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Family Functioning and Intensive Family Preservation Services

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ABSTRACT

Family Functioning and Intensive Family Preservation Services

This study examined changes in the functioning of families who received intensive family preservation services (IFPS). Fourteen families referred by child welfare workers to an IFPS program in Regina, Saskatchewan, participated in the study. Depending on the family composition, data were collected from mothers, fathers and at-risk children 10 years of age or older. Participating family members completed standardized measures of family functioning and children's behaviour at the time of admission and discharge. In addition, data concerning program and sample characteristics were collected through case files and service activity checklists. Analysis based on the Wilcoxon Matched Pairs Signed Ranks Tests, indicated that the functioning of families improved while they received IFPS in the areas of problem-solving, communication, affective responsiveness, affective involvement, roles, behaviour control, general family functioning and children's behaviour.

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DEDICATION

To my wife, Monica. Like a praire sky, your love and support was endless, your sacrifices immense and any expression of my thankfulness seems so small in view of what you did.

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CHAPTER 1

INTRODUCTION

During the past two decades, the permanency planning movement and growing concerns about the number of children being placed into substitute care supported the development of new child welfare service strategies. While child welfare agencies have maintained their fundamental charge of ensuring the well-being and safety of children deemed to be at risk, increased emphasis is being placed on children's need for continuity, stability and a family living environment. This shift in child welfare thinking has led to increased interest in family preservation services as a child welfare modality. In general, family preservation services maintain a family focus and are designed to resolve child welfare issues while keeping children and their families together (Whittaker et. al., 1990).

Support for family preservation services is apparent in both the literature and in amendments to child welfare legislation in Canada and the United States. Recurrent literature reports support the importance of children being reared with their own families and the efficacy of family-focused, child welfare services (Wells & Whittington, 1993; Maluccio, Fein & Olmstead, 1986; Denholm, Ferguson & Pence, 1987). In the United States, the passage of Public Law 96-272 requires that reasonable efforts be made to prevent family

disruption before the removal of children from their home. Similar legislative revisions have occurred in many Canadian provinces in order to ensure that child welfare interventions are in the best interests of the child and the least intrusive and disruptive to families (O.A.C.A.S., 1991).

Although interest in child welfare services designed to preserve families is increasing, the term "family preservation services" refers to a wide range of programs. Family preservation programs are often grouped together according to the common goal and philosophy of family preservation, but they are not all the same. Family preservation programs vary according to staffing patterns, target populations, components of service and intensity of service.

In recent years, efforts have been made to establish criteria for distinguishing between various placement prevention programs (Child Welfare League of America, 1989; Wells & Biegal, 1991;). The Child Welfare League of America (1989) differentiates between three types of family-centered services: family support and education services, family-centered services and intensive family-centered crisis services. Of these three, the present study focuses on intensive family-centered crisis services or what is commonly referred to in the literature as "intensive family preservation services" (Blythe et. al., 1994, Wells & Biegel, 1991 Whittington, 1993; Whittaker et. al., 1990).

Intensive family preservation services (IFPS) are

generally conceptualized as services designed to prevent family dissolution through the provision of a broad range of clinical and concrete services within a family's home. Although there is no clear consensus regarding the definitive elements of IFPS, they are generally family-focused, intensive, time-limited and provided to families with one or more children at imminent risk of placement (Frankel, 1988; Whittaker et al., 1990; Wells & Biegel, 1991). The goals of IFPS programs are to resolve the crisis that is putting the child at risk of placement and to teach the family the skills they need to stay together.

Intensive family preservation programs are becoming a prevalent service option for child welfare agencies throughout North America. With legislative reforms in child welfare favouring the continued expansion of intensive family preservation programs, research regarding these services is critical. To date, the majority of research on these programs has focused on whether families who receive these services stay together. The primary outcome measure used has been the out-of-home placement prevention rate. Several programs have reported impressive placement prevention rates. For instance, a well-known intensive family preservation program called Homebuilders, reported that 95% of families served had not had a child placed out of the home 3 months after discharge, and 91% after 12 months (Kinney & Haapala, 1991).

As impressive as these results are, the effectiveness of

intensive family preservation services continues to be questioned. Many studies of IFPS programs have been criticized for poor research designs, limited measures, inadequate program descriptions and simplistic analyses (Frankel, 1988; Rossi, 1991; Fraser, Pecora & Haapala, 1991; Staff & Fein, 1993). Recent studies have attempted to be more rigorous by utilizing comparison groups, multiple measures and more complex analysis strategies, but many questions remain.

One area of contention with research on IFPS relates to the prevalent use of placement prevention as the sole outcome measure. Data relating to this measure have been shown to be subject to flaws in both measurement and logic (Rossi, 1991; Blythe, Salley, and Jayaratne, 1994). For this reason, recurrent reviews of the research have recommended that future studies examine outcomes additional to placement prevention (Rossi, 1992; Wells & Biegal, 1992; Frankel, 1988). One area recommended for study concerns the functioning of families who receive intensive family preservation services (Frankel, 1988; Wells & Biegal, 1992; Blythe, Salley, and Jayaratne, 1994).

The paucity of research on the functioning of families in IFPS is a problem that needs to be addressed. An assumption implicit in the rationale and widespread support of these programs is that they prevent placement by improving family functioning. However, few studies have examined changes in family functioning in any detail.

There are a number of questions about family functioning

and intensive family preservation services that would be useful to address. First of all, does the functioning of families who receive these services improve? A few studies have identified improvements in family functioning, but further research is required as many of these studies have a number of limitations (Spaid, Fraser & Lewis, 1991; Wells & Whittington, 1993; Feldman, 1991; Scannapieco, 1993). Secondly, what areas of family functioning change? In addition to examining changes in general family functioning, it is also important to examine what particular aspects of functioning improve while families receive IFPS. The extent of change in the functioning of families who receive IFPS is currently not well known.

PURPOSE OF STUDY

The purpose of the present study is to examine changes in the functioning of families who receive intensive family preservation services. Specifically, this study has two aims: 1) to examine whether the functioning of families improves while they receive IFPS, and 2) to identify some of the aspects of family functioning, if any, that improve while families receive IFPS.

