991) in their evaluation of the Homebuilders programs. In the next section, empowerment interventions will be addressed.

Empowerment Interventions

Engaging clients in the treatment process is particularly difficult, and more so when a family is at risk of losing a child to substitute care. As a result, intensive family preservation workers focus on engagement at the beginning of services by building services around treating clients as colleagues throughout the service period. Their entry into the home is defined as a working partnership in the identification and attainment of goals. Goal setting, a cornerstone of intensive family preservation practice, is accomplished with the family's charge and is individualized according to family strengths and needs. This approach to and respect of clients contributes to the high level of client engagement (Berry, 1997).

The director of FIP director confirms that adhering to an empowerment approach to working with families allows workers to make better connections. He also acknowledged that in general, the service community at large is assuming a strengths-based approach to family work. Empowerment approaches had become more commonplace and were being used successfully. Therefore, he implied that a more coordinated treatment philosophy and approach was being delivered to families in the child welfare service system in Ulster County.

Every family in this sample received some type of empowerment intervention with 86% (86.3) of families served receiving 10 to 15 empowerment interventions. These services

are described as empowerment services (Fraser, et al., 1997) and in the intensive family preservation literature are considered a subcategory of soft services (Berry, 1997). Table 73 depicts the frequency with which specific empowerment practices were provided.

Table 73: Frequency of Empowerment Interventions

Empowerment Practice	N	%	M	SD
Explores problems	116	100	1	0
Focus and define problems	113	97.4	0.97	0.16
Define obstacles to task achievement	112	96.6	0.97	0.29
Identify family strengths	110	94.8	0.92	0.22
Discuss problem impact on health	110	94.8	0.95	0.22
Generate action plan	108	93.1	0.93	0.25
Contracting and negotiating	106	92.2	0.91	0.29
Discusses future hopes and goals	92	79.3	0.79	0.41
Explores family coping skills	92	79.3	0.79	0.41
Solution-focused services	82	70.7	0.29	0.46
Explore family respect and support	77	66.4	0.66	0.47
Develops behavioral contracts	71	61.2	0.61	0.49
Explore religion and spirituality	65	56.0	0.56	0.50
Draws genograms	10	8.6	0.86	0.28
Draws eco-maps	5	4.3	0.43	0.20

In contrast to other studies (Fraser, et al., 1991; Pecora, et al., 1991; Berry, 1997, 1994, 1992) which have explored services, the present study found several empowerment services to be associated with placement prevention, including solution-focused interventions, generating action plans, and identifying family strengths. Solution-focused interventions can be characterized as “goal driven” problem-solving techniques focused on the generation of solutions by family members. Some of the specific interventions that were used by FIP include the “scaling question”, which is an assessment tool; the “pink elephant” which is a reframing tool, and compliments, which utilize language to identify and reinforce client strengths. The following tables illustrate these associations.

Table 74: Placement by Solution-Focused Services

	<u>Solution-Focused Services Provided</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	69	84.1	33	97.1	102	87.9
Placement Occurred	13	15.9	1	2.9	14	12.1
Total	82	100.0	34	100.0	116	100.0

$(\chi^2 = 3.776, df = 1, p < .06)$

In 84 % (84.1) of families who did not receive solution- focused services, placement was prevented as compared to 97 %(97.1) of families who received solution-focused services. This trend fell just short of statistical significance. Families referred by mandated prevention, where a child had committed a status offense, as well as families

where parental mental illness was absent seemed to be responsive to solution-focused interventions.

Table 75: Placement by Solution-Focused Services by Mandated Prevention

	<u>Mandated Prevention</u>		<u>Solution- Focused Services</u>		<u>Total</u>	
	<u>No</u>		<u>Yes</u>			
	N	%	N	%	N	%
Placement Prevented	44	81.5	31	96.9	75.0	87.2
Placement Occurred	10	18.5	1	3.1	11	12.8
Total	54	100.0	32	100.0	85	100.0

($\chi^2 = 4.268$, $df = 1$, $p < .05$)

In families who were referred by Mandated Prevention 82 % (81.5) who did not receive solution-focused services had placement prevented as compared to 97% (96.9) of families who received the service.

Table 76: Placement by Solution-Focused Services by Status Offense

	<u>Status Offense Committed</u>				<u>Solution-Focused Services</u>	
	<u>No</u>		<u>Yes</u>		<u>Total</u>	
	N	%	N	%	N	%
Placement Prevented	27	73.0	19	100.0	46	82.1
Placement Occurred	10	27.0	-	-	10	17.9
Total	37	100.0	19	100.0	56	100.0

($\chi^2 = 6.251, df = 1, p < .05$)

For families where a child committed a status offense, 73% who were not provided with solution-focused interventions placement was prevented as compared to 100% who received the service. The two previous tables address children from the same population, those who have behavior problems at home, at school and in the community. Thus these findings are quite impressive and support the effectiveness of the short-term, family empowerment perspective that solution focused interventions embody. These outcomes are particularly interesting in light of the results of other studies which report a lack of success with children who have committed status offenses and have been adjudicated delinquent (Fraser, et al., 1991). However, for families where a child had not committed a status offense, solution focused services were not associated with placement prevention.

Table 77: Placement by Solution-Focused by No Parental Mental Illness

	<u>Parental Mental Illness is Absent</u>					
	<u>Solution- Focused Services</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	53	80.3	26	96.3	79	84.9
Placement Occurred	13	19.7	1	3.7	14	15.1
Total	66	100.0	27	10.0	93	100.0

($\chi^2 = 3.833$, $df = 1$, $p = .05$)

In families where parental mental illness was absent, 80% who did not receive solution-focused services had placement prevented as compared to 96 % (96.3) of families who received this intervention. In contrast, in families where parental mental illness was present, solution focused services had no differential impact on placement prevention.

Identifying family strengths is a core ingredient of intensive family preservation service delivery, thus moving away from a diagnosis and problem orientation. When identification of family strengths was analyzed relative to placement prevention, no significant association was found. However, when considered in the context of families where substance abuse was a family risk and in the case of children who had not committed a status offense, it emerged as associated with placement prevention. The following tables will illustrate these findings.

Table 78: Placement by Identifies Strengths by Substance Abuse

	<u>Substance Abuse is a Problem</u>		<u>Identifies Family Strengths</u>		Total	
	No		Yes			
	N	%	N	%	N	%
Placement Prevented	-	-	38	79.2	38	77.6
Placement Occurred	1	100.0	10	20.8	11	22.4
Total	1	100.0	48	100.0	49	100.0

($\chi^2 = 3.527$, $df = 1$, $p = .06$)

When substance abuse was a problem, the only family that did not receive this intervention required placement, as compared to 79% of those who together with their worker identified family strengths. On the other hand, when substance abuse was not a family problem, there was no association between the identification of family strengths and placement prevention.

Table 79: Placement by Identifies Strengths by No Status Offense

	<u>Status Offense Not Committed</u>					
	<u>Identifies Family Strengths</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	2	66.7	54	94.7	56	93.3
Placement Occurred	1	33.3	3	5.3	4	6.7
Total	3	100.0	43	100.0	60	100.0

($\chi^2 = 3.609$, $df = 1$, $p < .06$)

This table illustrates how for families where no status offense was committed, 67% of families who did not identify family strengths in the treatment process had placement prevented as compared to 95% (94.7) who identified family strengths. This trend was slightly less than statistically significant. On the other hand, in families where a status offense was committed, there was no trend noted between identification of family strengths and placement prevention.

The process of family members brainstorming and negotiating necessary and desired behavioral changes can be a powerful and empowering tool toward improving family communication and general healing. Behavioral contracting, although not significant when associated with placement alone, appears to be associated with placement prevention for families with children presenting with emotional disturbance, as the next table illustrates.

Table 80: Placement by Behavioral Contracting by No Emotional Disturbance

	<u>Emotional Disturbance is Absent</u>					
	<u>Behavioral Contracting</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	20	74.1	25	92.6	45	83.3
Placement Occurred	7	25.9	2	7.4	9	16.7
Total	27	100.0	27	100.0	54	100.0

($\chi^2 = 3.333$, $df = 1$, $p < .07$)

In families where a child is not diagnosed with an emotional disturbance.

74 %(74.1) who did not utilize behavioral contracting had placement prevented, as compared to 93 %(92.6) of families who received this service. This trend was not statistically significant however. In contrast, for families where a child was diagnosed with an emotional disturbance that was no association between behavioral contracting and placement prevention. This service may not be as useful to parents with emotionally disturbed children who need more immediate action and care.

The empowering intervention, which appears to have the most influence on placement prevention, is the generation of action plans. This service entails a rapid assessment of the situation and an immediate response by assigning tasks to both family members and worker. The following tables will show the findings of this service as associated with

referral source, substance abuse, family composition, status offenses, emotional disturbance, and parental mental illness.

Table 81: Placement by Generates Action Plan

	<u>Generates Action Plan</u>				Total	
	No		Yes		N	%
	N	%	N	%	N	%
Placement Prevented	4	50.0	98	90.7	102	87.9
Placement Occurred	4	50.0	10	9.3	14	12.1
Total	8	100.0	14	100.0	116	100.0

($\chi^2 = 11.649$, $df = 1$, $p < .05$)

In 50% of families who did not participate in generating an action plan, placement was prevented as compared to 91 % (90.7) of those who did generate an action plan together with their worker.

Table 82: Placement by Generates Action Plan by Mandated Prevention

	<u>Mandated Prevention</u>					
	<u>Generates Action Plan</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	3	50.0	72	90.0	75	87.2
Placement Occurred	3	50.0	8	10.0	11	12.8
Total	6	100.0	80	100.0	86	100.0

($\chi^2 = 8.006$, $df = 1$, $p < .01$)

Families who were referred by mandated prevention, 50% who did not generate an action plan with their worker had placement prevented as compared to 90% who received the service.

Table 83-a: Placement by Generates Action Plan by Dual Parent

	<u>Dual Parent Family</u>					
	<u>Generate Action Plan</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	2	50.0	58	95.1	60	92.3
Placement Occurred	2	50.0	3	4.9	5	7.7
Total	4	100.0	61	100.0	65	100.0

($\chi^2 = 10.745$, $df = 1$, $p < .01$)

In dual parented families, 50% of those who did not generate action plans had placement prevented as compared to 95% who received this service.

Table 83-b: Generates Action Plan by Single Parent

	<u>Single Parent Family</u>					
	<u>Generates Action Plan</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	2	50.0	40	85.1	42	82.4
Placement Occurred	2	50.0	7	14.9	9	17.6
Total	4	100.0	47	100.0	51	100.0

($\chi^2 = 3.126$, $df = 1$, $p < .08$)

A similar, but non-significant trend was noted in single parent families. In these families, 50% of those who did not generate action plans had placement prevented as compared to 85 % (85.1) who received this service. Thus, generation of action plans appears to be associated with placement prevention in all families, dual and single-parented alike.

Virtually all families in which substance abuse was absent participated in the generation of action plans. Therefore no association could be found between this intervention and placement prevention for this population. However, when substance abuse was a family problem this intervention appears to be associated with placement prevention.

Table 84: Placement by Generates Action Plan by Substance Abuse

	<u>Substance Abuse is Present</u>					
	<u>Generates Action Plan</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	2	33.3	36	83.7	38	77.6
Placement Occurred	4	66.7	7	16.3	11	22.4
Total	6	100.0	43	100.0	49	100.0

($\chi^2 = 7.679$, $df = 1$, $p < .01$)

When substance abuse was a problem, 33 % (33.3) of the families who did not generate action plans had placement prevented as compared to 84 % (83.7) who did engage in this service.

In the case of families where a child had not committed a status offense, all of these families generated an action plan with their worker making it impossible to consider its association with placement prevention. These findings were in direct contrast when a child committed a status offense, as the following table will illustrate.

Table 85: Placement by Generates Action Plan by Status Offense

	<u>Status Offense was Committed</u>					
	<u>Generates Action Plan</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	4	50.0	42	87.5	46	82.1
Placement Occurred	4	50.0	6	12.5	10	17.9
Total	8	100.0	48	100.0	56	100.0

($\chi^2 = 6.574$, $df = 1$, $p < .05$)

In 50% of those families where a status offense was committed, those who did not generate an action plan with their worker, had placement prevented as compared to 88 % (87.5) of those who did generate an action plan.

Table 86-a: Placement by Generates Action Plan by No Emotional Disturbance

	<u>Emotional Disturbance is Absent</u>					
	<u>Generates Action Plan</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	1	33.3	44	86.3	45	83.3
Placement Occurred	2	66.7	7	13.7	9	16.7
Total	3	100.0	51	100.0	54	100.0

($\chi^2 = 5.718$, $df = 1$, $p < .05$)

For those families where emotional disturbance was not a problem, 33 %(33.3) who did not generate an action plan with their worker had placement prevented as compared to 86 %(86.3) who recieved this service.

Table 86-b: Placement by Generates Action Plan by Emotional Disturbance

	<u>Emotional Disturbance is Present</u>					
	<u>Generates Action Plan</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	3	60.0	54	94.7	57	91.9
Placement Occurred	2	40.0	3	5.3	5	8.1
Total	5	100.0	57	100.0	62	100.0

($\chi^2 = 7.481$, $df = 1$, $p < .01$)

Likewise, in families where emotional disturbance was a problem, 60% of those who did not generate an action plan with their worker had placement prevented as compared to 95% who received this service.

Table 87: Placement by Generates Action Plan by No Mental Illness

	<u>Mental Illness is Absent</u>					
	<u>Generates Action Plan</u>					
	No		Yes		Total	
	N	%	N	%	N	%
Placement Prevented	3	42.9	76	88.4	70	84.9
Placement Occurred	4	57.1	10	11.6	14	15.1
Total	7	100.0	86	100.0	93	100.0

($\chi^2 = 10.487$, $df = 1$, $p < .01$)

To further analyze the association between empowerment services as a group and placement prevention, a one-tailed independent samples t-test was conducted using the empowerment scales of Fraser et al(1997) and Berry (1997). The following tables show the findings.

Table 88: Placement by Summated Scale of Empowerment Services by Fraser

	M	SD	t	p
Placement Prevented	12.08	2.17	1.801	0.037
Placement Occurred	10.93	2.73		

A mean score of 12.08 was found for empowerment services received by families where placement was prevented as compared to a mean score of 10.93 for families where placement occurred. These findings were statistically significant at $p < .05$ level, indicating that the receipt of empowerment services was predictive of placement

prevention. In contrast, Berry's (1997) empowerment services did not indicate an association with placement prevention, as the following table illustrates.

Table 89: Placement by Scale of Empowerment Services by Berry

	M	SD	t	p
Placement Prevented	5.55	1.78	0.778	0.269
Placement Occurred	5.14	2.21		

A mean score of 5.55 was received for empowerment services by families who had placement prevented as compared to a mean score of 5.14 for those families where placement occurred. These findings did not achieve statistical significance, indicating that the receipt of empowering services using Berry's scale was not predictive of placement prevention.

Summary

Empowerment services may also be referred to as family strengths and resiliency interventions, under the larger rubric of soft or clinical services (Berry, 1996 and Fraser et al 2001). To analyze the relationship between this scale and placement prevention, a Pearson chi square test was conducted and showed a statistically significant relationship existed between placement prevention and empowerment services ($\chi^2=12.836$, $df=7$, $p<.08$), suggesting that placement prevention is sensitive to the empowerment interventions. Of the four-empowerment services, generating an action plan seems to be most closely associated with placement prevention.

Crisis Intervention Services

All families referred to FIP were at risk of imminent placement, as identified by both the referral agent and the FIP director. The occurrence of crisis events is common for families struggling with mental illness, poverty, homelessness, domestic violence and child endangerment. Round the clock availability permits a window of opportunity for treatment engagement and change to become a reality, especially during a crisis. Of the 116 families in this sample, 93% received crisis intervention services. However, none of the particular crisis interventions were predictive of placement prevention. Table 90 provides frequency information for all crisis services provided to families.

Table 90: Frequency of Crisis Services Provided

Intervention	N	%	M	S.D
Encourages client to call during crisis	101	87.1	0.87	0.34
Provides structure during crisis	88	75.9	0.76	0.43
Suicide Assessment and Recognition	30	25.9	0.26	0.44
Crisis card	3	2.6	0.25	0.16

The crisis services are subsumed under the rubric of soft services. A one-tailed independent samples t-test did not find a statistically significant association between the provision of crisis intervention services and placement prevention.

Tailoring Services to Meet Family Needs - The Creative Services

The enrichment of the family and their coping resources can be accomplished formally by linking a family to daycare, respite or mental health services, providing couple counseling, or crisis intervention. Equally important are less tangible resources, such as those that build a client's sense of competency, self-esteem, patience, motivation and interest in the world. The "data mining" process also revealed a variety of non-traditional interventions provided to FIP families. These activities were designed to fit the specific needs, strengths, and desires of each individual family member and the family as a whole. The following table reports interventions that were provided more than one time, however, there were a number of interventions that were provided to a specific family just once, including teaching a child yoga, meditation, or tai chi, taking a family on a window-shopping excursion to the mall, going to a museum, church, or on a foot race together. These "creative" interventions exemplify the family preservation philosophy of "doing whatever it takes" to meet family needs. Although the tailoring of services is a hallmark of intensive family preservation services, none of the following services was associated with placement prevention.

Table 91: Frequency of “Creative Therapies”

Intervention	%	N
Painting, drawing, sculpting	36.2	42
Indoor and outdoor games	35.3	41
Preparing dinner together	12.9	15
Hiking and walking	12.9	15
Caring for animals/pets	3.4	4
Making a garden	3.4	4
Affirmations and chanting	2.6	3
Photography	2.6	3
Talking stick	1.7	2

Summary

The findings reported in this section confirm the eclectic, diverse, and wide-ranging nature of services provided by FIP. There was a high usage of an array of soft services. The mean number of soft services provided per family was 47. This average exceeded that which was reported by Lewis (1991). The soft services provided a heavy concentration of psychotherapeutic techniques, as well as a substantial number of “skill building” or psycho-educational interventions, empowerment interventions, and crisis intervention services. The enabling services provided to families most often, which bridge the gap between the soft and hard services (Berry, 1997) were advocacy with social services, schools, courts, and landlords, followed by accompaniment of clients to service

organizations. It was encouraging that all families received some type of support to facilitate linkages with both formal and informal support systems.

Utilizing Berry's service scale, families that remained intact received 7 more of all types of services per intervention period than those families who had a child placed in care. Those who experienced a placement received fewer soft/clinical services, in particular. These results were consistent with Fraser's typology, where it was found that families experiencing child removals received fewer services overall, and particularly fewer family and marital interventions. All categories of service were provided slightly more often to families that remained intact than to those families who experienced a child removal. One can speculate that families who had a child placed may have been less receptive to the intensive nature of services, or given that the treatment period was cut short by placement, fewer services could be provided.

In contrast to these findings, Berry (1994) examined a subset of 116 cases for the provision of services and placement and reported that the softer/clinical services were provided in greater amounts (though not significantly) to families who subsequently had a child placed. The services which were least effective and were provided most often, were assessment, counseling, crisis intervention, and legal help. These same families were most likely to have a child placed.

Families were most likely to remain intact when enabling and concrete services were provided. In particular, modeling parenting skills and acquiring household resources were

at the top of the list. Studies conducted by Fraser, Pecora and Lewis (1991) and Berry, Cash and Brook (2000) report that the provision of concrete services significantly reduced the risk of placement. In both studies, an association was drawn between the intensity of treatment time in the home and the non-placement of children. The number of hours spent in the home was not a variable this study examined, due to the absence of this information in the record. However, it was apparent from the case notes, that practitioners were making daily home visits, excepting weekends, unless an emergency occurred.

Again, a one-tailed independent samples t-test was conducted to determine the overall impact of intensive family preservation services on placement prevention. In utilizing Berry's (1997) scale and Fraser et al's (1997) scale, the findings indicate that a positive association exists between the provision of services and placement prevention, as the following tables will illustrate.

Table 92: Placement by All Berry's (1997) Services

	M	SD	t	p
Placement Prevented	57.7	9.68	2.566	0.006
Placement Occurred	50.29	13.15		

A mean score of 57.70 was received for all services by families where placement was prevented as compared to a mean score of 50.29 for families where placement occurred.

These findings were statistically significant at $p < .01$, indicating that the receipt of intensive family preservation services was predictive of placement prevention.

Table 93: Placement by All Fraser et al. Services

	M	SD	t	p
Placement Prevented	57.76	10.13	2.451	0.008
Placement Occurred	50.43	13.03		

A mean score of 57.76 was received for all services by families where placement was prevented as compared to a mean score of 50.43 for families where placement occurred. As in the Berry findings, statistical significance was achieved at a $p < .01$ level, indicating that the receipt of intensive family preservation services was predictive of placement prevention.

Discussion of the Core Elements of Service

Both the general public and human service decision makers demand that programs produce effective outcomes in the delivery of services to clients (Berry, 1997). Effectiveness in the field of family preservation has been operationally defined as the prevention of child placement (Feldman, 1991; Kinney, Haapala and Booth, 1991; Nelson, Landsman and Deutelbaum, 1990; Pecora, Fraser and Haapala, 1991; Schwartz, AuClaire, and Harris, 1991). Although experts in the field feel that far too much research emphasis has been focused on placement prevention as the primary outcome indicator of program success (Berry, 1996; Besharov and Bachler, 1992; Fraser

et al., 1991; Rossi, 1992a; Scannapieco, 1992; Wells and Biegel, 1991, 1992), it continues to be an essential element to be evaluated relative to service delivery, particularly for program planners, policy-makers, and practitioners.

Information contained in the FIP case records indicated that approximately 88 % (87.9) of families served were intact at case closure. This finding was consistent with the results of Berry's study (1994) where a placement prevention rate of 86% was achieved. Likewise, an 89% placement prevention rate was achieved in the study conducted by Berry, Cash and Brook (2000). Pecora, Fraser, Bennett, and Haapala (1991), reported similar results, an 85% placement prevention rate was achieved in the program under study. Comparable results were reported by Schwartz, Au Claire, and Harris (1991), a 91 % placement prevention rate was found in the population they studied. As in the aforementioned studies, FIP did not have information as to how long families remained intact after services were terminated.

Evaluations of intensive family preservation services have found little association between family or child characteristics and program success or failure (Berry, 1994; Fraser, Pecora and Lewis, 1991). Characteristics of children that were "mined" from the case records, including reason for referral, age, gender, emotional disturbance, previous placement, sexual abuse, or being an adoptee, were not found to be predictive of placement prevention. However, for families where a child committed a status offense, placement prevention was achieved , which is consistent with other studies. Fraser et al.

(1997) reported that intensive home based services appeared to be moderately effective in preventing placement of children who are in early adolescence and who are referred for behavior problems such as truancy, oppositional behaviors and other delinquent acts. Additionally, as discussed in the previous section on family violence, there was a reduction in family violence following service provision when families were referred because of unmanageability and reunification.

A significant association was not found between placement prevention and children referred for mental health issues, child abuse, or child neglect. These findings are consistent with previously conducted studies. Intensive family preservations services have not been considered to be effective and have shown little success (Berry, 1992; Nelson and Landsman, 1992) with families where children have been referred for reasons of neglect and abuse. For this group, Fraser purports "In child welfare, most of the studies fielded so far have not been able to establish a margin of benefit in child protection and placement prevention" (Fraser et al. 1997 p.150).

Considering the complexity and overlapping nature of family problems, a modicum of success in placement prevention has been achieved by FIP. It is possible that positive outcomes are a result of tailoring services based on the presentation of family problems, the expertise of FIP practitioners in partializing complex family problems so they are manageable, and the commitment of families to maintaining their family system.

Intensive family preservation services are theoretically intended to be flexibly responsive to the needs of a family relative to placement risk. The model proposes that the core service components; hard, soft, and enabling services should be "tailored" to meet individual needs, while strengthening the family to reduce the risk of placement and protect the safety of children (Berry, 1997). The driving force behind this study was a curiosity in understanding and delineating the range of services and interventions provided to at-risk families, their impact on family functioning, and assessing their function in preventing placement. The findings of this study are somewhat striking in their confirmation of the eclectic use of service, but more importantly, that family education and advocacy seemed to be most influential in improved family functioning and placement prevention.

At first analysis of bivariate relationships, it appeared that only a very few services were associated with placement prevention. However, with the specification of a third variable (family characteristic), insignificant relationships between the independent and dependent variables were found to be statistically significant (Rubin and Babbi, 1990). For example, when placement outcome was associated with an intervention, such as the provision of financial resources, a significant association was not found. However, when absence of status offense was specified, a significant association was found between intervention, family characteristic and placement prevention. The following table illustrates the family characteristic, the service, and the association to placement prevention.

Table 94: Placement Prevention Significance by Service by Population

Service	Characteristic	p
Provides financial resources	Status offense not committed	<.05
	Emotional disturbance absent	<.07
Provides information on resources	Single Parent	<.05
	Substance abuse is absent	<.01
Accompanies client to other services	Dual parent	<.01
	Status offense not committed	<.01
	Emotional disturbance absent	<.07
Teaches to negotiate local service systems	Single & Dual Parented	<.08,.06
	Substance abuse is present	<.06
	Emotional disturbance absent/present	<.05
	Status offense not committed	<.06,.08
	Mental illness is absent	<.06
Couples counseling	Substance abuse is absent / present	<.05
	Emotional disturbance	<.07
	Mental illness is absent	<.05
Reflect and validate feelings	Substance abuse is present/ absent	<.06,.05
	Emotional disturbance absent	<.01
	Status offense not committed	<.01
Provides Encouragement	Substance abuse is present	<.05
	Single parent family	<.06
	Parental mental illness absent	<.08
Discuss progress at termination	Substance abuse is present/absent	<.09,.05
	Emotional disturbance absent	<.05
Teaches Problem solving	Substance abuse is present	<.05
	Emotional disturbance	<.05
	Committed status offense	<.09
	Single parent family	<.06
	Mental illness absent	<.05
Teaches parenting skills	Dual parent	<.08
	Status offense not committed	<.01
Teaches through role-play	Substance abuse is present	<.05
	Status offense committed	<.05
	Single parent family	<.05
Behavioral contracting	Emotional disturbance absent	<.07
	Mental illness absent	<.05
Solution-focused interventions	Status offense committed	<.05
Building in structure and daily routine	Single parent	<.06
	Status offense not committed	<.07
	Substance abuse is present	<.06
Identifies family strengths	Status offense not committed	<.06
	Substance abuse is present	<.06
Generate action plan	Single parent family	<.08
	Substance abuse is present	<.01
	Status offense committed	<.05
	Emotional disturbance present/absent	<.01,.05
	Mental illness absent	<.01

The preceding table provides some clues to the elements of success in the FIP program and may help to identify the “differential contribution of elements of service- skills training, concrete problem solving, and empowerment - to outcomes” (Fraser et al, 1997, p 150). It appears that three major service components contribute to placement prevention.

First, the enabling services, which are aimed at assisting families in establishing much needed community supports through advocacy efforts, seemed to be associated with better outcomes. These interventions were particularly successful with single parent families, substance abusing families, and families with an emotionally disturbed child. Workers spent time throughout the treatment period as advocates for their families with the courts, schools, social services, family members, medical system and landlords. In advocating for clients, workers not only modeled appropriate behavior for interacting with formal and informal supports, but also were a link to resource information.

The emotional disturbance of a child places families in a complicated web of difficulties including, medication management, educational issues, as well as problem behavior at home and school. Many families, regardless of socioeconomic class, find these children most challenging. Without the knowledge of how to manage both the child and the various systems, families are at risk of placement.

Secondly, the soft services, marital and family interventions, empowerment activities, and skill-building services, appear to have been the most sensitive to placement prevention. Previous studies of services report that the soft services have been the least successful in preventing placement (Berry, 1997) due to the multi-problem nature of families and a limited treatment period. The primary intent of "soft" services is in establishing treatment relationships, promoting client cooperation, supporting families by listening and instilling hope, and modeling life skills (Berry, 1996, Fraser et al, 1991). This treatment approach appears to have been successful in families with older (12-14) children, presenting with issues such as truancy, unmanageable behaviors at home and school, and emotional disorders.

The marital and family interventions, including couples counseling, reflecting and validating, encouraging, and discussing progress at termination, seem to have influence on placement prevention with families where substance abuse and emotional disturbance is a problem, and with single parent families. In analyzing referral source and reason for referral relative to service provision, the outcomes suggest that soft and enabling services were associated with placement prevention when families were referred by the Mandated Prevention Unit and when the specified reason for referral was unmanageable behavior. Third, the skill building activities and the empowerment activities are especially applicable to short term interventions, in which less tangible emotional support is available and/or required. Skill building activities which focus on mood and self-management activities to control and redirect anger, improve communication, improve

understanding of child and adolescent behavior, and establish structure and reinforcers, seem to have had a positive impact on families with emotional disturbance, children who committed a status offense and were in need of more supervision, or parental substance abuse. Many families have no understanding of their child's problems, or how to manage it. FIP workers provided hands on activities and modeling during a crisis to help parents and children communicate, problem solve, and interact more productively and positively.

Single parent families appeared to have been more responsive to the enabling services, as well as soft service provision. FIP workers form a working alliance with families which includes day in and day out support in making parenting decisions, working with other social service systems, and managing crises. For a single parent, the complexity of day-to-day living can be alleviated by the connection with another available and consistent individual. In the absence of another caretaker, this partnership between parent, child and worker can act as an invaluable support and learning experience.

It is also significant that all families who were referred for reunification were successfully reunified. This positive placement prevention outcome could be attributed to the provision of skill-building and empowerment activities in the re-establishment of family rules and roles. Once a child has been removed from the home, much of the immediate and intensive work centers on reconstructing the family unit. Such interventions as generating action plans, teaching problem-solving skills, and teaching

parenting skills, as well as some soft services that were associated with placement prevention in this study, are likely to have had an influence on placement prevention.

The concrete services were not particularly associated with placement prevention. Only when the provision of financial resources was correlated with the family characteristics of 1) no emotional disturbance and 2) no status offense committed, was a significant association produced. Although “clinical data mining” did reveal that all clients had received some type of concrete service, the absence of significance is atypical. Less emphasis may be placed on concrete service provision for a number of reasons: 1) program budget constraints may preclude monetary investment in families-many of the earlier studies were conducted at the peak of family preservation funding when there was a greater allotment of funds specifically ear-marked for concrete service provision; 2) families may have had less financial need (without socioeconomic indicators, this information is intangible); 3) workers may have been more adept and skilled at assessment, family and individual counseling; 4) the nature of families referred- those where children had committed status offenses, where emotional disturbance was a problem and where substance abuse was also an issue, may have required more family and child counseling effort, as opposed to the provision of concrete services.

This study finds that the enabling services and the soft services are more highly correlated with families’ avoiding placement than the concrete services. In “mining the case records” it is apparent that workers were very committed to the family preservation

philosophy of “doing whatever it takes”- these were not people who simply “talked” about family problems. They also performed concrete tasks, such as helping to clean a house, transporting families to various destinations, caring for children, helping to fix broken windows and doors, helping to insulate the house for the winter, and grocery shopping on a budget.

The skill-building activities, the empowering services, as well as the enabling services appear to have had the most influence in helping families to remain intact. These outcomes suggest that the teaching, advocating, listening, and doing with and for families contributed to positive outcomes for parents, children, and practitioners, alike. This final section in this chapter will discuss the family’s view of service provision.

Parents View of Services

This final section will move clients to center stage (Rapp and Poertner, 1987) in focusing on their view of the process of service provision. Experts in the child welfare field have highlighted the benefits associated with obtaining client’s perspectives in assessing service effectiveness (Pecora, Bartolome, Magana and Sperry, 1991), particularly that the client’s perspective identifies areas for improvement and solutions that other evaluation methods may overlook.

Traditionally, program evaluation studies in child welfare have not focused on client satisfaction or client reports of improvement (Pecora, Bartolome, Magan and Sperry,

1991). Part of the reason may be due to problems associated with privacy, client recall of experiences, and response bias. This researcher felt that a view of the client's world would better inform FIP of areas where they were experiencing success, as well as areas where there was room for improvement. However, of the 116 families who were sent a self-administered questionnaire, only 21 returned a completed client survey.