Secondary research interests, albeit important, include identifying the services provided to study families and comparing the reports of family functioning obtained from

parents and children. Identifying the characteristics of the IFPS program involved in this study is important in order to ensure that it is an IFPS program and because not all IFPS programs are the same. Comparing the reports of functioning obtained from parents and children is important because studies have found significant differences between these reports and have cautioned against assuming that parental reports are more accurate since parents may be more prone to minimize family difficulties (Sawyer et. al., 1988; Herjanic & Reich, 1982).

The results of this study may provide information that will help to address a perceived gap in the research on intensive family preservation services. While it is generally believed that IFPS programs prevent placement by improving family functioning (Whittaker et. al., 1990; Scannapieco, 1994; Fraser, Pecora & Haapala, 1991), reviews of the research have concluded that very little is known about the functioning of families who receive these services. (Rossi, 1991; Wells & Biegal, 1992). By examining changes in the functioning of families who receive IFPS, this study may help to build a basis for future explanatory studies and provide useful information for IFPS practitioners.

RESEARCH QUESTIONS AND DESIGN - SUMMARY

The present study utilized a non-randomized, one group pretest-posttest design to investigate the following two research questions:

1. Does the general functioning of families who receive intensive family preservation services improve from admission to discharge?

2. Does the functioning of families improve from admission to discharge in any of the following areas: problem-solving, communication, roles, affective involvement, affective responsiveness, behaviour control and children's behaviour?

The IFPS program that participated in this study was Family Builders, which is operated by the Province of Saskatchewan in Regina.

The descriptive design used for this study has been used in a number of studies on IFPS, but it is limited by several threats to internal and external validity. The study's design will not permit any conclusions to be drawn about whether observed changes in family functioning are due to intensive family preservation services. Nevertheless, this design will enable the study to investigate the research questions and identify whether improvements in family functioning occurred during the time that families received IFPS.

The writing of this study has been divided into five chapters. After this introduction, chapter two presents a literature review of relevant IFPS research and provides key conceptual definitions. The methodology of this study is

described in chapter three, while the analysis and findings are presented in Chapter four. The fifth and final chapter provides the discussion and conclusion.

CHAPTER 2

LITERATURE REVIEW

This chapter is divided into four main sections. The first section presents a historical and conceptual context for understanding intensive family preservation services. This section includes a discussion of the conceptual framework which will be used in Chapter Three to describe the IFPS program involved in the present study. The second section supports the rationale for this study through a review of the prior research on IFPS. Particular emphasis is given to reviewing research pertaining to IFPS and family functioning. In the third section, a conceptual definition of family functioning is provided. The final section summarizes the perceived gaps in the research on IFPS and presents the research questions for this study.

HISTORICAL CONTEXT OF IFPS

At the end of their chapter entitled "One Hundred Years of Social Work Practice with Multiproblem Families", Wood and Geismar (1989) note that social work lacks a tradition of historical analysis. According to them, advocates of new social work practice approaches often appear unaware of similar preceding efforts. Although current forms of family-centered, home-based services like IFPS have many novel

features, they have a longstanding and rich tradition in social work. Unfortunately, while some of the reviews of IFPS literature include a discussion of these antecedent forms of service (Frankel, 1988; Wells & Biegal, 1990; Fraser, Pecora and Haapala, 1991), the majority do not.

Early history of home-based, family services

Family-centered, home-based services are not so much a new form of social work practice, as a combination of traditional and innovative service approaches. Working with families in their homes has long been a part of social work practice. The very beginnings of the profession are commonly traced to the "friendly visiting" of immigrant and poor families by untrained volunteers in the late 1800's (Franklin, 1986; Wood & Geismar, 1989). Pecora (1991) indicates these volunteers worked in the homes of families to promote self-sufficiency and assimilation into American society.

Overlooking the early history of family-centered, home-based services has led some writers to erroneously credit the family therapy movement for founding the basic concepts that guide current IFPS programs. For example, Insoo Kim Berg (1994) states,

> The basic concepts and philosophy of family-based services are heavily influenced by family therapy. Family therapy developed over the past forty years from the simple observation that an individual's behaviour happens within the context of an environment . . . (p. 7).

According to Insoo Kim Berg (1994), by "adapting the basic knowledge and skills developed in the field of family therapy" (p.1), family-based programs became a specialized child welfare service that views the family, rather than the parent or child, as the target of intervention (Insoo Kim Berg, 1994, p.1).

Long before the family therapy movement though, charity organization society volunteers operated from the view that the family, rather than the individual, was the focus of service (Woods & Geismar, 1989). In fact, a strong argument can be made that a family focus - and other basic concepts of family therapy - originated in early forms of home-based, social work services (Woods & Geismar, 1989). Consider Zilpha Smith's reminder to volunteers in 1890, not to view the people they served as "removed from family relations. We deal with the family as a whole" (Smith 1890, as cited in Wood & Geismar, 1989, p.48).

A family service orientation was not a mere anomaly that went undeveloped. Thirty years after Smith, but more than 20 years before the family therapy movement, Frank Bruno (1925) argued that social case work is primarily interested in the family because "its primary nature forces us to take it into special consideration as we treat the individual as a social being" (p.119). He discussed some of the challenges facing family social work in a manner consistent with a family focus and appropriate for even today's practitioners.

> As I see it, therefore, family social work has, as its main task, first a clearer understanding of the function of the family, of each member of the family; of how it is promoted and how retarded; of how its sources may be tested; . . . the demands made upon it in our ever increasing complex social organization, and the success with which it meets its functional requirements (pp. 121-122).

Initial forms of family-centered, home-based services were directly related to the development of social work as a profession. When Mary Richmond led the quest for professionalism, she encouraged the establishment of training courses. The first social work class ever taught was titled, "The Treatment of Needy Families in Their Own Homes" - held at the Charity Organization Society's Summer School of Applied Philanthropy in New York (Wood & Geismar, 1989). Hartman and Laird (1983) noted that Mary Richmond founded an initial generation of professional caseworkers who practised primarily with families through home visits. Caseworkers during this era provided concrete services, mobilized informal support networks and realized the benefits of home visits for both engagement and assessment purposes (Frankel, 1988).

Although some key features of IFPS service delivery can be traced backed to the Charity Organization Society movement and Mary Richmond, Pecora (1991) notes that the treatment philosophy of IFPS is more closely aligned with Jane Addams and the Settlement House movement (p.47). Charity

Organization Society workers tended to believe that social problems were the result of character flaws, whereas Settlement House followers defined problems environmentally and adopted a more nonblaming stance (Franklin, 1986). According to Pecora (1991), IFPS workers, like the settlers, place high value on nonpaternalistic, egalitarian service relationships.

When social work professionally aligned itself with psychiatry and the psychoanalytic perspective after World War I, the development of family-centered, home-based services was more or less pre-empted. The "family-centered" aspect of these services lost appeal as social workers became more attracted to the individual orientation of psychoanalytic theory. The "home-based" aspect of these services was viewed as unprofessional and intrusive by the most trained social workers (psychiatric) of the day (Woods, 1988). According to Woods (1988), as psychiatry became more entrenched in the social service institutions, "the locus of treatment became the office or hospital setting" (Woods, 1988, p.211).

Family-centered, home-based services regained the interest of some social service professionals around the late 1940s and early 1950s. During this time period, a number of family-centered projects were initiated to serve multiproblem families (Frankel, 1988; Wood & Geismar, 1989). The most notable of these was the St. Paul Family Centered Project (Wood & Geismar, 1989). Geismar and Camasso (1993) describe

the St. Paul Project as "an intensive, reaching out service to families with multiple problems whose children were held to be at risk" (p.132). Workers involved with this program carried reduced caseloads, utilized home visits and were mandated to provide for all of the family's psychosocial needs (Frankel, 1988).

Although the St.Paul Project is described by Geismar and Camasso (1993) as "intensive", it was not as intensive as current forms of IFPS. Caseloads for St. Paul workers remained high and client contact was limited to once per week or once per month for up to two years (Hutchinson & Nelson, 1985, as cited in Pecora, 1991). Nevertheless, projects like St.Paul's represented a renewal of family-centered, home-based services and a break from the predominantly individual approach to child welfare that existed for over three decades. Researchers connected with the St.Paul Project generated a wealth of knowledge regarding the functioning and service needs of multiproblem families.

Recent developments

During the 1970s, a variety of family-based models designed to prevent the placement of children slowly emerged. There was growing recognition of the importance of emergency intervention services in the form of crisis counsellors, homemakers and emergency caretakers (Pecora, 1991). Many programs were multidisciplinary and provided a combination of

concrete and clinical services. The New York State Preventive Services Demonstration and the Supportive Child Adult Network (SCAN) in Philadelphia were two such programs. Like the majority of family-centered, home-based services then, these programs were neither as intensive nor as time-limited as current forms of IFPS. The SCAN program is reported to have delivered only two to four hours of weekly service in the homes of families for a duration of 9 to 15 months (Frankel, 1988; Pecora, 1991).

It was the Homebuilders program, developed in 1974 in Tacoma, Washington, that provides the first example of a family-centered, home-based program which qualifies as an intensive family preservation service (Pecora, 1991). Homebuilders was initially intended to offer a specialized foster care service, but program developers experimented with placing workers in the homes of at-risk families in order to prevent foster care placement (Kinney, Haapala & Booth, 1991). In contrast to other home-based services at the time, therapists with Homebuilders carried smaller caseloads of two to six families and provided a higher intensity of services: 37 client contact hours in 30 days (Pecora, 1991). Therapists were also specifically referred families with children at "imminent" risk of placement, which was understood to mean that children would be placed within one week unless services were provided.

Interest in home-based, family preservation services as

a child welfare modality increased dramatically in the 1980s and early 1990s. Although family-centered, home-based services have a long tradition in social work, until the 1980's, they were not commonly provided to families with children at high risk of placement (Frankel, 1988). Parents and other members of these families were often viewed as part of the problem, rather than as part of the solution and few attempts were made to include them in the treatment process (Whittaker et al., 1990). The increased interest in providing family preservation services to families with children at high risk of placement stemmed from changes in child welfare practice philosophy, developments in theoretical perspectives, reforms in child welfare legislation and economic factors.

As both a philosophy and a method of child welfare practice, the permanency planning movement supported the expansion of family preservation services. Permanency planning places emphasis on time-limited, decisive action to maintain children in their own homes or to place them permanently with other families (Maluccio, Fein & Olmstead, 1986). Since IFPS are home-based, time-limited, goal-directed services designed to keep children with their families, they are consistent with the concept of permanency planning.

The emergence of numerous theories and studies pertaining to child development and functioning also supported the development of family preservation programs. Theoretical perspectives which hastened the development of family

preservation services include: the primacy of parent-child attachment (Hess, 1982), the child's need for continuity and stability (Hess, 1982), the significance of the biological family to the child's identity (Laird, 1979) and the impact of separation and placement on child and parent (Jenkins, 1981). It was generally acknowledged that multiple substitute care placements negatively effect children's psychosocial development (Mallucio, Fein & Olmstead, 1986).

Additional theoretical support for family preservation services comes from the ecological perspective that emphasizes the importance of addressing the interactions between individuals, families and their environments (Mallucio, Fein & Olmstead, 1986; Garbarino, 1983). The ecological perspective is viewed as a fundamental approach to social work practice and it supports the general approach of most all intensive family preservation programs (Barth, 1990; Mallucio, Fein & Olmstead, 1986). It encourages a broad view of the stresses, resources and other factors contributing to a family's situation and allows for the provision of a wide range of clinical and concrete services.

The growth of family preservation services was also buttressed by changes in child welfare legislation throughout North America. Growing concerns in Canada and the United States about the inappropriate use of foster care, the lack of permanency planning, and the over-representation of minorities in substitute care, stimulated legislative reforms which

favoured family preservation services. In the United States, the passage of PL 96-272, The Adoption Assistance and Child Welfare Act of 1980, accelerated the growth of family preservation services by requiring that reasonable efforts be made to prevent family disruption (Nelson, 1991). A critical aspect of this legislation makes funding for substitute care costs dependent upon whether agencies have made sufficient efforts to prevent out-of-home placements and preserve families (Frankel, 1988).