Part I of the survey addressed how services were provided, essentially asking if workers were timely, considerate, did they listen to the family, did the client feel understood, was the client encouraged to call during a crisis and in general, were services helpful. Largely, respondents answered positively, either with an "Always" or "Most of the time" to all of the above questions. In approximately 15% (4) of the 21 surveys, respondents answered rarely or never to these questions.

Part II of the survey asked the parent/caretaker to identify services that the intensive family preservation model claims to deliver. They were also asked to identify which services they wished had been provided. All 21 families received family counseling and crisis intervention services. Approximately 60% received, individual counseling, advocacy services, parent education, and communication skills training. Less than 50% said they had received transportation services, yet they did not indicate the need for this service. Approximately 50% of the respondents said they had not received financial help, however, only 2 of those reported that they wished they had received financial help. The "data mining" process similarly revealed that 56% of the total sample (N=116) had

received financial assistance. Interestingly, these findings are consistent with the information gleaned from the case records.

Approximately 20% of families reported having received anger management and assertiveness training. Another 15% of respondents reported that they wished they had received anger management and assertiveness services. The case records indicated that approximately 65% of families received anger management services, while only 24% received assertiveness training. Given the percentage of children referred for unmanageable behaviors, it seems that both of these services could have been provided more to families with more regularity.

In Part III of the survey, consumers were asked if they identified goals together with their worker. All 21(100%) of the consumers stated that they identified goals with their worker, suggesting that workers utilized an empowerment approach to treatment. When asked if they had accomplished their goals successfully, approximately 75% stated that they had. Despite the very small number of respondents, 85% stated that their family situation was either very much improved or improved. The remaining 15% reported that their situation had worsened or stayed the same. This same 15% felt that the workers were invasive, lacked an understanding of their family problems, and were critical of their parenting.

In the last section of the survey, there were four open-ended questions to which there were few replies. Client quotes taken from the surveys have been used illustratively at the beginning of chapters. As an example, only 4 people identified goals that the family focused on, which included anger management, reduction in family violence, finding a new apartment, and finding a job. Similarly, only 4 respondents described the changes that occurred in their family as a result of accomplishing the goals. These changes included: "less violent behavior," "child is attending school now," "child went to the hospital and got the help she needed"; and "he didn't go into foster care."

Only 15% said that their worker should have done something differently. These responses were family specific, yet implied that the worker had not helped the family control their child, "he should have gotten her into a hospital", "she should have spent more time getting the kid to go to school". The remainder of the surveys provided glowing accounts of their workers' kindness, patience, and availability.

The last open-ended question requested that the respondent comment on positive or negative thoughts or feelings they might have had about the program. The majority of families, 80%, felt the service was helpful, but more service time was needed to accomplish the family's goals.

Although this self-administered questionnaire produced a very small response rate, these views from the families could be useful to FIP in program planning and training. Most

importantly, a variety of specific worker services and behaviors were rated as helpful, most of which comprise the core philosophy of IFPS. However, because so few people responded, it is impossible to generalize these findings.

Chapter VI will discuss the fidelity to program model, the use of “clinical data mining” for future studies, and implications for policy, practice and research in the context of developments in the field.

Chapter VI

What Does the Research Tell Us? What Next?

A mother is quoted:

The worker I had helped me in ways they will never know. My family has come so far from their help and education. They have made an impact in my life. I won't forget the help I received in my time of need. As quoted from client survey)

This final chapter will address three questions: 1) does FIP demonstrate fidelity to the intensive family preservation program model? 2) is "clinical data mining" a feasible research strategy for investigating family preservation intervention technology and outcomes? and 3) what are the implications of this study's results for future research, practice, policy and program development?

Overview

For quite some time now, experts in the child welfare field have questioned the utility of placement prevention as the single outcome measure of IFPS program effectiveness (Berry, 1997; McCroskey and Meezan; Pecora, et al, 1991; Rossi, 1991). The child welfare literature has acknowledged that remaining at home is not always in the best interest of the child and that not every family can or should be preserved. Placement prevention is conceptually flawed as a primary outcome criterion (Pecora, et al, 1991). To better serve children and their families, program outcomes should be defined more broadly and not limited to placement prevention. Because placement has many causes, it

is important that a measurement of outcomes address the impact of services on the whole family and the individuals that are a part of that family unit.

There are many aspects of family preservation programs that are in need of evaluation, as they bear heavily on placement outcomes. Essential program components that need to be measured include client characteristics, program goals and objectives, improvement of child and family functioning, the presence and extent of the range of services provided to families, measurement of the knowledge and skill family members have acquired, reduction in family risk factors, and identification of family strengths. It has been suggested (Berry, 1997) that documentation of family preservation practices has focused almost entirely on quantitative studies, which have been difficult to interpret and are inconclusive. Qualitative studies that reach for depth, description, holism and aim to generate new and improved practices, is essential to developing intensive family preservation services as a credible service model. As has already been demonstrated, "clinical data mining" is a promising method for gaining insight into program process, service and intervention technology, and the impact on child and family functioning.

The goals and philosophy underpinning intensive family preservation services garnered a great deal of positive recognition from child welfare experts and policy makers as a new and innovative strategy in child welfare. The Edna Mc Connell Clark Foundation, a key-funding source, hastened the development and expansion of family preservation services nationwide. However, research reports that questioned IFPS effectiveness (Rossi, 1991),

and the media which highlighted the deaths of children who “may” have been in IFPS programs (Adam, 1994), have contributed to the philosophical tides in child welfare to shift away from IFPS. Within the past five years, foundation funding for IFPS is nearly non-existent, state funding for IFPS services is decreasing, and child welfare agencies are developing initiatives in other areas, such as adoption. Despite these changes in the field, the practice of IFPS continues, and as this study suggests, treatment is effective in improving family functioning and prevention placement.

The reader should be reminded that this was not an outcome study, but rather a case study of one specific IFPS program with the intent of defining, identifying, and characterizing interventions, services and “best practice” within this field of practice. This was a feasibility study to determine if “clinical data mining” was an appropriate intervention research method for study of IFPS, but more broadly, in child welfare. Agency-based research of service provision, outcomes, and family demographics, utilizing existing clinical records, seems to have enormous possibilities for identifying “best practice” methods for at-risk families. The following section will discuss program fidelity relative to the FIP model of IFPS.

Program Fidelity

Program fidelity, the degree to which the interventions that comprise a program’s design, are delivered to clients as they were intended (Bickman, 1990; Rubin and Babbi, 2001), has been a confounding issue in the research of intensive family preservation service

delivery (Pecora, et al, 1995, Rossi, 1991, Schuermann, Rzepenicki and Littell, 1994). Family preservation services have been admonished by many researchers for not adhering to the prescribed model of practice and thus making it difficult to evaluate program effectiveness (Rossi, 1991, Schuerman, et al, 1994). The variability in program design and the lack of adherence to the intensive family preservation model has presented obstacles in the determination of program effectiveness, comparative analysis between and amongst programs, and in identifying the impact of specific program features in improving family functioning. It is suggested that model "drift" (Pecora, Fraser, Nelson, McCroskey and Meezan, 1995) or lack of program fidelity (Bickman, 1990), in intensive family preservation programs is a result of a complex interaction of forces: 1) program theory is inadequately explicated; 2) implementation strategy of intensive family preservation programs encourages variability; 3) a consistent and well-formulated model of practice is not identified; 4) "imminent risk of placement" is vague, thus giving workers great latitude in family referral; 5) inability of workers to adequately assess risk- thus suitable and unsuitable cases alike are referred; and 6) the occurrence of "creaming" (Rossi, 1991) which is defined as the acceptance of families into a program who were guaranteed to succeed.

The core components of intensive family preservation theory have been outlined previously, but for the reader's ease of understanding, it will be briefly covered again. The FIP program is designed to replicate the Homebuilders model of intensive home-based services. Four principles collectively constitute the content characteristics that

define intensive family preservation practice- family centeredness; in-home intensive service provision; generic and integrated response to multiple family problems; and time-limited service duration. These practice principles serve as a foundation for service delivery.

A first distinctive characteristic of this model is that the entry point for service eligibility is a child's risk of imminent placement. Rapid response to referrals is a significant service element. Clients are viewed as colleagues and partners in the process of goal setting, which is a crucial and empowering element of this practice (Berry, 1996; Nelson, 1990). A second distinguishing characteristic of the Homebuilders model is the in-home locus of service delivery. Families and children are seen in their homes because it is assumed that clients are better served in the environment in which the problem occurs (Berry, 1997). A third distinctive feature of this model is the multi-problem orientation, which charges practitioners with the responsibility for recognizing and responding to a broad range of needs and difficulties simultaneously. This objective entails a triangulation of responses including practical problem solving; instructional assistance to address family conflicts, behaviors, and communication; multi-modal counseling; linking families to other resources for continued treatment needs; and the provision of concrete services (Berry, 1997). A final distinguishing characteristic of the Homebuilders model lies in the nature and duration of the worker-family relationships (Nelson, 1990). Typically, families are provided with services for four to eight weeks, based on the expectation that change can occur rapidly. The intensity of the

practitioner's involvement with the family (10-20 hr. per week), the ready availability of the worker to the family (being on call as needed) and flexibility of scheduling (workers carry only two clients at a time) allows the practitioner to tailor services and observe the family process in action. Beyond this basic framework, services are intended to be flexibly tailored to the specific and individual needs and strengths of each family (Berry, 1996; Kinney et al, 1990; Nelson, 1990). Utilizing this framework, the FIP program will be assessed for fidelity to program model.

FIP is modeled very closely after the Homebuilder's approach to intensive family preservation. First, the entry point for all referrals is through an umbrella agency of the Division of Social Services, mental health, or the schools. In the process of reading through each case record, referral and intake revealed that only children who were at immediate risk of placement (72 hours by FIP standards) into substitute care were accepted by FIP for treatment. Once a referral is made, the family is contacted and a home visit is scheduled within 48 hours. The program's philosophy, to join with the client as partners in treatment, was exemplified by the empowerment interventions documented in the case record, such as mutual goal setting. To illustrate a follow-up survey question asked parents: "Did you and your worker identify goals together?" All twenty-one respondents said that they identified goals together with their worker.

Congruent with the intensive family preservation model, the primary locus of treatment was the family home. On occasion, workers might take clients on recreational activities

outside of the home, shopping excursions, would meet with clients at the FIP office, or in the case of meeting with an adolescent, would take them for a ride or go to the mall. The extent and variety of interventions provided to families was quite impressive and drew from a number of theoretical perspectives. Workers engaged with clients in cleaning refrigerators, doing laundry, cleaning front lawns, changing diapers, and helping families move, and all are examples of concrete service provision, a core ingredient of IFPS program philosophy. These activities encouraged joining with clients, as well as the modeling and practicing of a range of skills.

Examination of process notes indicated almost daily family contact, in many cases, even on weekends. As a part of the initial FIP intake, workers discuss the program requirement of meeting approximately 15 hours per week or more if needed (the amount of time spent with families was not recorded). Family appointments were designed to meet family crisis needs, family work schedules, and family problems which might necessitate contact at a particular time of day (for instance, getting children off to school) as part of the treatment plan. The client survey asked families if workers scheduled meetings at the convenience of their family. Sixteen respondents said the worker always did, 3 responded that most of the time they did, and 2 said that some of the time they scheduled meetings at their convenience. Per the intensive family preservation model, services were provided for a brief, but intensive period, with a mean service time of 6 ½ weeks. Each practitioner carried 2 families at any given time, allowing for a tailoring of services to meet family

needs and individualized attention, which permitted workers to respond with concentrated care to the multi problem nature of the families.

The "data mining process" unequivocally confirms that FIP did hold to the basic tenets of the structure of service delivery recommended for intensive family preservation services, and represents a generalist social work practice orientation. Practitioners are expected to utilize a person-in-environment perspective- assessing family strengths and needs; engaging family members in the treatment process; in the elements of client/case advocacy; in providing family-life and communication skills; in negotiating and obtaining concrete resources, and finally, in the discharge stage, linking families to formal, as well as informal support services. As in the provision of any social work service, assessment is an ongoing process, with a constant monitoring of family stability and child supervision and safety needs.

A primary goal of this retrospective, descriptive, and associational study was to gain a clearer understanding of service delivery and its' potential effectiveness with families. The detailed notations of FIP workers clearly mapped the journey of service provision, always referring back to the goals, objectives, and action steps to be taken by both the family and the FIP worker. Workers approached their day-to-day activities with a unique sensitivity and ingenuity in engaging, advocating and treating the whole family. This is contrary to some who believe that intensive family preservation practice is comprised of a group of well-meaning but thoughtless idealists:

“In effect, family preservation is the reinvention and glorification of an archaic form of helping. For all practical purposes, it is an updated version of “friendly visiting,” albeit without the religious overtones.” “ Using similar goals (with the exception of strict moral instruction), the family preservationists of the 1990s have sanitized “friendly visiting”: by creating a secular and professionalized version of it. Thus despite the updated jargon, family preservation is for all intents and purposes virtually indistinguishable from “friendly visiting” (Costin, Karger, and Stoesz. 1996, p.156).”

The clinical data mining process provided renewed understanding and belief in the role of intensive family preservation services as part of a continuum of care for families and children. The following section will address the feasibility of “clinical data mining” as a research method for this study and future similar studies.

Feasibility of “Clinical Data Mining” as a Research Strategy

Berry (1997) writes, “Evaluators and researchers must begin to broaden the lists of design and measures available from which to choose, to include not only scientific and standardized methods but also qualitative methods in order to answer the evaluation questions, the research questions or some combination of both (p. 171).” Likewise, Schuerman, Rzepnicki and Littell (1994) comment about the deficits of intervention research: “So the evaluator must search for the proper level of description of program activities. Mere structural features are not enough, nor are the identification of the prescribed model of practice (p.206).” This study of intervention research was undertaken

with a commitment to explicate with as much clarity as possible, the nature and depth of intensive family preservation service delivery, as well as its impact on child and family functioning.

The intention of this study was to both explore and describe service variables, as associated with family demographics and placement prevention. Clinical data mining has helped this researcher to clarify which interventions appear to have had a significant impact on placement prevention and with which particular child or family problem. The process of “panning” (Epstein, 2000, p 21) process notes, three and six week summaries, and assessments, yielded service variables and family demographics not considered in other studies of interventions. “Mining the data” helped enumerate a range of interventions that are often glossed over in the literature as simply “marital and family” or “enabling” services. The character of the work and of the families became vivid in the rich descriptions of family problems, interventions used, and outcomes. It was good fortune that the director of FIP maintains a high standard for thorough and detailed process notes. (The director turned notes back to workers because they were too vague. He read each note on each family written by each worker). These detailed descriptions of family and agency interactions, typically conveyed social work knowledge, values and skills. Practice wisdom in family preservation and child welfare, informed the creation of the extraction instrument, as well as objectively identifying services. A final supporting element of “clinical data mining” concerns its unobtrusiveness. This retrospective study

of FIP made possible the in-depth study of service provision and families with no interference for family or worker.

The findings in this study produced comparable results to published findings using prospective measures (Fraser et al, 1991), particularly with regard to the positive association between placement prevention and enabling services, skill-building services, and empowering services. For example, the quasi-experimental study conducted by Fraser, Pecora, and Haapala (1991) and Lewis (1991) identified that the provision of financial assistance was associated with placement prevention in families where children had not committed a status offense and were not diagnosed with an emotional disturbance. These findings were consistent with the outcomes of the present study.

Fraser, Pecora, Haapala, and Lewis (1991) found that placement was prevented when the following interventions were provided: parenting education, child development education, self-esteem enhancement, relationship development skills, and case management. Similarly, the present retrospective study found that the soft services, which focus on relationship building and improving family dynamics, as well as those, devoted to skill building and advocacy activities were associated with placement prevention.