Similar legislative revisions have occurred in Canadian provinces such as Ontario, British Columbia, Nova Scotia, Alberta and Saskatchewan (O.A.C.A.S., 1991). In Saskatchewan, the stated purpose of the Child and Family Services Act (1989-90) clearly supports the development of family preservation services,

> to promote the well-being of children in need of protection by offering, wherever appropriate, services that are designed to maintain, support and preserve the family in the least disruptive manner (c.C-7.2, s.3).

In Alberta, the Child Welfare Act (1984) favours the establishment of family preservation services through statements such as,

> a child should be removed from the family only when other less intrusive measures are not sufficient to protect the survival, security or development of the child (C-8.1,s2).

In these provinces, legislation seeks a balance that results in child welfare interventions which are in the best interests of the child, the least intrusive to the family and the least

disruptive of the child's relationship with the family (O.A.C.A.S., 1991).

Support for family preservation services also comes from economic factors that confront many governments in North America. The rising costs of out-of-home placements have led to the search for less expensive alternatives (Whittaker et al., 1990). Although there is debate surrounding the basis for determining the cost effectiveness of family preservation services, many studies report that these programs result in significant financial savings (Frankel, 1988; Kinney & Haapala, 1991; Wells & Biegal, 1990).

INTENSIVE FAMILY PRESERVATION SERVICES

The increased interest in family preservation and placement prevention programs throughout North America has led to the development of several different varieties of service. Intensive family preservation services are only one type of family preservation service, albeit one of the most common types. The variation in placement prevention services has created some confusion for researchers and program developers as dissimilar programs have been categorized and referred to by the same title. In recent years, attention has been given to establishing specific criteria that differentiate intensive family preservation services from other placement prevention programs (Child Welfare League of America, 1989; Wells et al.,

1991;). One of the results of this is that the Child Welfare League of America (1989) has differentiated between three types of family-centered services: family support and education services, family-centered services and intensive family-centered crisis services.

According to the Child Welfare League of America (1989), intensive family-centered crisis services - more commonly referred to as intensive family preservation services - are designed for families with children at imminent risk of placement or with children about to be returned from out-of-home care. They share many of the same features as family-centered services, but are more intensive. Therapists carry caseloads of two to six families and families are seen in their homes on average of eight to ten hours per week. At least 60% of therapist time is spent in direct face-to-face contact with clients and services are provided for approximately four to twelve weeks. The focus is on the provision of clinical, educational and supportive services to families with the goal of protecting children, resolving child welfare concerns and preserving families.

The definition of IFPS provided by Child Welfare League of America (1989) helps to distinguish IFPS from other placement prevention programs, but it does not help to describe differences between IFPS programs. IFPS programs may share many common features, but they are not all the same. IFPS programs are typically grouped together and categorized

according to common structural features like short-term, intensive services and small caseloads, but the types of service provided within these structures may vary greatly between programs. In order to recognize and organize differences between IFPS programs, a more comprehensive conceptual framework is required (Unrau, 1994).

A conceptual framework for IFPS

A commonly accepted conceptual framework for IFPS would be helpful when comparing individual programs and interpreting research findings. IFPS research studies have been generally criticized for providing too few details about the programs examined (Rossi, 1991; Frankel, 1988; Staff & Fein, 1994). Rossi (1991) believes that without adequate descriptions, the IFPS programs examined in studies have to be regarded as "black boxes" (p.28). Staff and Fein (1994) continue with this analogy and argue that it is neither reasonable nor helpful, especially given the newness of many IFPS programs, to assume that what is inside the black box is the same for all IFPS programs. Information produced by IFPS studies may not be useful to those interested in replicating or modifying IFPS programs unless it is accompanied with a comprehensive description of the particular program studied.

In their article, Staff and Fein (1994) raise the question of what is the best window into the black box? (p. 197). Although they suggest an approach for describing

individual IFPS programs that focuses on the amount of time spent on various aspects of service delivery, they acknowledge that this approach provides only a limited perspective. Other attempts to describe IFPS have also focused on limited aspects of these programs such as the theories guiding treatment (Barth, 1990; Grigsby, 1993) or on selected service characteristics (Edna McConnell Clark Foundation, 1985; Child Welfare League of America, 1989). Although these approaches to describing IFPS are all useful, they result in incomplete descriptions of individual IFPS programs.

In response to this issue, Unrau (1994) has developed a more comprehensive conceptual framework for organizing IFPS service delivery. According to Unrau (1994), there are three separate but related components of IFPS that appear common to the majority of IFPS programs: program philosophy, service structure and treatment approaches. These three components form a general conceptual framework that can be used to examine, describe and compare individual IFPS programs. It is this framework that will be used in the chapter on methodology to describe the particular IFPS program that participated in this study.

Program Philosophy

Within the framework put forth by Unrau (1994), the component entitled "program philosophy" refers to the set of beliefs, values or presuppositions that guide IFPS programs.

Most IFPS programs are guided by a family preservation philosophy and so it is difficult to distinguish one program from another on this basis. IFPS programs are commonly based on beliefs like "families are the best place for children to grow and develop", "families are able to change, grow and resolve problems", and "working with families, rather than with individuals separately, is the preferred approach to child welfare practice".

Although it is difficult to make distinctions between IFPS programs based on family preservation values, differences may be observed in regard to other beliefs. For instance, IFPS programs may vary according to beliefs about the nature and origin of family problems, the style of therapist-client relationships, the use of authority or the locus of family strengths and needs. While many of the key beliefs that guide individual IFPS programs may be stated explicitly in their program manuals, other beliefs may become apparent only through communicating with program staff. However observed, it is worthwhile to examine and describe the fundamental beliefs that guide individual IFPS programs.

Service structure

The "service structure" component of Unrau's (1994) framework refers to the program features that influence and support the implementation of treatment. As mentioned earlier, common IFPS structural features include home-based

treatment, small therapist caseloads of 2 to 6 families, the brief 4 to 12 week duration of services and the intensive amount of services that can average 5 to 20 hours per week (Fraser, Pecora & Haapala, 1991; Unrau, 1994). The structural features of individual IFPS programs will vary within these parameters though, due to factors such as program philosophy, client and community needs, and treatment perspectives.