Likewise, Feldman (1994) in an experimental study found that the soft services, particularly, child management education, relationship building skills, communication skills, as well as advocacy activities were associated with placement prevention. The

present retrospective study found that soft services and empowerment services were associated with placement prevention, including, problem solving, solution-focused interventions, couple counseling, providing validation, encouragement, and advocacy. In Berry's studies of services, it was found that enabling services were associated with better family outcomes (1992) and placement prevention was associated with counseling (1995). Similarly, the present study found that couples counseling, as well as a number of other soft services, were associated with the prevention of placement.

There were limitations to utilizing "clinical data mining" in this study which must be taken into consideration: 1) each practitioner possessed their own frame of reference, worldview, and style of treatment, which influenced how and what was documented in the case record; 2) this research method did not employ a control group; and 3) the sample size was small. Therefore, generalization to other programs is risky, and the ability to infer causality within the data is not realistic. In addition, "clinical data mining" is time consuming; however once the definitions are operationalized and the extracting tool is created, work proceeds smoothly. Despite these limitations, use of available clinical records, although not experimental, and therefore not employing the "gold standard" of research, is a very feasible method of research in evaluation of services and outcomes in social work practice, child welfare, and family preservation practice. It allows one to get "at the heart" of services and their effectiveness.

Implications for Policy, Research, Practice, and Education

In this study, approximately 50% of children at risk had committed a status offense, were considered to be unmanageable by the referral source, and were diagnosed with an emotional disturbance. Program planners, child welfare policy-makers and practitioners must seriously consider the multi-problem nature of at-risk families and the need for representatives of child welfare, social services, and mental health to work as a team in treating family problems, designing services, and hiring staff.

Equally important is the ongoing education needed to support the creativity and ingenuity of workers who are engaged with families whose problems may have a long history.

Family preservation practitioners must be selected for their ability to advocate for their clients, for their skill at assessment of child safety, and their ability and ease in working with a cadre of family problems and service providers. If the social work profession hopes to conduct more research using “clinical data mining”, as well as advance the practitioner-research model toward improving service delivery, front line workers must be provided with the opportunity and education to be involved in program evaluation.

The foundational values of the profession of social work: dignity and worth of the individual, belief in the worth of all people, and client self-determination, which can be traced back to the early days of the profession, are also central to the practice of intensive family preservation (Tyler, 2002). Biestek and Gehrig (1978, p10) identify the following principles as essential to self-determination: 1) client participation; 2) client

responsibility for plan making; 3) self-help; 4) self-direction; and 5) self-expression.

These principles are also essential to the practice of intensive family preservation and other home-based service delivery models.

Home visitation, which can be traced back to the Charity Organization Society developed at the turn of the century (Popple and Leighninger, 1999) and could be said to be a forerunner of IFPS programs. As in family preservation practice, the early COS workers called for a balance of social justice and individual intervention, the caseworker being alert to the implications of individual reform, as well as the provision of concrete services. A crusading for human betterment, as executed by a case-by-case personal contact, is the backdrop of our profession (Reynolds, 1963), and that of intensive family preservation services.

In the present study, family therapy, couples counseling, crisis intervention and a variety of concrete services were provided in a family's home environment. The importance of working with a client in their environment has been rated highly by primary caretakers as the most helpful program components (Pecora, et al. 1997). Many of the most dysfunctional families cannot or will not attend sessions held in an office. It has been reported by IFPS practitioners that working with families in their homes allows for ongoing and more accurate family assessment, worker persistence, loyalty, and commitment can be emphasized, while new behaviors are being modeled and family boundaries are enforced. Furthermore, the clients' home environment permits the

practitioner to more readily assume a supportive position with the family, while reinforcing parental control and ability to make choices.

Professional preparation for family preservation practice must give greater attention to the differences between working in the home and working in the office. The educational preparation should also emphasize collaborative skill development so that family-serving individuals can work more effectively together. Students should be educated to participate actively in the development of practical and usable outcome measures, conversant in the research methods, and capable of translating service data into more structured formats that will capture the service delivery process. Finally, social work education must prepare students to the characteristics and dynamics of developing effective working relationships between and among families and communities of all kinds.

Conclusion

Intensive family preservation services, as a particular model of child welfare practice, attempts to convey a respect and dignity for family strengths, limitations, culture, and aspirations through this very specific medium of service delivery. Families, who may once have fallen through the cracks, find hope, discover new methods for dealing with old problems, and regain a degree of control and dignity in their lives. Sometimes, placement is necessary and is a positive intervention itself. For those families where children have been placed, they too learn something new about themselves, their style of

parenting, and how to meet the needs of their child. Intensive family preservation services experienced an intense backlash because some child welfare experts felt it was ineffective, or because they did not understand the philosophical underpinnings and intervention technology. This study was an attempt to reveal the precise nature of service delivery, to give voice to recipients and providers of services, as well as to engage practitioners in observing their own practice.

As one FIP worker stated in her case notes:

“I have been struck by their humor and affectionate nature. We ended with heartfelt hugs and good wishes all around.”

Appendix 1

Inventory of Demographics and Services

1. Demographics

1. Case number
2. Days of service
3. Referral source: 1 Mandated Prevention___ 2 CPS___ 3 Foster Care___
4 Family Court___ 5 Self-referred___ 6 Other___
4. Parental Substance abuse 1 Yes___ 2 No___
5. Number of Children 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10 ___
6. Family Composition: 1 Intact/Nuclear___ 2 Single Mother___
3 Single Father___ 4 Grandparent___ 5 Blended___ 6 Foster Family___
7 Adoptive___ 8 Gay/Lesbian___ 9 Other___
7. Age of identified child _____
8. Sex of identified child 1 Male___ 2 Female___
9. Pins petition in place 1 Yes___ 2 No___
10. Parent was a foster child 1 Yes___ 2 No ___
11. Order of protection is filed 1 Yes___ 2 No ___
12. Child/children previously placed in care 1 Yes___ 2 No___
13. Child is a sexual abuse victim 1 Yes ___ 2 No___
14. Identified child is adopted 1 Yes___ 2 No___

(Appendix 1, cont'd)**2. Presenting Problems**

1. Reason for referral:
 - 1 Abuse___ 2 Neglect___ 3 Domestic Violence__
 - 4 Committed Status Offense __ 5 Unmanageable___
 - 6 Reunification __ 7 Mental health risk_____ 8 Health_____
 - 9 Other___

- 2 Risk factors at opening
 - 1 Abuse__ 2 Neglect__ 3 Domestic Violence__
 - 4 Parental Substance Abuse__ 4 Emotional disturbance __
 - 5 Unmanageable behaviors

- 3 Family is homeless 1 Yes___ 2 No_____

- 4 Child presents with an emotional disturbance 1 Yes ___ 2 No___

- 5 Parent(s) diagnosed with mental illness 1 Yes ___ 2 No __

- 6 Degree of risk for violence at opening
 - 0 None___ 1 Low__ 2 Moderate__
 - 3 High__

- 7 Demonstrates suicidal or homicidal ideation 1 Yes ___ 2 No___

- 8 Child's diagnosis
 - 1 Bi-polar___ 2 Schizophrenia___ 3 ADHD___
 - 4 Depression___ 5 Oppositional Disorder ___ 6 PTSD_____ 7 Other_____
 - 8 None___

(Appendix 1, cont'd)**3. Interventions: Place a check if client received the service**

1. Worker encourages client to call during crisis
- 2 Building in structure and daily routine
- 3 Providing structure during crisis
- 4 Focus and define client's problems, goals, treatment
- 5 Define obstacles to task achievement
- 6 Explore problems
- 7 Generate action
- 8 Contracting and negotiating
- 9 Homework assigned between appointments
- 10 Building in hope
- 11 Seeking verbal reports between sessions of progress
- 12 Encouraging individual ventilation and catharsis
- 13 Examine current behaviors and consequences
- 14 Examine past behavior and consequences
- 15 Analysis of transference
- 16 Listening to client
- 17 Offering support
- 18 Reframing situation for client
- 19 Providing reinforcement
- 20 Behavioral contracts
- 21 Teaching cognitive self-control
- 22 Teaching problem-solving
- 23 Teaching time out
- 24 Teaching use of token system
- 25 Teaching anger management
- 26 Teaching child behavior management skills
- 27 Teaching communications skills
- 28 Teaching negotiation skills
- 29 Teaching relaxation skills
- 30 Teaching social skills
- 31 Teaching through role-playing
- 32 Examine behavior patterns as how goal achievement is affecting
- 33 Clarifying family rules
- 34 Clarifying family roles

- 35 Use of family process
- 36 Use of family sculpting
- 37 Provides information on child development
- 38 Provides literature
- 39 Provides information on resources
- 40 Tracking or charting behaviors-child
- 41 Teaching parenting skills
- 42 Teaching assertiveness and advocacy skills
- 43 Teaching self-management skills
- 44 Teaching home-management skills
- 45 Develop a time line-chronology of problems, developmental issues, important events
- 46 Restraining change-suggesting clients go slow, speculating on consequences of change
- 47 Hypothesizing function of symptom-purpose
- 48 Drawing ecomaps/ assessing social support
- 49 Drawing genograms-history taking
- 50 Behavior rehearsal/role-play for future
- 51 Structured family interview
- 52 Predicting relapse
- 53 Circular reasoning
- 54 Identifying behavioral sequences
- 55 Using metaphor to convey a point
- 56 Encouraging client to get family facts
- 57 Confrontation
- 58 Daily journal use encouraged
- 59 Tracking parent behavior or affect
- 60 Self-disclosure of practitioner
- 61 Arrange for daycare or respite
- 62 Recreation or activity therapy- take client out
- 63 Accompanying client to other agencies/ resources
- 64 Providing concrete resources-furniture, food, cash, rent
- 65 Providing transportation
- 66 Testifying/attending court hearings
- 67 Teaching how to develop or use leisure time
- 68 Teaching how to negotiate local service systems
- 69 Advocating for family-school social services
- 70 Building informal support systems
- 71 Providing case management systems
- 72 Teaching sex education- birth control, avoiding victimization

- 73 Teaching job-hunting skills
- 74 Help client find housing or move
- 75 Use crisis card
- 76 Use miracle exercise
- 77 Solution-focused techniques used
- 78 Information and referral provided
- 79 Values clarification
- 80 Recognize and assess
- 81 Makes supportive phone contact
- 82 Makes purposeful phone call to family
- 83 Gives advice/direction
- 84 Worker observes
- 85 Worker physically restrains child
- 86 Discussed termination
- 87 Discussed progress at termination
- 88 Reflect and validate feelings
- 89 Provides praise
- 90 Discussed future hopes and goals
- 91 Discussed problem impact on health
- 92 Explores family respect and support
- 93 Explores family coping skills
- 94 Explores religion
- 95 Couples counseling is provided
- 96 Uses art as a therapeutic tool
- 97 Makes dinner together
- 98 Uses paradox
- 99 Uses games as activity
- 100 Makes a garden
- 101 Hikes/walks
- 102 Uses animals as a therapeutic activity
- 103 Co-therapist used
- 104 Chores are an activity
- 105 Utilizes affirmations as a technique
- 106 Recognized birthdays or special family occasions
- 107 Family night celebration
- 108 Visualization is used
- 109 Helps with homework
- 110 Talking stick used as an intervention
- 111 Uses a sand tray
- 112 Photography used as an intervention

- 113 Identifies family strengths
- 114 Encourages family/child
- 115 Identifies feelings

(Appendix 1, cont'd)**4. Outcomes**

1. Placed during TX 1 Yes _____ 2 No _____
2. Child reunified with family 1 Yes _____ 2 No _____
3. Degree of risk for violence at closing
0 None _____ 1 Low _____ 2 Moderate _____ 3 High _____
4. Transferred to CCS 1 Yes _____ 2 No _____

Appendix 2:

Existing Instruments Used to Create the “Inventory of Services and Demographics”

Concrete Services Checklist:

1. Provide transportation
2. Provide recreation activities
3. Help client get a job
4. Do housework with client
5. Arrange recreation activities
6. Help secure financial assistance
7. Provide child-care
8. Give financial assistance
9. Provide food
10. Help get food
11. Help with transportation
11. Help obtain medical/dental services
12. Provide toys or recreation equipment
13. Help obtain utility benefits
14. Help secure child-care
15. Arrange life-skill classes
16. Help obtain housing
17. Help secure clothing
18. Provide household goods
19. Help obtain household goods
20. Help obtain legal aid
21. Provide clothing
22. Move client to a new location
23. Provide a job
24. Help arrange cleaning services

Clinical Services Checklist:

1. Listening to client
2. Encouraging
3. Offer support/understanding
4. Relationship building
5. Use of reinforcement
6. Setting treatment goals
7. Reframing

8. Natural/logical consequences
9. Clarify problem behaviors
10. Child development
11. Provide literature
12. Rational-emotive therapy concepts
13. Building hope
14. "I" statements
15. Anger management
16. Monitoring clients
17. Consultation with other service agencies
18. Clarify family rules
19. Improve compliance
20. Active listening skill
21. Defusing crisis
22. Providing reinforcers
23. Make treatment plans
24. Rational-emotive therapy techniques
25. Tracking behaviors
26. Build self-esteem
27. Track/chart behaviors
28. Clarify family roles
29. Handle frustration
30. Process of change
31. Refer to other counseling
32. Problem ownership
33. Build structure/routine
34. Negotiation skills
35. Time-out
36. Problem-solving
37. Environmental controls
38. De-escalating
39. Behavioral rehearsal/role play
40. Use of crisis card
41. Refer to other counseling
42. No-lose problem solving
43. Meet with other providers
44. Accepting "no"
45. Self-criticism reduction
46. Depression management
47. Pleasant events
48. Impulse management
49. Advocacy with schools
50. Refer to social service

51. Give and accept feedback
52. Teach use of leisure
53. Social skills
54. Assertiveness
55. Anxiety management
56. Values clarification
57. Relaxation
58. Conversational skills
59. Family council
60. Provide paper/pencil tests
61. Track emotion
62. Develop informal supports
63. Fair fighting
64. Money management
65. Appropriate sexual behavioral
66. Recognize suicide potential
67. Time management
68. Attend/testify at court
69. Teach job hunting
70. Academic skills
71. Territoriality concepts
72. Protect from sexual abuse
73. How to use journal
74. Advocacy with utilities
75. Multiple-impact therapy

Fraser, M., Pecora, P., & Haapala, D. (1991). *Families in crisis: The impact of intensive family preservation services*. Hawthorne, NY: Aldine de Gruyter.

Appendix 2 (cont)

Major Techniques Checklist:

1. Focus on structure
2. Building structure/daily routine
3. De-escalating (providing structure during crisis)
4. Structuring interview: focus client on goals, problems
5. Structuring treatment situation
6. Focus on problem-solving
7. Analysis of obstacles to task achievement
8. Contract setting/negotiation
9. Exploration
10. Generating alternative actions, planning details of problem-solving steps
11. Homework assignments (tasks)
12. Seeking verbal reports of between-session experiences
13. Focus on Individual psychological functioning
14. Encourage catharsis/ventilation
15. Examining client's current behavior and its consequences
16. Examining client's past life experiences and their effects
17. Examining patterns of client behavior, how they affect goal achievement
18. Analysis of transference
19. Focus on individual behavior
20. Behavioral contracting
21. Teaching cognitive self-control
22. Reinforcement
23. Simulation (modeling, role playing, behavioral rehearsal)
24. Systematic desensitization
25. Teaching use of time-out
26. Teaching use of token system
27. Focus on the family
28. Clarifying family roles
29. Clarifying family rules
30. Use of family process
31. Family sculpture
32. Reframing
33. Focus on skills
34. Anger management skills
35. Child management
36. Communication skills
37. Negotiation skills
38. Problem-solving skills
39. Relaxation skills

40. Social skills
41. Provision of information
42. Provide information on child development
43. Provide literature
44. Provide resource information
45. Monitoring
46. Daily journal use by client
47. Repeated use of scales of questionnaires
48. Tracking child behavior
49. Tracking parent behavior or affect
50. Other techniques
51. Accompanying client to other agencies/resources
52. Advice, direction or instruction
53. Providing concrete resources
54. Encouraging and building hope
55. Use of group process
56. Recreation or activity therapy
57. Self-disclosure or practitioner
58. Values clarification

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

Therapeutic Interventions Inventory:

1. Drawing ecomaps/assessing social support
2. Confrontation
3. Behavior rehearsal/role play (practice for future use)
4. Circular questioning
5. Structured family interview
6. Identifying behavioral sequences
7. Speaking in metaphor
8. Reframing (relabeling, positive connotation)
9. Prescribing the symptom
10. Predicting the relapse
11. Drawing genograms (multigenerational history)
12. Encouraging clients to get the family facts
13. Positive/negative reinforcement
14. Tracking or charting behaviors
15. Multiple impact therapy
16. Hypothesizing the function of the symptom (i.e., purpose, effect, or gain)
17. Coaching verbal or non-verbal expression (e.g., "I" statements, direct requests)
18. Blocking (e.g., refusing eye contact, moving seats, interrupting)
19. Unbalancing (allying with subsystem, e.g., telling parents they managed a difficult situation well)
20. Restraining change (e.g., suggesting clients go slow, speculating on the consequences of change)
21. Developing a time line (chronology of problems, important events, developmental issues)
22. Child behavior management skills (consequences, behavior charts, token economics, PET, STEP)
23. Other parenting skills (e.g., age-appropriate care and expectations, nurturance, child development)
24. Communication skills (e.g., "I" messages, active listening, feedback, negotiation)
25. Cognitive interventions/self-management skills (self monitoring, changing "self-talk" values clarification)
26. Assertiveness/self advocacy skills (e.g., levels of irritation, assertive responses, accepting "no" from others)
27. Anger/conflict management skills (e.g., identification of emotions/areas of conflict, fair fighting)
28. Problem-solving skills (e.g., prioritizing problems, no-lose problem solving, problem ownership)
29. Home/financial management skills (e.g., cleaning, shopping, cooking, bud-getting, daily routine)
30. Leisure time activities (e.g., teaching how to develop or use)

31. Sex education (e.g., birth control, avoiding victimization, dealing with sexual training)
32. Negotiating local service systems (what services are available, how to access)
33. Coordinating services
34. Accompanying family/member to appointment
35. Advocating for the family
36. Building informal support networks
37. Developing community resources
38. Testifying/attending court hearings
39. Providing or arranging for concrete services
40. Information and referral (not arranging for services)

Concrete Service Inventory:

1. Provide transportation (e.g., you drove client to Job Service)
2. Help client get transportation
3. Provide food
4. Help client get food
5. Give financial assistance to client
6. Help client obtain financial assistance (e.g., AFDC, SSI)
7. Provide childcare/baby-sitting
8. Help client obtain childcare/baby-sitting
9. Provide clothing
10. Help client obtain clothing
11. Help client obtain legal aid
12. Move client to a new dwelling
13. Help client obtain housing
14. Help client obtain utility benefits or services
15. Do housework/cleaning with client
16. Help arrange homemaker cleaning services
17. Help client obtain medical or dental services (e.g., visiting nurses)
18. Provide a job
19. Help client find a job
20. Provide furniture or other household goods
21. Help client obtain furniture or other household goods
22. Provide toys or recreational equipment
23. Provide recreational activities
24. Arrange for recreational activities (e.g., YMCA, girl/boy scouts)
25. Arrange for life skill classes (e.g., driver education classes, other educational programs)

Pecora, P.J., Fraser, M., Nelson, K., McCroskey, J., & Meezan, W. (1995). *Evaluating family based services* (pp. 65-89). Hawthorne, NY: Aldine de Gruyter.

**Appendix 3:
Operational Definitions of Services and Interventions**

1. **Worker encourage client to call during crisis:**
Worker suggests, recommends, and/or encourages family members to call during crisis
2. **Build structure/routine:**
Work with family on organization, chores, time limits, help the build charts/schedules, define consequences/rewards; reinforce parent follow-through
3. **Providing structure during:**
Structure situation; allow venting/sharing of feelings in safe environment, clarify problems, look at options, counter "awfulizing," use time out/separation of clients
4. **Focus and define client's problems, goals, and treatments:**
Worker and family members explore and define specific problems; negotiate expectations, work for mutual agreement on goals, methods, measurement of success
5. **Define obstacles to task achievement:**
Identify events, relationships and behaviors that interfere with successful accomplishments of tasks, goals and/or behaviors
6. **Explore problems:**
Work from generalized labels of problematic behavior down to specifics; break into small, manageable goals; examine why this is a problem; determine problem ownership, family goals/values in relation to problem
7. **Generate action plan:**
Negotiate mutual agreement on treatment methods to be used, how to measure success, consequences, timetables
8. **Negotiating and contracting:**
Following the brainstorming of how to act, negotiation of specific goals, methods and timeframes all agreed upon in contract form
9. **Homework assigned between appointments:**
Worker assigns behavioral activities for individual family members and/or family as whole to complete and practice

10. **Build in hope:**
Model positive view; conveying confidence that something beneficial will emerge from their work together. Specification of tasks from the simple to the complex which will provide for the potential of success.
11. **Seeking verbal reports between sessions of progress:**
Client and worker communicate between face-to-face sessions to review client/family progress; monitoring client activities and compliance to treatment plan
12. **Encouraging individual ventilation and catharsis:**
Help clients to express themselves, tell their stories, and share their pain and happiness; self-reflection
13. **Examine current behaviors and consequences:**
Pointing out patterns and themes of behavior and the results of the behavioral decisions
14. **Examine past behavior and consequences:**
Reflecting on behavior patterns and themes from the distant past as it might be relevant or applied to present situation and treatment
15. **Analysis of transference:**
Discuss feelings that the client may feel in relation to the worker
16. **Listening to client:**
Workers closely attend to family's verbal and non-verbal messages; use reflective, empathetic listening to assess problems, build relationships, de-escalate feelings
17. **Offering support:**
Listening, empathetic response, ask for clarification, encouraging
18. **Reframing situation:**
Help family look at different views of their situation/problems; help them relabel behaviors in more benign, non-threatening description. Putting a positive connotation to a destructive behavior; naming it as an effort to preserve the family unit; defining a problem as a solution to another problem
19. **Providing reinforcement:**
Providing affirmation for positive changes made in attitudes or behaviors-rewards for positive behavior

20. Behavioral contracts:
Creation of a written document/ charts in which rules and responsibilities of each party is identified and recorded
21. Teaching cognitive self-control:
Identify with parents and child situations when one is likely to be impulsive (i.e., shoplifting); teach consequential decision-making; give homework on what one does or doesn't want to happen. make prevention plan
22. Teaching problem solving:
Teach how to isolate problems and break them down into smaller manageable issues; help family practice on areas of conflict; defining issues; developing means to deal with the life issue; evaluating means; selecting and carrying out specific action
23. Teaching time out:
Teach parent time out as a personal coping skill and also a behavioral consequence; prepare child for the consequence; model approach to help parent develop skill; teach what happens after time out is administered
24. Teach use of token systems:
Help parents set up structure/behavioral management arrangements utilizing a tangible reward system to encourage positive behavior (ex. giving points for positive behavior to be turned in later for a much desired object)
25. Teaching anger management:
Teach persons how to identify anger at earlier stages and interrupt anger chain; rehearse; teach de-escalation techniques (self and others)
26. Teaching child-behavior management skills:
Instruct parents in appropriate limit setting. how to handle their child's frustration and temper tantrums; "I" messages, positive self-talk
27. Teaching communication skills:
Teach specific skills to manage interpersonal situations. how to listen, body language; relationship dynamics through the use videotapes, handouts, coaching sessions
28. Negotiation skills:
Teach ways to work together toward a specific agreement - avoid conflict, power struggles; teach brainstorming techniques, how to evaluate/revise solutions

29. **Relaxation:**
Use progressive relaxation/imagery instruction; show and then watch client self-instruct; may use tapes; also teach/employ breathing exercises, physical exercise
30. **Social skills:**
Teach skills to handle specific interpersonal situations, development of etiquette, and awareness of relationship dynamics
31. **Teaching through role-play**
Teaching families the theory of how using a simulated event can be useful in preparing for future events
32. **Examine behavior patterns as to how goal achievement is affected:**
Review and analyze behavior trends and impact on family functioning
33. **Clarify family rules:**
Help family members to define, communicate, agree on rules, write down and post
34. **Clarify family roles:**
Assess member roles in family; help family set appropriate and clear expectations
35. **Family council:**
Teach how to arrange and conduct a family meeting, identify and model rules, procedures, and work to accomplish
36. **Family sculpting:**
Family members are asked to imagine others as malleable and place them in spatial and postural relation to one another as a means to expressing feelings and relationships
37. **Provides information on child development:**
Teaching parents to understand developmental stages, age-appropriate behaviors, changing needs of children, to have realistic expectations based on age, how to help a child learn self-dependence; use child development materials, handouts
38. **Provide literature:**
Give handouts on topics being discussed
39. **Provides information on resources:**
Provides necessary resource information to client-contact information, phone numbers, addresses, and services provided
40. **Tracking/charting child behaviors:**

- Show parents how to count frequencies of problem behavior, how to graph behavior, how to analyze trends; show children how to make out their own behavioral charts
41. **Teaching parenting skills:**
Teach concept and skill; help parents identify consequences; prepare child for the consequence; model approach to help parent develop skill; teach what happens after consequence; identify with parents and child situations when one is likely to be impulsive (i.e., shoplifting); teach consequential decision-making; give homework on what one does or doesn't want to happen, develop prevention plan
 42. **Teaching assertiveness and advocacy skills:**
Teaching family members how to directly and honestly express both positive and negative feelings in interpersonal situations
 43. **Teaching self-management skills:**
Identify and question/dispute person's irrational thoughts and beliefs; practice with client to help reduce unhelpful thoughts, identify cues that generate such thoughts, challenge these negative thoughts and make more realistic appraisals; give homework
 44. **Teaching home-management skills:**
Teach budgeting techniques and management of expenditures; help clients set up budgets; monitor budgets/expenditures; teach and help persons implement techniques for organizing their time; prioritizing activities; scheduling time; teach how to implement home safety measures
 45. **Draw a time-line:**
Developing a graphic experience of individual and /or family chronology which represents successes, benchmarks, traumas, stressors, births, deaths
 46. **Restraining change:**
Teach how behaviors are learned and are learnable; how to recognize progress; slowing the process of change; recognizing the consequences of change
 47. **Hypothesizing function of symptom:**
Speculating why the client cannot change problem behavior
 48. **Drawing eco-map:**
Drawing a diagram with family, which visually depicts formal and informal support systems
 49. **Drawing genograms:**

- A format for drawing a family tree that presents information about family members and their relationships for at least three generations, charting births, deaths, marriages and divorces
50. **Behavioral rehearsal/role play:**
Family members rehearse behaviors related to events or situations they anticipate arising in the future with the worker and with one another, such as parenting issues, assertiveness, social skills, communication problems
 51. **Structured family interview:**
A pre-planned interview with a designated family sub-unit
 52. **Predicting re-lapse:**
Warn families of attitudes and behaviors, which are predictive of relapse-particularly Pertains to substance abuse
 53. **Circular questioning:**
Reaching for a feeling with client to invite further discussion; shifting focus from situation to feelings and back for fuller understanding
 54. **Identifying behavioral sequences:**
Teach person to monitor own or family members' emotions or moods, to recognize emotion prior to escalation of a behavior, to identify both frequency and intensity. often includes charting
 55. **Using metaphor to convey a point:**
Helping family to gain a clearer understanding and invite further discussion by using a figure of speech
 56. **Encouraging family to get family facts:**
Suggesting to family members that identifying their family history might be useful in understanding their present situation
 57. **Confrontation:**
An even-tempered assertion initiated by worker in order to mobilize energy for work and challenge avoidance
 58. **Daily journal use:**
How to keep journal; applications to improve self-talk, track personal or family member behavior, for ventilation/ de-escalation
 59. **Tracking parent behavior or affect:**

Teaching child to monitor parents' emotions or moods, to recognize emotion prior to escalation, to identify both frequency and intensity, often includes charting-for the purpose of understanding and self-protection

60. Self-disclosure of practitioner:
Appropriate sharing of worker's personal information concerning life experiences, attitudes, and feelings
61. Arrange for day care or respite services:
Negotiate for day care or respite program for client- make the contact, accompany client
62. Recreation or activity therapy:
Take clients on excursion to museum, shopping trips, lunch/dinner/breakfast dates, hikes, walks, use artwork or games as an individual or family activity
63. Accompanying clients to other agencies:
Meet in case coordination, provide and request/receive information, share information, solve problems, negotiate on clients' behalf
64. Providing financial resources:
Provide cash assistance to pay for food, clothing, household furnishings and repairs, car repairs, utility and housing deposits
65. Provides transportations:
Transport clients to and /or from social service, medical, court, school, and employment appointments
66. Attend/testify at court:
Make progress reports or recommendations to the court; accompany clients to court Proceedings as a form of advocacy and support
67. Teach use of leisure:
Develop lists of possibilities; help select and plan appropriate activities
68. Teaching how to negotiate local service systems:
Teach clients how to appropriately assert themselves with other social service organizations; expressing opinions; standing up for own rights; teach skills to handle specific interpersonal situations
69. Advocacy with schools and social services:
Negotiate for special programs or allowances; staff cases, share information, solve problems, get child into programs, sit on IEP meetings; speak on behalf of family

70. **Develop informal supports:**
Teach how to make friends; teach clients how to ask for help from neighbors and relatives; help client to learn about social support networks in their community, such as, church groups and informal support groups
71. **Providing case management services:**
Negotiates, coordinates, and ensures the linkage between clients and the receipt of necessary services
72. **Teaches sex education:**
Teach responsible sexuality; birth control information; use books, tapes, films; teach personal boundaries, impulse control
73. **Teach job hunting or interviewing skills:**
Teach how to interview for a job, grooming, hygiene, and attire
74. **Help client find housing or move:**
Help client to identify affordable, safe, and appropriate housing; transport family belongings
75. **Use of crisis card:**
Make up an individual crisis card with person; recognize emotions prior to escalation, and identify calming activities
76. **Miracle Exercise:**
Help clients to identify their hopes and dreams by imagining what their world would be like if a miracle occurred
77. **Solution-focused techniques:**
Families rate their programs on a scale of 1 to 10 at beginning, middle, and end of treatment
78. **Information and referral provided:**
Provides information about resources and eligibility requirements/intake procedures; includes advice on how to access services and be good consumers
79. **Values clarification:**
Discuss values/motivations of parent and child, help them identify differences and how these affect behavior; bridge age gap; use values clarification tools
80. **Recognize suicide potential:**
Conducts risk assessment, discusses with client and family, intervenes where appropriate

81. **Makes supportive phone call:**
Make unplanned phone call to show availability, concern, and understanding
82. **Makes purposeful phone call:**
Makes scheduled phone call to show availability, concern, and understanding, follow-up on activities or actions to be taken
83. **Gives advice or direction:**
Suggesting, urging, warning, where appropriate
84. **Worker observes:**
Taking into account physical development and cultural influences of family; notes significant shifts in nonverbal behaviors; assesses family dynamics; discrepancies between verbal and non-verbal communication; condition of home; safety of children
85. **Worker physically restrains child:**
If a child is physically violent to self or others, worker gently and calmly holds child
86. **Discusses termination:**
Worker establishes termination date at first session and periodically reminds the family of the ending date
87. **Discusses family progress at the time of termination:**
Worker and family discuss original purpose of contact, goals, and accomplishments immediately before ending (1 week) and at the final meeting
88. **Reflect and validate feelings:**
Clarifying the content and /or feelings of a client's message in order to encourage expression, control and manage feelings and actions, support and encourage
89. **Provide praise:**
Reinforce family/client success with positive reinforcement; acknowledge and compliment
90. **Discusses future hopes and goals:**
Identify what the family envisions as their ideal future for each family member
91. **Discuss problem impact on health:**
Dialogue with family concerning how the risk within the family has influenced the health of family members

92. Explore family respect and support:
Dialogue with family members concerning how respect is exhibited or not; how family members help and support one another or not
93. Explores family coping skills:
Dialogue with family regarding their ability to cope with family/environmental problems
94. Explores religion:
Dialogues with family about their involvement in religion, the importance it has in their family life
95. Couple counseling:
With the partners explores divergent views; legitimizes differences in perceptions; awareness; makes therapeutic demands
96. Uses art as a therapeutic tool:
Engages family member/s in drawing, painting, sculpting
97. Makes dinner together:
Shop for, prepare, and eat the meal as a family
98. Uses paradoxical intention:
Presenting an oppositional/counter suggestion to stimulate change, reactivity, family solidarity
99. Uses games as an activity:
Therapeutic games, board and card games are played with the family unit
100. Makes a garden:
An individual and family activity of planning an indoor or outdoor garden
101. Hikes/Walks:
Planned walks and hikes with family members
102. Animals are used as a therapeutic activity:
Small animals are purchased and children are taught to care for them
103. Co-therapist:
A two person therapeutic team works with family

104. Chores are an activity:
Worker assists client in completing household chores, such as laundry, cleaning, safety proofing home
105. Utilizes affirmation:
Identifying the strengths of the family and reinforce these through a positive statements, which may be used repeatedly and the client may adopt
106. Recognizes birthdays or special family occasions:
Worker acknowledges special occasion (birthdays, weddings, births) with a family function and possibly a present
107. Family night celebration:
Family plans a celebration with the worker to commemorate a success, a beginning or an ending
108. Visualization:
Imagining, projecting into the future, envisioning through graphic representation to enhance understating
109. Helps with homework:
Assists children with their homework assignments
110. Talking stick:
In a family meeting the "talking stick" is to be held by the individual speaking thus allowing for coordinated communication; models positive social skills
111. Uses a sand tray:
Children play in a simulated sand box
- 112: Photography:
Taking pictures of the family, having them developed and sharing what people see and feel about the picture
113. Identifies family strengths:
Each family member presents their view of the family assists and the worker also present their perception of family strengths
114. Encourages family:
Makes supportive statements to family/recognizing all successes no matter how small

115. Identifies feelings:

Assist clients in examining, discussing, investigating, and naming their feelings

Appendix 4: Cover Letter to Families from Director of FIP**NEW YORK FOUNDLING**

AN ENVIRONMENT FOR UNLIMITED POTENTIAL

*Helping Children and Families Succeed***Dear**

We have always wanted to provide the best possible service to families we work with. In order to continue providing this type of service with other families we need to know how our service helped or did not help your family.