The need for researchers to describe the structural features of IFPS programs is highlighted in Blythe, Salley and Jayaratne's (1994) review of the research. After they note the current debate in the field about whether it is necessary to adhere to the features of the Homebuilders Model, they state that IFPS studies failed to consistently provide enough information to shed much light on the issue (Blythe, Salley & Jayaratne, 1994). According to them, only a small number of studies examined programs that were as short-term as Homebuilder's four to six week period and most IFPS programs also appeared to be less intensive (Blythe, Salley & Jayaratne, 1994). However, they state that it is difficult to draw conclusions about service intensity because investigators defined intensity and contacts with families differently.

Treatment

The final component in Unrau's (1994) conceptual framework is the treatment component. This component is described as including all of the intervention strategies

utilized with clients to produce progress. While the common distal treatment goal of IFPS is to resolve child welfare concerns and keep families together, the particular treatment approaches used in programs may differ significantly. These differences may be due to program philosophy, client or community needs, service structure constraints, and even therapist skills or preferences.

Therapists within IFPS programs typically design treatment packages for families on a case-by-case basis by choosing from a general pool of intervention approaches (Unrau, 1994). The "pool" of available treatment options is generally determined by the IFPS program. Hence, therapists and families are allotted a degree of flexibility, while at the same time, treatment uniformity is maintained. In general, IFPS programs provide a combination of concrete and clinical services.

Concrete services. The provision of concrete services is an important component of many IFPS programs because families with children at risk of placement are often struggling to meet basic, instrumental needs. A distinction between "doing for" and "enabling" concrete services is drawn in the IFPS literature (Kinney et. al., 1991). "Doing for" concrete services include providing families with food, clothing, money, transportation, shelter, babysitting and so on, while "enabling" services entail assisting and teaching families to obtain these same resources independently. Families may be

initially provided with resources in order to stabilize their situation, but as treatment continues, more emphasis is placed on enabling families to meet their own needs so as to prevent future problems.

As is the case with other general features of IFPS, the emphasis given to the provision of concrete services may vary between IFPS programs depending upon factors like the populations served, the availability of community resources and program beliefs. The Homebuilders Model of IFPS places central importance on the provision of concrete services (Lewis, 1991; Kinney et. al., 1991). Based on an analysis of 453 families who were involved with Homebuilders, Lewis (1991) reports that 74.2% received some type of concrete service. Lewis (1991) indicates that transportation was the only concrete service provided in more than 50% of these cases and he notes the diversity of services needed by families which included recreation, financial assistance, child-care, food, toys, housecleaning, employment and legal aid. Overall, concrete services accounted for more than one-fifth of direct service time, which indicates the importance of this component of service in the Homebuilders model of IFPS.

Clinical services. The clinical services provided by IFPS vary and are described by a variety of theoretical orientations. Four main theories are commonly used to describe the treatment activities of IFPS programs: crisis intervention theory, social learning theory, family systems

theory and the ecological perspective.

Crisis intervention theory is used by some IFPS programs to explain the short-term, intensive nature of many of their clinical services, but others have questioned the general usefulness of the theory for IFPS (Barth, 1990). Social learning theory is used heavily in IFPS programs like Homebuilders to inform clinical services that focus on teaching parents and children new skills and behaviours. The use of family systems theory among IFPS programs varies from the full-scale use of a particular form of systemic family therapy to the more generic use of basic family systems concepts. For example, the IFPS program in Hennepin County (Tavantzis et. al. 1985) is described as providing home-based, structural family therapy, whereas Homebuilders therapists may use an array of basic family therapy techniques.

While individual IFPS programs may vary in their use of some theories, the ecological perspective is often identified as the perspective that underlies IFPS treatment in general. In brief, the ecological perspective encourages IFPS therapists to look at family members, their environments and the relationships between the two, and to intervene in any or all of these areas so as to improve the clients' situation. Despite the agreement about the importance of the ecological perspective for IFPS programs, little attention has been paid to describing the specific ecological models used to guide IFPS treatment.

Given the wide variety of theories used to explain IFPS treatment, it should not be surprising that the range of clinical techniques actually used by therapists in some IFPS programs is very broad. In one study of a Homebuilders IFPS program, therapists reported an average of 31.8 different clinical service activities per case (Lewis, 1991). Of the nine most common techniques used by Homebuilder therapists in this study, four related to activities used to foster therapeutic relationships (listening, offering support, relationship building and encouraging), two pertained to contracting (clarifying problems and setting treatment goals), while the other three were reframing, the use of reinforcements and the identification and use of natural and logical consequences (Lewis, 1991).

Although it is commonly agreed that IFPS therapists use a variety of clinical techniques, Barth (1990) states that the field is a long way from determining the best mix of approaches. Whether it is possible - or even desirable - to establish one unilateral approach to IFPS treatment though, is questionable. Nevertheless, adequate descriptions of clinical offerings are required. IFPS studies have been generally criticized for not providing enough information in this regard. In the absence of information about which approaches are effective with which populations, it is difficult for program planners and therapists to make informed treatment decisions.

Summary

The growth and variation of placement prevention services throughout North America has created some confusion for researchers as dissimilar programs have been referred to by the same title. In recent years, efforts have been taken to define IFPS programs in a manner that differentiates them from other placement prevention programs (Child Welfare League of America, 1988). While these definitions are useful and have met their intended purpose, they are typically limited and do not help researchers, program planners and others to identify and describe differences between IFPS programs. In order to compare and contrast individual IFPS programs, a more comprehensive conceptual framework is necessary.

One useful conceptual framework for describing IFPS programs has been developed by Unrau (1994). It includes three main components: program philosophy, service structure and treatment. In general, "program philosophy" refers to the set of beliefs that guide the program, "service structure" refers to the features that support program implementation and "treatment" refers to the clinical and concrete services provided to families in order to reach treatment goals. By examining individual IFPS programs along these lines, a more comprehensive program description can be constructed. It is this conceptual framework that will be used in the methodology section to describe the particular IFPS program involved in this study.

PRIOR RESEARCH

In contrast to other child welfare programs, Blythe, Salley and Jayartne (1994) state that family preservation services have an impressive tradition of collecting data to monitor goal achievement. Although the majority of this data is positive, the effectiveness of IFPS continues to be questioned (Blythe, Salley and Jayartne, 1994). Advocates of IFPS claim that these programs represent an effective and cost-efficient way of working with at-risk families, but there is reason to be cautious. IFPS research findings have been contradictory and many studies have been compromised by poor research designs, limited measures, incomplete program descriptions and inadequate analyses (Feldman, 1991; Rossi, 1991; Fraser, Pecora, & Haapala, 1991; Frankel, 1988; Blythe, Salley and Jayartne, 1994). In view of the increased use of IFPS as a child welfare modality and given the risks of leaving children in potentially unsafe homes, research relating to these services is critical.

IFPS and placement prevention

The primary outcome measure used in research on IFPS is the "out-of-home placement prevention rate". Although there is some debate about the operationalization of this variable, in general, it is measured according to whether children are living at home or not, after their families receive services.

Since IFPS programs typically only accept families of children deemed at "imminent risk" of placement, families who remain intact after receiving services are considered to have had a successful outcome. In some studies, placement data is collected for only one target child, while in other studies it is collected for all of the children (Blythe, Salley and Jayartne, 1994). Either way, IFPS programs generally determine their effectiveness by calculating the percentage of families who avoid having a child or children placed.

Advocates of home-based services report impressive placement prevention rates. For instance, studies on the Homebuilders program, one of the most clearly articulated and thoroughly researched models of home-based services, report placement prevention rates as high as 95% after 3 months and 91% after 12 months (Kinney & Haapala, 1991). A national review of programs in the United States estimated that 70 - 90% of the children who received home-based services were enabled to remain at home (National Resource Center on Family Based Services, 1983). Since comparison or control groups were not used in these studies, the importance of these findings depends upon how willing one is to assume that all of the children would have been placed had they not received family preservation services.

Pecora, Fraser and Haapala (1991) examined the placement rates of six intensive family preservation programs utilizing a small comparison group of 26 families who were referred, but

unserved by, these programs. They matched comparison with treatment families and compared placement rates. Twelve months after the start of treatment, the placement rate was higher for the comparison group: 85% of the children had been placed, compared to the treatment group: 44% of matched treatment cases were placed.

AuClaire and Schwartz (1986) also used overflow, unserved families to study the effectiveness of these services to prevent placement. Unserved families were sampled randomly to produce a comparison group, while an equal number of families were recruited to the treatment group. Cases assigned to the comparison group were placed in foster homes, group homes, hospitals and so on. The placements of children over a 12 to 16 month period was tracked. The main findings were that the average number of placements did not differ between the groups, but treatment group families experienced less days in placement.

Wood, Barton, and Schroeder (1988) also report favourable findings in relation to placement prevention. In this study, 26 families, from a pool of 50 families with at least one child at risk of placement, were assigned to a home-based program. The other 24 families received traditional services. The home-based program was a FamiliesFirst program which is reported to be based on the Homebuilders Model. At the end of a year, 74% of children in the treatment group were able to stay at home compared to only 45% of the children in the

comparison group.

As promising as these results appear for IFPS programs, the use of "placement prevention" as an outcome measure is questionable for several reasons. First of all, the number of "out-of-home placements" may be influenced by the number of available placement resources within a community and by policies determining access to those resources. Thus, it is possible that placements may be prevented more by diminishing resources, than by IFPS. Secondly, an out-of-home placement is not always a negative result such as when a young person enters a substance abuse program. Thirdly, definitions of "out-of-home placements" vary among studies (Pecora, Fraser & Haapala, 1991, Rossi, 1992). Fourthly, it is not certain that all children who receive IFPS would have been placed out-of-home in the absence of these services (Blythe, Salley and Jayartne, 1994; Wells & Biegal, 1990; Pecora, Fraser & Haapala, 1991, Rossi, 1992).

The last point undermines a premise commonly assumed in the research arguments of placement prevention studies. Although it may seem reasonable to assume that children who are deemed to be at imminent risk of placement would have been placed without IFPS, it is highly questionable. In one review, Rossi (1992) states the literature indicates clearly that the determination of imminent risk by child welfare agencies, is neither reliable nor precise. After an extensive review of IFPS studies which used comparison groups, Blythe,

Salley and Jayartne (1994) conclude that it is rarely the case that all or nearly all of the comparison families had children placed. However, if comparison group children were not at imminent risk of placement, then experimental group children may not have been at imminent risk of placement (Blythe, Salley and Jayartne, 1994). Thus, placement prevention may not be a very sound indicator of IFPS treatment success

Even if one accepts "placement prevention" as a legitimate outcome measure, many IFPS studies rely on it as the sole variable for measuring program effectiveness. Many questions regarding the well-being and functioning of children and families who receive these services have not been addressed (Frankel, 1988; Pecora, Fraser & Haapala, 1991, Rossi 1992). By focusing exclusively on placement prevention, many IFPS outcome studies have not provided practitioners and program planners with a broad enough understanding of the effect of these services on families.

IFPS and family functioning

The understanding of what constitutes IFPS treatment "success" must be expanded in order to fully understand the effect of these services on families. In response to recurrent recommendations, research on IFPS has begun to broaden the understanding of success to include family functioning variables (Wells & Biegal, 1990; Frankel, 1988; Jones, 1991; Pecora, Fraser & Haapala, 1991; Scaanapieco,

1993). Family functioning is considered to be an important area to study because of the implicit assumption in the research and practice literature that IFPS prevent placements by improving family functioning (Frankel, 1988). Even though this presupposed relationship is essential to the rationale for many IFPS programs, few researchers have examined how these programs effect family functioning or what the relationship is between family functioning and placement prevention (Frankel, 1988).