Daria Hanssen, a long time provider of services to children and families, is a doctoral candidate who is conducting a research study of the services we offer at Families First, as part of a project known as a dissertation. Ms. Hanssen has enclosed a letter explaining how you can participate in the study, if you choose to do so and how she intends to compensate you for the time you take to complete the survey.

It is important for you to know that confidentiality is essential to Ms. Hanssen's research. In other words, we will not know how you answered the survey. In addition, you will certainly not be penalized in any way if you choose not to participate. . But your input will be helpful to us in providing quality services.

Thank you for taking the time to read the enclosed letters and questionnaire from Ms. Hanssen.

Sincerely,**Walter Chrisman, Director****ST. AGATHA HOME • ULSTER PREVENTION SERVICES****6.Adams Street, Kingston, NY 12401 • (914) 338-3090 • Fax: (TO) 338-4773**

**Appendix 5:
IRB Proposal and Cover Letter to Families from Researcher**

Daria Hanssen, MSW, Doctoral Candidate
12 Bernhart Road
Wallkill, New York 12589
845-895-8179 – daria.hanssen@marist.edu

October 11, 2001

To: Institutional Review Board Committee

From: Daria Hanssen

Re: Revisions to IRB Protocol Submission

Project: A Look Inside the Black Box: Exploring Service Delivery
in an Intensive Family Preservation Program

The following resubmission addresses the questions and concerns raised by the Committee.

I. Major Objectives of Research

Few empirical studies have been undertaken to examine the specific nature of service and intervention characteristics of intensive family preservation practices. In light of this gap in research, the purpose of this dissertation study is to examine and describe the characteristics of intensive family preservation service delivery and to gain an understanding of the relationships between placement of children, interventions provided, and the characteristics of families served.

This author hypothesizes that defining the specific interventions can enhance practice, program development, social work practice and education.

This dissertation addresses the following research questions:

1. Is there a specific constellation of interventions that intensive family preservation workers provide for various identified family problems?
2. What are the interventions that are associated with positive outcomes for families participating in the Families First program?
3. Is there a relationship between improved family functioning and a pattern of services provided?
4. Are there services/interventions that families find to be the most and least helpful?
5. Are there differences in family characteristics, identified problem, service constellation and outcomes as referred by varying referral sources?

II. Research Plan and Procedures

This research design combines a quantitative and qualitative approach. The quantitative approach will use available clinical information obtained from existing client records from closed cases of Families First, the site of the research study. The objectives of the quantitative design are to:

1. Gather demographic data, referral sources, family risk factors, interventions and services provided, and outcome of service provision.
2. Explore the relationships between types of services provided and a variety of variables, particularly child and family functioning and placement prevention.

The outcome of services: child placement, reunification, and improvement in child/family functioning are the dependent variables. The independent variables include all services and interventions provided during the course of treatment. The inventory of services and interventions has been derived from a combination of existing intervention and service scales/inventories (see attached Inventory of Variables for Family Characteristics and Services appendix 1 & 2).

The source of service/intervention data and the selection criteria will be conducted as follows. The researcher will examine all closed clinical records of families served from January 1, 2000 through December 31, 2001. In order to protect the confidentiality and identity of the family in question,

identifying family data will be stripped from the record and a code will be assigned to each closed case, prior to examination by researcher. Data to be gathered from the record and subsequently analyzed includes: services and interventions, family composition, risk factors, referral source, and outcome data, including placement or reunification outcome data. The researcher named on this application/proposal is the only person who will be responsible for the collection, analysis, and storage of data from the closed case records. Data retrieved from closed cases will be translated into numerically coded categories and immediately entered on a social science statistical program to disk to be analyzed in aggregate form, at a later date. All disks will be stored in a locked storage cabinet at the home of the researcher. No other individual will have access to the storage cabinet. All data will be preserved for three years and then destroyed.

There have been few qualitative studies of intensive family preservation services published to date. The qualitative methodologies allow a look at the intangible issues of importance to practitioners, including how families experience services and whether families felt empowered by services. The qualitative portion of this study will aid in understanding the services provided to families and their affect, from the perspective of the parents. Of particular interest is the availability of the worker to the family, goals the family believes they achieved or did not achieve, the impact services had on the family, and the overall helpfulness of intensive family preservation services.

A self-administered mail-in survey (appendix 6) will be utilized to collect data regarding the family's experience of services. A list will be compiled by the agency director of cases that were closed between January 2000 and December 2001 (approximately 130 cases) and each will receive a survey. A master list, which will identify family by name and address, will be given a code. This code will also be applied to the questionnaire/survey for the purpose of identifying those individuals responded so that they can be remunerated for their participation and to protect their identity so that the researcher can not identify who the respondent is. There will be no attempt to link the questionnaire code to the closed case record.

Each family on the master list will receive a questionnaire and information packet from the agency. The agency has agreed to send out the initial mailing which will include: 1) a letter from the agency director on agency letterhead explaining their participation in the research study, assuring the family that their choice to participate is confidential and will not be made known to the agency. Further, the letter will assure them that if they are willing to

participate in the research project, access to future services from Families First will not be affected (appendix 3); 2) a cover letter from the researcher to the family describing the research project and its goals, efforts to protect their privacy and confidentiality and remuneration information (appendix 4); 3) the informed consent form (appendix 5) should they agree to participate; 4) the survey (appendix 6) and a self-addressed stamped envelope for the completed questionnaire to be returned directly to the researcher. The agency will have no knowledge of who responds or does not respond to surveys.

Each family that completes the questionnaire will receive a \$10.00 money order to compensate them for their time and energy.

Data obtained from the surveys will be reviewed and translated into numerical codes by the researcher who will enter them on a coding form. Data from these forms will be transferred to a computer file. Data will be analyzed in aggregate form. All data, including computer disks, hard copy interpretation forms, the completed surveys, and the master list will be stored in a locked file cabinet in the home of the researcher to which no one else has access. Three years following completion of the project, the data will be destroyed.

III. Potential Harm to Human Subjects

Given that the case records to be reviewed are closed and the focus is specifically service provision, demographic data, and outcomes, there is no identifiable risk to the participant.

Surveys will be addressed and completed by parents or guardians who received services from Families First. Although remuneration is offered in exchange for the time and energy it takes to complete the survey, it is modest and therefore not coercive in nature.

There is no known risk to those who participate in completing a survey of this nature. Families are reassured in the letter from the researcher that participation or non-participation in the completion of the survey will not affect their ability to access services from Families First in the future, particularly since Families First will not have knowledge of who responds or does not respond. Case record reviews cannot be cross-referenced to surveys.

In order to insure that families do not feel coerced to complete questions that may cause them discomfort, the directions that accompany the survey suggest they only answer those questions that they feel comfortable responding to.

IV. Model Letter to Families

**Daria Hanssen, MSW
12 Bernhart Road
Walkill, New York 12589
845-895-3961**

I am a social worker and a doctoral candidate at the Hunter College School of School Work and I am writing to invite you to participate in a study that is part of a research project known as a dissertation. The dissertation is a requirement for the completion of my doctoral degree. Professor Irwin Epstein from the Hunter College School of Social Work supervises my activity as a doctoral candidate.

The purpose of my study is to learn about the services and interventions you received when working with Families First. I am particularly interested in knowing what services were the most and the least helpful to you and your family. The knowledge obtained from this study will be helpful to people planning family and children's services so they can better serve families in need.

There are no known risks to participating in the completion of this questionnaire. Nor will your participation in filling out the questionnaire affect your ability to receive future services from Families First. I will be the only person that will know whether you have participated in this survey or not. As well, the results of your responses to questions will not be discussed with anyone from Families First. Nor will the information you share become a part of any permanent file. However, it is likely that I will be discussing the results of all of the questionnaires, with my advisors at Hunter College School of Social Welfare.

The focus of the questionnaire concerns the types of services you received from Families First. In order to protect your privacy, each questionnaire has a code assigned to it; therefore, your name will not appear on the questionnaire. The code will refer me to a master list, which includes your name and address. This will enable me to identify that you have returned the form, so that I can compensate you for your time and energy. All of the completed questionnaires and the master list will be kept in a locked file, I will be the only person who has access to the questionnaires and your name will not appear on any research form. At the completion of the study, all of the information will be destroyed.

Please do not answer any question you do not feel comfortable responding to. Your decision to participate or not will not be discussed with Families First.

If you have any questions about the research, you can contact me directly, at my confidential phone number, 845-895-3961. If at any point you have questions about the research that is being conducted, or about your rights as a participant in a research study, please contact: The Committee for the Protection of Human Subjects, Hunter College, 695 Park Avenue, NY 10021 at 212-772-4020. The Committee is in charge of research protocols at Hunter College School of Social Welfare. You may also contact my advisor, Dr. Irwin Epstein at 212-452-7030, if you have any concerns.

In recognition of the important contribution you are making by participating in the research and in compensation for your time, you will receive a \$7.00 money order upon receipt of the completed questionnaire.

Your signature below indicates that you understand your rights in the research and are participating in this study freely.

Thank you for helping to improve services for all families.

V. Informed Consent

Agreement:	
Your signature indicates that having read the information provided above, you have agreed to participate in the research and that you have received a copy of this form.	
_____	_____
Signature	Date

NEW YORK FOUNDLING

AN ENVIRONMENT FOR UNLIMITED POTENTIAL
Helping Children & Families Succeed

June 27, 2001

Hilary Fisher, Director of Sponsored Research
 Graduate Center
 CUNY Office for Sponsored Programs
 365 5 Avenue
 New York, NY 10016-4309

Dear Ms. Fisher:

As the supervisor of the Families First program of Ulster Prevention Services, I grant permission to Daria Hanssen to do her doctoral research at our agency. Specifically, she is granted permission to review our clients' files as well as to interview former clients.

If you have any further questions regarding this matter, please feel free to give me a call at (845) 338-4760.

Sincerely,

Walter Chrisman, M. S.

ST. AGATHA HOME • ULSTER PREVENTION SERVICES
 6 Adams Street, Kingston, NY 12401 • (914) 338-3090. Fax (914) 338-4773

Appendix 6: Self-administered Questionnaire

Code Number _____

Instructions: You are being asked to evaluate the service you received from Families First. Please mark with an X the column that best describes your experience with your worker from Families First. All of your comments will remain confidential. Your responses will not be discussed with Families First. Please answer as many questions as you can.

SERVICES	1. Always	2. Most of the time	3. Some of the time	4. Rarely	5. Never	6. Not Sure	7. No Comment
1 Worker scheduled appointments at my convenience							
2 Worker met with me often enough							
3 I felt my worker listened to me							
4 I felt my worker understood my situation							
5 My worker encouraged me to call anytime I needed help							
6 I called my worker when I had an emergency							
7 The emergency worker responded in a helpful way							
8 The service I received from Families First was helpful to me and my family							

Code Number _____

Please indicate with an X whether or not you received the following services from your Families First worker.

SERVICES	1. Yes	2. No	3. Don't know	4. Wish I had received but didn't
1. Family counseling				
2. Individual counseling				
3. Crisis intervention				
4. Substance abuse counseling				
5. Transportation				
6. Advocacy with various agencies and schools				
7. Recreation activities				
8. Financial help				
9. Parent education				
10. Communication skill development				
11. Assertiveness training				
12. Anger management				

Code Number _____

Please answer the following questions to the best of your knowledge.

1. Did you and your worker identify goals together?

Yes No

2. Please describe the kinds of goals you focused on.

3. Were you successful at accomplishing these goals?

Yes No

4. Please describe what changed in your family as a result of accomplishing these goals.

5. Since working with Families First, my situation has:

Very much improved Improved stayed the same

Worsened Very much worsened

6. Is there anything that your worker should have done differently?

7. Do you have any other positive or negative thoughts or feelings about Families First or your worker that you would like to share?

Appendix 7: Return Postcard

Two weeks ago I sent a questionnaire asking about services you received from FIP. If you are interested in participating in this study, please return the questionnaire in the self-addressed and stamped envelope. I will promptly send you \$10.00 for participating in the study.

Thank you for your help.