Of the studies to date, Feldman's (1991) is the only one that examined the effect of IFPS on family functioning using an experimental design. In this study, 96 experimental families and 87 control families were evaluated on 18 measures of family functioning during the first week, at termination and at three months after termination. Experimental group families showed improvements on 10 family functioning measures, but differences between them and the control families were statistically significant for only two of the measures. In addition, it was found that experimental families had a statistically significant lower placement rate from 1 to 9 months after termination, but after 12 months the differences were not statistically significant.

In Feldman's (1991) study, an IFPS program was defined as a program based on the Homebuilders model. On average, study families received 54.85 hours of direct and indirect service over 5.35 weeks. The program treatment orientation was

described as primarily behavioral, but included therapeutic techniques from other orientations. One of the strengths of Feldman's study was that comprehensive efforts were taken to examine the service delivery characteristics of the study programs by having caseworkers complete the following measures: number of visits, hours of contact, clinical services checklist, concrete services rating sheet, duration of service and goal attainment scales.

Family functioning was not conceptually defined in Feldman's (1991) study, but it was operationally defined and measured using the Family Environment Scale (Moos & Moos, 1981) and the Child Well-Being Scales (Magura & Moses, 1986). The Family Environment Scale measures a family member's perception of the social environmental characteristics of his or her nuclear family and assesses three main dimensions: relationships, personal growth and system maintenance. The Child Well-Being Scales measures a family's or child's position on 43 child welfare anchored rating scales.

The results of Feldman's (1991) study reinforce the importance of undertaking further research in the area of IFPS and family functioning. Although the functioning of families receiving IFPS improved from the pretest, it was not possible to conclude that these improvements were due to IFPS because few differences were found between the control and treatment groups. Furthermore, the lack of differences observed between the functioning of experimental and control families, coupled

with the differences observed between their placement rates, does not support the assumption that IFPS prevent placement by improving family functioning. If placement is solely dependent upon family functioning, then the placement rates for the two study groups from 1 to 9 months should have been the same since there were few differences observed in their functioning.

There are a number of limitations in Feldman's (1991) study though, which may have had an influence on the results. A major limitation of the study was that services offered to control families were not tracked and compared to those received by the treatment group. It was simply reported that control families received traditional services. Since it is conceivable that the services received by control families were effective, it is difficult to interpret the meaning of finding only a few statistically significant differences between the two study groups. The issue is not whether IFPS are the only effective service for at-risk families. Traditional child welfare services may help to improve the functioning of at-risk families, but advocates of IFPS argue that their programs do so in a less disruptive manner.

Another concern with Feldman's (1991) study regards the instruments used to measure family functioning. By not providing a conceptual definition of family functioning, the rationale for its operationalization is unclear. For this reason, it is difficult to determine how relevant the Family

Environment Scale (Moos & Moos, 1981) is to the treatment goals of IFPS. A concern with the Child Well-Being Scales that became apparent in this study, relates to its "ceiling" effect. The highest level that it measures is "adequate" and so it is questionable whether it was able to measure true gains in the treatment group at discharge. In sum, the lack of meaningful differences between the functioning of treatment and control families may be partly due to these issues.

In a much larger study, Spaid, Fraser, and Lewis (1991) examined the relationship between participation in an IFPS program and changes in family functioning. The study used a one group, pretest-posttest design and involved 453 families that received brief and intensive home-based family services. The results indicated that participation in IFPS was correlated with improved family functioning in areas of child management, behaviour of children and conditions in the home.

In this study an IFPS program was also defined as a program based on Homebuilders. In order to ensure that this model was used, caseworkers recorded the number of visits, hours of contact, duration of services and the type of clinical and concrete services provided. The dependent variable was family functioning, which was conceptually defined as including the following dimensions: a parent's child management skills, parent and child health related factors, family problem-solving capacity (adaptability and cohesion), and social support. Four instruments were used to

measure family functioning: 1) the Family Risk Scales (Magura & Moses, 1986), 2) the Family Adaptability and Cohesion Scales (FACES III) (Olson, 1986), 3) the Milardo Social Support Inventory (Milardo, 1983) and 4) parent problem ratings from the Consumer Outcome Inventory (Magura & Moses, 1986).

The results of Spaid, Fraser and Pecora's (1991) study are interesting. Based on the change scores for three of the measures, participation in IFPS was highly correlated with improvements in areas of family functioning such as child management, behaviour of children and conditions in the home. The FACES III scores though, which measure family typologies based on the dimensions of adaptability and cohesion, did not improve as expected. The authors suggest that FACES III may be an inappropriate outcome measure of IFPS programs for two reasons: 1) a short-term, crisis-related intervention program should not be expected to cause changes in enduring family traits and 2) less than three quarters of the items on FACES III were consistent with the major treatment goals set by families and workers. This exemplifies the importance of utilizing measures of family functioning that are determined to be relevant to the rationale and clinical goals of IFPS.

Although Spaid, Fraser and Pecora's (1991) study involved a large number of participants, it did not utilize a control or comparison group. This limits the study's findings due to internal threats to validity such as history, maturation, selection and regression to the mean. The authors state that

the pattern of change that emerges in the study makes it difficult to argue that the pre-post differences are merely the result of these factors. Given the results of Feldman's (1991) study though, this can not be known with any certainly. The functioning of experimental families in Feldman's (1991) study also improved, but few significant differences were found in relation to the control group.

In a more recent study, Wells and Whittington (1993) examined the functioning of children and families who received the services of an intensive family preservation program. Study subjects consisted of 42 adolescent children and 42 parents; one child and one parent from each family. Subjects were studied at three different points in time: at admission, at discharge and between 9 and 12 months after discharge. Data were drawn from semi-structured interviews with children, their parents and their caseworkers. These interviews included the use of four standardized measures. Univariate and multivariate analyses indicated the following: 1) family and child functioning had improved between admission and discharge and did not decline between discharge and follow-up; 2) families and their children were functioning at a lower level at follow-up than nonclinical samples; and 3) child and family factors were more strongly related with family functioning at follow-up than treatment factors.