Daria Hansen

Appendix 8: Frequency Distribution of Soft Services

Type of Services	Frequency	%
Explore problems	116	100.0
Makes purposeful phone call	114	98.3
Defines treatment plan	113	97.4
Examines past behavior/consequences	113	97.4
Examines current behaviors	112	96.6
Define obstacles to task achievement	112	96.6
Provides praise	110	94.8
Discusses problems impact on health	110	94.8
Makes supportive phone call	110	94.8
Explores family coping skills	110	94.8
Reflect and validate feelings	109	94.0
Identifies family strengths	109	94.4
Listens to client's story	109	94.0
Generates action plan	108	93.1
Provides praise	108	93.1
Gives advice and direction	105	90.5
Contracting and negotiating	105	90.5
Encourage individual ventilation	104	89.7
Offers support and understanding	104	89.7
Use of family process	102	87.9
Worker observes	102	87.9
Teaches parenting skills	101	87.1
Discusses termination	101	87.1
Seeks verbal reports between sessions	100	86.2
Clarifies family rules	100	86.2
Conducts structured family interview	100	86.2
Builds in structure and daily routine	98	84.5
Discusses progress at termination	96	82.8
Builds in hope	96	82.8
Discusses future hopes and goals	92	79.3
Explores family coping skills	92	79.3
Provides structure during crisis	88	75.9
Confrontation	88	75.9
Examining behavior patterns	88	75.9
Clarifying family roles	84	72.4
Developing a time-line	82	70.7
Identifying behavior sequences	81	69.8
Values clarification	79	68.1
Teaching communication skills	77	66.4
Explores family respect and support	77	66.4
Provides information on child development	76	65.5
Teaching anger management skills	74	63.8
Teaching Child behavior management skills	72	62.1
Explores religion and spirituality	65	56.0

Tracking Parent Behavior or Affect	43	37.1
Behavioral Contracting	71	61.2
Tracking /charting child behaviors	70	60.3
Teaching Problem Solving	59	50.9
Teaching Through role-playing	52	44.8
Reframing Situation for Client	50	43.1
Behavioral rehearsal	47	40.5
Provides Literature	47	40.5
Uses art as a therapeutic tool	42	36.2
Teaching relaxation skills	41	35.3
Uses games as a therapeutic activity	41	35.3
Couples counseling	41	35.3
Solution-focused techniques used	34	29.3
Encourages family and child	31	26.7
Teaching time out	30	25.9
Recognize and assess for suicide	30	25.9
Teaching use of token system	29	25.0
Teaching assertiveness	28	24.1
Hypothesizing function of symptom	28	24.1
Encouraging clients to get family facts	24	20.7
Teaching social skills	23	19.8
Worker physically restrains child	23	19.8
Predicting relapse	21	18.1
Using metaphor to convey a point	21	18.1
Restraining change	15	12.9
Identifies feelings	15	12.9
Makes dinner together	15	12.9
Hikes/walks	15	12.9
Daily journal use encouraged	14	12.1
Drawing genograms	10	8.6
Visualization	6	5.2
Drawing eco-maps	5	4.3
Self-disclosure of practitioner	4	3.4
Makes a garden	4	3.4
Uses animals as a therapeutic activity	4	3.4
Co-therapist is used	16	13.8
Using crisis card	3	2.6
Affirmations are used as an intervention	3	2.6
Photography	3	2.6
Use of family sculpting	2	1.7
Miracle exercise	2	1.7
Circular questioning	2	1.7
Talking stick	2	1.7
Uses paradox	1	.9
Uses a sand tray	1	.9

References

- Adams, P. (1994). Marketing social change: The case of family preservation. *Children and Youth Services Review, 16*, (5/6), 417-431.
- Ainsworth, M. D. (1989). Attachments beyond infancy. *American Psychologist, 44*, 709-716.
- AuClaire, P. & Schwartz, I. M. (1986). *An evaluation of the effectiveness of intensive home- based services as an alternative to placement for adolescents and their families*. Minneapolis: MN: Hennepin County Community Services Department, and the University of Minnesota, Hubert H. Humphrey Institute for Public affairs.
- Auslander, G., Doborf, J., & Epstein. I. (2001). Comparing social work's role in renal dialysis in Israel and the United States: The Practice-Based Research Potential of Available Clinical Information. In I. Epstein and S. Blumenfield (Eds), in *Clinical data mining in practice-based research*. New York: Haworth Press pp.129-151.
- Austin, D.M. (1998). *A report on progress in the development of research resources in social work*. Austin: University of Texas School of Social Work.
- Babbie, E. (1990). *Survey research methods*. California: Wadsworth Publishing Company.
- Bandura, A. J. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice-Hall.
- Barth, R. P. (1990). Theories guiding home-based intensive family preservation services. In J. K. Whittaker, J. Kinney, E. M. Tracey, & C. Booth (Eds.), *Reaching high risk families: Intensive family preservation in human services* (pp. 89-112). New York: Aldine de Gruyter.
- Barth, R.P. (1997). Family reunification. In J. Berrick, R. Barth, & N. Gilbert (Eds.), *Child welfare research review*, Vol. 2. (pp. 219-228). New York: Columbia University Press.
- Barth, R. P. & Berry, M. (1987). Outcomes of child welfare services under permanency planning. *Social Service Review, 61*, 71-90.

- Bath, H.I. & Haapala, D.A. (1994). Family preservation services: What does the outcome research really tell us? *Social Service Review*, 68, 386-404.
- Bath, H. I., Richey, C.A. & Haapala, D.A. (1992). Child age and outcome correlates in intensive family preservation services. *Children and Youth Services Review* 14, 389-406.
- Bell, J. Associates, Inc. and Chapin Hall Center for Children (1995). *A review of family preservation and family reunification programs. U.S. Department of Health and Human Services* (<http://aspe.hhs.gov/hsp/cyp/fpprogs.htm>).
- Berg, I.K. (1994). *Family based services: A solution-focused approach*. New York: W.W. Norton & Company, Inc.
- Berlin, G., (1992). Choosing and measuring interventions. *Children and Youth Services Review*, 14, 99-118.
- Bernard, D. (1992). The dark side of family preservation. *Affilia*, 17 (2), 152-159.
- Berry, M. (1992). An evaluation of family preservation services: Fitting agency services to family needs. *Social Work*, 37(4), 314-321.
- Berry, M., Cash, S. J., & Brook, J. P. (2000). Intensive family preservation services: An examination of critical service components. *Child and Family Social Work*, 5, 191-201.
- Berry, M. (1997). *The family at risk: Issues and trends in family preservation services*. Columbia, South Carolina: University of South Carolina Press.
- Berry, M. (1995). An examination of treatment fidelity in an intensive family preservation program. *Family Preservation Journal*, Summer, 25-67.
- Berry, M. (1994). *Keeping families together*. New York: Garland.
- Besharov, D. J., & Bachler, K. (1992). Demonstration and evaluation strategies. *Children and Youth Services Review*, 14, 1-18.
- Bickman, L. (1990). Study design. In Y. Y. Yuan & M. Rivest (Eds.), *Preserving families: Evaluation resources for practitioners and policymakers* (pp. 132-166). Newbury Park, CA: Sage Publications.

- Bickman, L. (1987). The functions of program theory. In L. Bickman (Ed.), *Using program theory in evaluation*. San Francisco: Jossey-Bass.
- Biestek, F. P. & Gehrig, C. C. (1978). *Client self-determination in social work: A fifty year history*. Chicago: Loyola University Press.
- Blythe, B. J., Salley, M. P., and Jayaratne, S. (1994). A review of intensive family preservation services research. *Social Work Research, 18*(4), 213-225.
- Bremner, R. (1971). *Children and youth in America: A documentary history*, Vol. 2. Cambridge, MA: Harvard Press.
- Brieland, D. (1995). History and evolution of social work practice. In R.L. Edwards & J.G. Hopps (Eds.), *Encyclopedia of social work* (pp. 739-744). Silver Spring, MD: National Association of Social Workers.
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge: Harvard University Press .
- Cheetham, J. (1992). Evaluating social work effectiveness. *Research on Social Work Practice, 2*(3), 265-287.
- Chen, H. T. (1990). *Theory-driven evaluations*. Newbury Park: Sage Publications.
- Chen, H. T. & Rossi, P. H. (1987). "The theory driven approach to validity." *Evaluation and Program Planning, 10*, 95-103.
- Cimmarusti, R. A. (1992). Family preservation practice based upon a multisystems approach. *Child Welfare, 72*(3), 241-256.
- Coleman, H. & Collins, D. (1997). The voices of parents: A qualitative study of a family preservation program. *Child & Youth Care Forum, 26*(4), 261-278.
- Corcoran, K. & Fischer, J. (2000). *Measures for clinical practice*. New York: The Free Press.
- Costin, L. B., Karger, H. J. & Stoesz, D. (1996). *The politics of child abuse in America*. New York: Oxford University Press.

- Craig-Van Grack, A. (1997). A taxonomy and recording instrument for process measurement of family preservation services. *Child Welfare* 75(2), 349-370.
- Dobrof, J., Dolinko, A., Lichtiger, E., Uribarri, J., & Epstein, I. (2001) Dialysis patient characteristics and outcomes: The complexity of social work practice with end stage renal disease population. In I. Epstein and S. Blumenfield (Eds.), *Clinical Data-Mining in Practice-Based Research*. New York: Haworth Press.
- Drisko, J. (1998). Utilization-focused evaluation of two intensive family preservation programs. *Families in Society*, 79, 62-74.
- Dylla, D. J., & Berry, M. (1998). The role of consistency and diversity in building knowledge in family preservation. *Family Preservation Journal*, 3(1), 1-19.
- Early, B. & Hawkins, M. (1994). Opportunity and risks in emerging family policy: An analysis of family preservation legislation. *Children and Youth Services Review*, 16(5/6), 309-318 .
- Epstein, I. (2001). Using available clinical information in practice-based research: Mining for silver while dreaming of gold. *Social Work and Health Care*, 4, 15-32.
- Epstein, I. (2000). *Using available clinical information in practice-based research: Mining for silver while dreaming of gold*. 2nd International Conference in Social Work in Health and Mental Health. Melbourne, Australia.
- Epstein, I. and Tripodi, T. (1977). Research techniques for program planning, monitoring, and evaluation. New York: Columbia University Press.
- Epstein, I. (1995). Promoting reflective social work practice. In P. Hess & E. Mullen. (Eds.), *Practitioner-researcher partnerships: Building knowledge from in and for practice*. Washington, DC: NASW Press.
- Epstein, I., Zilberfein, F. & Snyder, S. (1997). Using available information in practice-based outcome research: A case study of psychosocial risk factors and liver transplant outcomes. In E. J. Mullen & J. L. Magnabosco (Eds.) *Outcome Measures in Human Services: Crosscutting Issues and Methods*. Washington, DC: NASW.

- Fanshel, D. & Shinn, E. (1978). *Children in foster care: A longitudinal investigation*. New York: Columbia University Press.
- Farrow, F. (1991). Services to families: The view from the states. *Families in Society: Journal of Contemporary Human Services* 72(5), 268-275.
- Fein, E., & Maluccio, A.M. (1992). Permanency planning: Another remedy in jeopardy? *Social Service Review*, 66, 335-348.
- Feldman, L. (1991). Evaluating the impact of intensive family preservation services in New Jersey. In D. Biegel & K. Wells (Eds.), *Family preservation services* (pp. 47-71). Newbury Park, California: Sage Press.
- Forsythe, P. (1992). Homebuilders and family preservation. *Children and Youth Services Review* 14, 37-47.
- Fortune, A. (2001). Intervention research. *Social Work Research*, 23, 2-3.
- Frankel, H., (1987). Family-centered, home-based services in child protection: A review of the research. *Social Service Review*, 62(1), 137-157.
- Fraser, M., Nelson, K., & Rivard, J. (1997). Effectiveness of family preservation services. *Social Work Research*, 21 (3), 138-152.
- Fraser, M. & Pecora, P. (1991). Family and child characteristics: Who received intensive family preservation services? In M. Fraser, P. Pecora and D. Haapala (Eds.), *Families in crisis: The impact of intensive family preservation services* (pp. 83-107). New York: Aldine de Gruyter.
- Fraser, M., Pecora, P., & Haapala, D. (1991). *Families in crisis: The impact of intensive family preservation services*. Hawthorne, NY: Aldine de Gruyter.
- Fraser, M., Pecora, P. & Lewis, R. (1991). The correlates of treatment success and failure for intensive family preservation services. In M. Fraser, P. Pecora and D. Haapala (Eds.), *Families in crisis: The impact of intensive family preservation services* (pp. 181-224). New York: Aldine de Gruyter.

- Garbarino, J. (1982). *Children and families in the social environment*. New York: Aldine de Gruyter.
- Garrison, B. & Blalock, L. (1996). Intensive family preservation services. *Journal of Prevention and Intervention in the Community*, 14, (1/2), 101-114.
- Gelles, Richard (1996). *The book of David, how preserving families can cost children's lives*. New York: Basic Books. Germain, C.B. (1979). Introduction: Ecology and social work. In C. B. Germain (Ed.), *Social work practice, people and environments* (pp. 103-124). New York: Free Press.
- Germain, C.B. & Gitterman, A. (1996). *The life model of social work practice*. New York: Columbia University Press.
- Germain, C.B. & Gitterman, A. (1995). Ecological perspective. In R.L. Edwards & J.G. Hopps (Eds.), *Encyclopedia of social work* (pp. 816-824). Silver Spring, MD: National Association of Social Workers.
- Germain, C.B. (1981). Teaching primary prevention in social work: An ecological perspective. *Journal of Education for Social Work* 18, 20-28.
- Germain, C. B. (1980). Social context of clinical social work. *Social Work* 25, 483-438.
- Gershenson, C. P. (1991). Foreword. In M. Fraser, P. Pecora, & D. Haapala (Eds.), *Families in crisis: The impact of intensive family preservation services* (pp. xi-xiv). New York: Aldine de Gruyter.
- Gitterman, A., & Germain, C. B. (1976) Social work practice: A life model. *Social Service Review* 50, 601-610.
- Goldstein, J., Freud, A., & Solnit, A. (1979). *Beyond the best interests of the child*. New York: The Free Press.
- Grinnell, Richard M. (1997). *Social work research and evaluation: Quantitative and qualitative approaches*. Itasca, Illinois: F.E. Peacock Publishers.

- Haapala, D. A., Pecora, P. J. & Fraser, M. W. (1991). Implications for practice, policy, research and the future. In M. Fraser, P. Pecora & D. Haapala (Eds.) *Families in crisis: The impact of intensive family preservation services* (pp. 289-312). New York: Aldine de Gruyter.
- Hartman, Ann (1993). Family preservation under attack. *Social Work, 38* (5), 509-512.
- Hawkins, J. D. & Catalon, R. (1990). "Intensive family preservation services: Broadening the vision for prevention." In J.K. Whittaker, J. Kinney, E.M. Tracey, & C. Booth (Eds.), *Reaching high-risk families: Intensive family preservation in human services* (pp. 179-192). New York: Aldine de Gruyter.
- Hayes, J. R. & Joseph, J. A. (1985). *Home-based family-centered project evaluation*. Columbus, OH: Metropolitan Human Services Commission.
- Hooper-Briar, K., Broussard, C., Ronnau, J., & Sallee, A. (1995). Family preservation and support: Past, present and future. *Family Preservation Journal, 5*-23.
- Jimenez, M. (1994). Permanency planning and the child abuse prevention and treatment act: The paradox of child welfare policy. *Journal of Sociology and Social Welfare, 17*, 55-72.
- Johnson, L. C. & Yanca, S. J. (2001). *Social work practice: A generalist perspective*. Boston: Allyn and Bacon.
- Jones, M. A. (1991). Measuring outcomes. In K. Wells and D. E. Biegel (Eds.), *Family preservation services: Research and evaluation*. Newbury Park, CA: Sage Press.
- Jones, M. A. (1985). *A second chance for families: Five years later*. New York: Child Welfare League of America.
- Jones, M. A., Neuman, R., & Shyne, A. W. (1976). *A second chance for families: Evaluation of a program to reduce foster care*. New York: Child Welfare League of America.
- Kammerman, S. B. & Kahn, A. J. (1990). Social services for children, youth and families in the United States. *Children and Youth Services Review, 12*, 1-185.

- Karger, H. & Stoesz, D. (1997). Learning from family preservation. *Children and Youth Services Review*, 19(1/2), 1-4.
- Karger, H. & Stoesz, D. (1997). Rethinking child welfare services: The children's authority. *Children and Youth Services Review*, 19(1/2), 119-133.
- Katz, Linda (1990). "Effective permanency planning for children in foster care." *Social Work*, May 1990, 220-226 . Katz, L. (1999). Concurrent planning benefits and pitfalls. *Child Welfare*, 75(1), 75-87.
- Kelly, S. & Blythe, B. J. (2000). Family preservation: A potential not yet realized. *Child Welfare*, 79(1), 29-42.
- Kemp, S. P., Whittaker, J.K., Tracey, E.M. (1997). *Person-environment practice: The social ecology of interpersonal helping*. New York: Aldine de Gruyter.
- Kinney, J., Haapala, D. & Booth, C. (1991). *Keeping families together*. New York: Aldine de Gruyter.
- Kinney, J., Haapala, D., Booth, C. & Leavitt, S. (1990). The homebuilders model. In James K. Whittaker, Jill Kinney, Elizabeth M. Tracy, and Charlotte Booth (Eds.), *Reaching high-risk families: Intensive family preservation in human services*, (pp. 31-64). Hawthorne, NY: Aldine de Gruyter.
- Kinney, J. M., Madsen, B., Fleming, T., & Haapala, D.A. (1977). Homebuilders: Keeping families together. *Journal of Consulting and Clinical Psychology*, 45(4), 667-673.
- Klein, W. & Bloom, M. (1995). Practice wisdom. *Social Work*, 40(6), 799-808.
- Lamb, M. & Sternberg, K., (1992). Establishing the design. *Children and Youth Services Review*, 14, 157-165.
- Landsman, M. J. (1985). *Evaluation of Fourteen Child Placement Prevention Projects in Wisconsin, 1983-1985*. Iowa City: National Resource Center on Family Based Services.

- Lewis, R. (1991a). What are the characteristics of intensive family preservation services? In M. Fraser, P. Pecora & D. Haapala (Eds.), *Families in crisis: The impact of intensive family preservation services* (pp. 93-107). New York: Aldine de Gruyter.
- Lewis, R. (1991b). What elements of service relate to treatment goal achievement? In M. Fraser, P. Pecora, and D. Haapala (Eds.), *Families in crisis: The impact of intensive family preservation services* (pp. 225-271). New York: Aldine de Gruyter.
- Lewis, R. (1994). "Application and adaptation of intensive family preservation services to use for the reunification of foster children with their biological parents." *Children and Youth Services Review*, 16(5/6), 339-361.
- Lindsey, D. (1994). Family preservation and child protection: Striking a balance. *Children and Youth Services Review*, 16(5/6), 279-294.
- Littell, J., (1997). Effects of the duration, intensity, and breadth of family preservation services: A new analysis of data from the Illinois Family First experiment. *Children and Youth Services Review*, 19(1/2), 17-39.
- Maas, H.S. & Engler, R. (1959). *Children in need of parents*. New York: Columbia University Press.
- Magazino, C. J. (1983). Services to children and families at risk of separation. In B. G. Mc Gowan & W. Meezan (Eds.), *Child welfare: Current dilemmas, future directions* (pp. 211-254). Itasca, IL: F. E. Peacock.
- Maluccio, A., Abramczyk, L., & Thomlison, B. (1996). Family reunification of children in out-of-home care: Research perspectives. *Children and Youth Services Review*, 18(4/5), 287-305.
- Maluccio, A., Fein, E. & Olmstead, K. (1986). *Permanency planning for children*. New York: Tavistock Publications.
- Maluccio, A., Pine, B. & Warsh, R. (1994). Protecting children by preserving their families. *Children and Youth Services Review*, 16(5/6), 295-307.
- Maluccio, A. & Whittaker, J. (1997). Learning from the "Family Preservation" initiative. *Children and Youth Services Review*, 19(1/2), 1-4.

- McCroskey, J. & Meezan, W. (1997). *Family preservation and family functioning* (pp. 143-175). Washington, DC: Child Welfare League of America.
- McDonald, H. (1994). The ideology of "family preservation." *The Public Interest*, 115, Spring, 45-60.
- McGowan, B. G. (1990). Family-based services and public policy: Context and implications. In J.K. Whittaker, J. Kinney, E. Tracey & C. Booth (Eds.), *Reaching high risk families: Intensive family preservation in human services* (pp. 91-114). New York: Aldine de Gruyter.
- Meezan, W. & McCroskey, J. (1996). "Improving family functioning through family preservation services: Results of the Los Angeles experiment." *Family Preservation Journal*, (Winter), 9-29.
- Minuchin, S. (1981). *Families and family therapy*. Cambridge: Harvard University Press.
- Murphy, P. (1988). Family preservation and its victims. *New York Times* p.21.
- Mullen, E.J. & Dumpson, J. R. (1973). *Evaluation of social intervention*. San Francisco: Jossey-Bass.
- Nelson, D. (1990). Recognizing and realizing the potential of "family preservation." In J.K. Whittaker, J. Kinney, E. Tracey & C. Booth (Eds.), *Reaching high-risk families: Intensive family preservation in human service* (pp. 13-30). New York: Aldine de Gruyter.
- Nelson, K. E. (1997). Family preservation-what is it? *Children and Youth Services Review*, 19 (1/2), 101-118.
- Nelson, K. E. (1994). Family-based services for families and children at risk of out-of-home placement. In R. Barth, J. Berrick & N. Gilbert (Eds.), *Child welfare research review, Vol. 1* (pp. 83-108). New York: Columbia University Press.
- Nelson, K. E. & Deutelbaum, W. (1992). *Alternative models of family preservation: Family-based services in context*. Springfield, IL: Charles C. Thomas
- Nelson, K. E., Landsman, M.J., & Deutelbaum, W. (1990). Three models of family-centered placement prevention. *Child Welfare*, 69, 3-21.

- Nilsson, D. (2001). Psycho-social problems faced by "Frequent Flyers" in a pediatric diabetes unit. In I.E. Epstein and S. Blumenfield (Eds.), *Clinical Data Mining in Practice based Research: Social Work in Hospital Settings* (pp. 53-69). New York: Haworth Press .
- Orlinsky, D. E. & Howard, K. I. (1986). Process and outcome in psychotherapy. In S. L. Garfield & A.E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp.311-384). New York: Wiley.
- Overton, A. (1953). "Serving families who don't want help." *Social Casework*, 34, 304-309.
- Patton, Q. A. (1990). *Qualitative evaluation and research methods*. Newbury Park, CA: Sage Press.
- Payne, M. (1997). *Modern social work theory*. Chicago, Illinois: Lyceum Books.
- Pearson, C. (1990). Service inputs and outputs. In Y. Yuan & M. Rivest (Eds.), *Preserving families* (pp. 62-76). Newbury, Ca: Sage Press.
- Pecora, P. J., Bartlome, J.A., Magana, V. L., & Sperry, C.K. (1991). How consumers view intensive family preservation services. In M. W. Fraser, P.J. Pecora & D. A. Haapala. (Eds.), *Families in crisis: The impact of intensive family preservation services* (pp 225-271). Hawthorne, NY: Aldine de Gruyter.
- Pecora, P. J., Fraser, M. W., Bennett, R. B. & Haapala, D.A. (1991). Placement rates of children and families served by intensive family preservation programs. In M.W. Fraser, P. J. Pecora & D.A. Haapala. (Eds.), *Families in crisis: The impact of intensive family preservation services* (pp 149-179). Hawthorne, NY: Aldine de Gruyter.
- Pecora, P.J., Fraser, M.W. & Haapala, D.A. (1991). Client outcomes and issues for program design. In K. Wells and D.E. Biegel (Eds.), *Family preservation services: Research and evaluation*. Newbury Park, CA: Sage Press.
- Pecora, P.J., Fraser, M., Nelson, K., McCroskey, J., & Meezan, W. (1995). *Evaluating family based services* (pp. 65-89). Hawthorne, NY: Aldine de Gruyter.

- Pecora, P., Whittaker, J., & Maluccio, A., Barth, R. & Plotnic, R. (1992). *The child welfare challenge, policy, practice and research*. New York: Aldine de Gruyter.
- Pelton, L. (1993). Enabling public child welfare agencies to promote family preservation. *Social Work*, 38(4), 491-493.
- Pelton, L. (1997). Child welfare policy and practice: The myth of family preservation. *American Journal of Orthopsychiatry*, 67(4), 545-553.
- Petit, M. R. & Curtis, P.A. (1997) *Child abuse and neglect: A look at the 1997 CWLA stat book*. Washington, DC: Child Welfare League of America.
- Petit, M.R., Curtis, P., Woodruff, K., Arnold, L., Feagans, L., & Ang, J. (1999). *Child abuse and neglect: A look at the states*. Washington, DC: Child Welfare league of America Press.
- Pierce, L. & Geremia, V. (1999). Family reunion services: An examination of a process used to successfully reunite families. *Family Preservation Journal*, 4(1), 14-31.
- Pillari, V. (2002). *Social Work Practice: Theories and Skills*. Boston: Allyn and Bacon.
- Pine, B. A. (1983). "Child welfare reform and the political process." *Social Service Review* 6(9), 339-359.
- Popple, P. R. & Leighninger, L. (1999). *Social work, social welfare, and American society* (4th ed.) Boston, MA: Allyn & Bacon
- Rapp, C.A. & Poertner, J. (1987). Moving clients from center stage through the use of client outcomes. *Administration in Social Work*, 11 (3-4), 23-38.
- Reed, K. & Kirk, M.R. (1998). The role of consistency building and diversity in building knowledge in family preservation. *Family Preservation Journal* 3(1), 1-21.
- Reynolds, B. C. (1942). *Learning and teaching in the practice of social work*. New York: Russell & Russell.
- Reynolds, B. C. (1963). *An uncharted journey: Fifty years of growth in social work*. New York: Citadel Press.

- Rossi, P. (1991). *Evaluating family preservation programs: A report to the Edna McConnell Clark Foundation*. New York: Edna McConnell Clark Foundation.
- Rossi, P. (1992a). Assessing family preservation programs. *Children and Youth Services Review*, 14(1/2), 77-97.
- Rossi, P. (1992b). Strategies for evaluation. *Children and Youth Services Review*, 14, 167-191.
- Rubin, A. & Babbi, E. (2001). *Research Methods for Social Work*. Belmont CA: Wadsworth Press.
- Rzepnicki, T., Schuerman, Littell, J., Chak, A., & Lopez, M. (1994). In J. Berrick, R. Barth, N. Gilbert (Eds.) *Child welfare research review*, 1. (60-82). New York: Columbia University Press.
- Scannapieco, M. (1993). The importance of family functioning to prevention of placement: A study of family preservation services. *Child and Adolescent Social Work Journal*, 10(6), 509-520 .
- Schuerman, J., Rossi, P., & Budde, S. (1999). Decisions on placement and family preservation: Agreement and targeting. *Evaluation Review*, Dec. 1999, 1-10.
- Schuerman, J. R., Rzepnicki, J. H., & Littell, J. H. (1994). *Putting families first: An experiment in family preservation*. Hawthorne, NY: Aldine de Gruyter.
- Schuerman, J., Rzepnicki, T., Littell, J., & Budde, S. (1992). Implementation issues. *Children and Youth Services Review*, 14, 193-206.
- Schwartz, I. (1995). The systematic impact of family preservation services case study. *Home-based services for troubled children*. Lincoln: University of Nebraska Press.
- Schwartz, I., AuClaire, P., & Harris, L. (1991). " Family preservation as an alternative to the out-of-home placement of adolescents: The Hennepin county experience." In K. Wells & D. Biegel (Eds.), *Family preservation services: Research and evaluation* (pp.33-46). Newbury Park, CA: Sage.

- Spaid, W. M., Lewis, R. E. & Pecora, P. J. (1991). Factors associated with success and failure in family-based and intensive family preservation services. In M. W. Fraser, P. J. Pecora, and D. A. Haapala (Eds.) *Families in Crisis*. New York: Aldine de Gruyter.
- Staff, I. & Fein, E. (1994). Inside the black box: An exploration of service delivery in a family reunification program. *Child Welfare*, 73(3), 195-212.
- Tatara, Toshio (1994). The recent rise in the U.S. child substitute care population: An analysis of national child substitute care flow data. In R. Barth, J. Berrick & N. Gilbert (Eds.), *Child welfare research review*, 1, (pp. 126-184). New York: Columbia University Press.
- Theiman, A.A. & Dail, P.W. (1992). Family reservation services: Problems of measurement and assessment of risk. *Family Relations* 41: 186-91.
- Thyer, B. A. (2001). What is the role of theory in research on social work practice? *Journal of Social Work Education*, 37(1), 9-25.
- Tracey, E., M. (1995) Family preservation and home-based services. *19th Encyclopedia of Social Work* (pp973-980), Washington, DC: NASW Press.
- Tracey, E. M. (1991). Defining the target population for family preservation services: Some conceptual issues. In K. Wells & D. Biegel (Eds.), *Family preservation services: Research and evaluation* (pp. 138-158). Newbury Park CA: Sage Press.
- Tracey, E. M. (1990). Identifying social support resources of at-risk families. *Social Work*, 35(3), 252-258.
- Tripodi, T., Fellin, P., & Epstein, I. (1978). *Differential program evaluation*. Itasca, IL: F.E. Peacock.
- Tyler, W. M. (2002). Teaching social work values within their historical context. *The Journal of Baccalaureate Social Work*, 7(2), 32-47.
- U. S. Department of Health and Human Services. Adoption and Foster care Analysis and Reporting System (1998-1999). Clearing House on Child Abuse and Neglect. (1999) Retrieved January 25, 2003 from <http://www.calib.com/nccanch/pub/factsheets/foster/cfm>.

- Videka-Sherman, L. (1988). Meta-analysis of research on social work practice in mental health. *Social Work*, 33, 325-338.
- Walton, E., Fraser, M., Harlin, C., & Lewis, R. (1995). Intensive family reunification services": A conceptual framework and case example. *Family Preservation Journal, Summer*, 50-65.
- Warsh, R., Pine, B., & Maluccio, A. (1995). The meaning of family preservation: shared mission, diverse methods. *Families in Society: The Journal of Contemporary Human Services*, 76(10), 625-629.
- Weiss, C. (1998). *Evaluation*. Upper Saddle, New Jersey: Prentice-Hall.
- Wells, K. (1995). Family preservation services in context: Origins, practices, and current issues. In M. Schwartz & P. AuClaire (Eds.), *Home-based services for troubled children* (1-28). Lincoln, Nebraska: University of Nebraska Press .
- Wells, K. (1994). A reorientation to knowledge development in family preservation services: A proposal. *Child Welfare* 93(5), 475-488.
- Wells, K. & Biegel, D. (1992). Intensive family preservation services research: Current status and future agenda. *Social Work Research & Abstracts*, 28 (1), 21-27.
- Wells, K. & Biegel, D. (Eds.) (1991). *Family Preservation Services: Research and evaluation*. Newbury Park, CA: Sage.
- Wells, K. & Freer, R. (1994). Reading between the lines: The case for qualitative research in intensive family preservation services. *Children and Youth Services Review*, 16 (5/6), 399-415.
- Wells, K. & Tracy, E. (1996). Reorienting intensive family preservation services in relation to public child welfare practice. *Child Welfare*, 75 (6), 667-692.
- Well, K. & Whittington, D. (1993). "Child and family functioning after intensive family preservation services." *Social Service Review*, 67, 55-83.
- Weinbach, R.W. & Grinnell, R. M. (1998). *Statistics for social workers, 4th edition*. New York: Longman.

- Whittaker, J. K. (1991). The leadership challenge in family-based services: Policy, practice and research. *Families in Society*, 72, 294-300.
- Whittaker, J. K., Kinney, J. M., Tracy, E. M., & Booth, C. (1990). *Reaching High-risk Families: Intensive Family Preservation in the Human Services*. Hawthorne, NY: Aldine de Gruyter.
- Whittaker, J. K. & Schinke, S. P., & Gilchrist, L. D. (1986). The ecological paradigm in child, youth, and family services: Implications for policy and practice. *Social Service Review* 60, 483-503.
- Whittaker, J. K. & Tracey, E. (1990). Family preservation services and education for social work practice: Stimulus and response. In J. Whittaker, J. Kinney, E.M. Tracey, & C. Booth (Eds.), *Families in crisis*. New York: Aldine de Gruyter.
- Wulczyn, F. & George, R. (1992). Foster care in New York and Illinois: The challenge of rapid change. *Social Service Review* 6(2), 278-294.
- Wulczyn, F.H., Harden, A.W., & George, R.M. (1997). *An update from the multistate foster care data archive: Foster care dynamics 1983-1994*. Chicago: University of Chicago, The Chapin Hall Center for Children.
- Yin, R. K. (1989). *Case Study Research: Design and Methods*. Newbury, CA: Sage Press.
- Yuan, Y.T. (1990). Cost analysis. In Y.Y. Yuan & M. Rivest (Eds.), *Preserving Families* (pp.102-131). Newbury, CA: Sage Press.
- Yuan, Y. Y., McDonald, W. R., Wheeler, C. E., Struckman-Johnson, D. & Rivest, M. (1990). Evaluation of AB 1562 in-home care demonstration projects, Volume 1: Final report. Sacramento, CA: Walter R. McDonald and Associates.
- Yuan, Y.Y., Wheeler, C.E., Struckman-Johnson, D.L.& Rivest, M. (1991). Placement outcomes for neglected children with prior placements in family preservation programs. In K. Wells & D.A. Biegel (Eds.), *Family preservation services: Research and evaluations* (92-118). Newbury Park, CA: Sage Press.