In Wells and Whittington's (1993) study, family functioning is conceptually defined in relation to three

dimensions considered relevant to the goals of IFPS programs: promoting family health, eliminating or reducing parent-child conflict and ameliorating child behavioral problems. Family health was measured by the General Functioning Index of the Family Assessment Device (FAD) -Version 3 (Epstein et. al., 1983). This scale assesses a family's general psychological health and consists of 12 items. Parent-child conflict was conceptually defined as perceived conflict and negative communication between parent and child and was assessed by the Interaction Behaviour Questionnaire (Robin & Foster, 1988). Child behavioral problems was operationalized using Achenbach and Endelbrock's (1983, 1987) Child Behaviour Checklist (CBCL) and Youth Self Report (YSR). Like other studies, the definition of IFPS was based on the Homebuilders Model.

Even though the multidimensional operationalization of family functioning is one of the strengths of Wells and Whittington's (1993) study, by only using the General Functioning Index of the FAD (Epstein et. al., 1983), information about changes in particular aspects of functioning such as communication or problem-solving was not collected. This type of information may be important for program planners in order to assess, refine and further develop IFPS clinical strategies.

Wells and Whittington's (1993) study is also one of the few IFPS studies to collect family functioning data from parents and children. The analysis of this data revealed that

parent and child scores on the same measure were related except for the measure of child behaviour problems. The analysis of changes in family functioning was not based on family mean scores though, but on the FAD scores completed by children and the CBCL scores completed by parents. This is interesting because even though child and parent scores on the measure of child behaviour problems were not related, only the parent scores were used in the analysis of change. Thus, children's views as to whether their own behaviour improved or not was not considered in the analysis. This is unfortunate and Wells and Whittington (1993) acknowledge in their discussion that the views of one family member should not be substituted for the views of another.

Research in areas outside of IFPS support the observation that children's reports of functioning should not be supplanted by the views of their parents. In a study that compared family members responses on the FAD, researchers found that adolescents from both clinic and community groups consistently rated their families as significantly less healthy than their parents (Sawyer et. al., 1988). In this study, few significant differences were found in the reports obtained from mothers and fathers. The authors indicate that the differences found between parent and adolescent reports of family functioning parallel similar poor agreement found in other studies that compared parent and adolescent reports on adolescent's behaviour (Sawyer et. al., 1988). In regard to

this issue, Herjanic and Reich (1982) caution researchers not to assume that parental reports regarding functioning are more accurate than those of adolescents simply because adults are older. According to Sawyer and colleagues (1988), parents may be more prone to minimize family difficulties due to ignorance or vested interest.

In another IFPS study, Scannapieco (1993) collected family functioning data from social workers rather than from family members. Based on this information, she reported that the functioning of families in the IFPS program improved to a statistically significant degree from admission to discharge. In addition, Scannapieco (1993) reported that the study results support a relationship between improvements in family functioning and placement prevention at the end of the program.

Scannapieco's (1993) study has a number of limitations. Family functioning was not conceptualized and its operationalization is questionable. Social workers - which appears to mean IFPS workers - were asked to complete a questionnaire that supposedly measured family functioning based on 7 indicators. Information about the validity or reliability of the instrument was not provided. Furthermore, the study did not actually implement a pretest-posttest design as social workers simultaneously rated the before and after functioning of families at a unspecified time after services had been provided. Similar to the other studies reviewed,

Scannapieco (1993) concludes with the recommendation that changes in the functioning of families in IFPS needs to be further researched.

Summary

The understanding of what constitutes IFPS treatment success must be expanded in order to fully understand the effect of these services on families. Placement prevention does not appear to be a very good indicator, let alone the sole indicator, of IFPS treatment success. In response to recurrent recommendations, IFPS research has begun to examine family functioning variables (Wells & Biegal, 1990; Frankel, 1988; Jones, 1991; Pecora, Fraser & Haapala, 1991; Feldman, 1991; Wells & Whittington, 1993; Scannapieco, 1993).

Although preliminary findings indicate that the functioning of families in IFPS improves over time, many studies have a number of limitations. To date, only one study has used an experimental design (Feldman, 1991), which may indicate the exploratory climate of research in this area. Apart from this, some studies have not included a conceptual definition of family functioning nor presented a rationale for its operationalization (Feldman, 1991; Scannapieco, 1993). This is a significant problem because questions have been raised about the validity of some of the measuring instruments used and their relevance to the general treatment goals of IFPS (Spaid Fraser & Pecora, 1991, Feldman, 1991; Scannapieco,

1993). In addition, there is reason to doubt the verisimilitude of family functioning information reported in studies which have not collected nor examined the perceptions of more than one family member (Sawyer et. al., 1988). In sum, further research regarding changes in the functioning of families in IFPS is required.

CONCEPTUALIZATION OF FAMILY FUNCTIONING

Based on a review of the research, it is apparent that IFPS studies have not been guided by a common understanding of family functioning. Although a common understanding of this concept may not be required, too many IFPS studies have failed to provide any conceptual definition of family functioning. By not providing an understanding of what "family functioning" means, the rationale for its operationalization is often unclear. This makes it more difficult to determine whether the instrument used to measure family functioning is relevant to the goals of IFPS programs.

Family functioning is a fairly abstract and broad concept with no clear consensus regarding its delimitation. This is why it is important for researchers to provide the rationale for their operationalization of the concept. For example, in Scannapieco's (1993) study, the measurement of family functioning included a measure of children's school behaviour while in Spaid, Fraser and Pecora's (1991) study, it included

a social support inventory. In the former study, no argument was provided to explain why children's school behaviour is an appropriate indicator of family functioning. On the other hand, Spaid, Fraser and Lewis (1991) provided the rationale for the inclusion of social support as a measure of family functioning, and in so doing, addressed a number of potential questions.

Apart from being abstract and often broadly understood, family functioning is also a concept that is highly susceptible to subjective influences. General beliefs about the purpose of a family, the expected roles and tasks of family members, and the "normal" or "healthy" family are all social constructs relative to the values and traditions of a particular group of people. For this reason, conceptual definitions of family functioning need to be understood as limited and as relative to certain theoretical and social contexts.

Most of the recent theorizing about family functioning has been strongly influenced by general systems theory (Olson, 1988). Within a systems perspective, the family is seen as a system consisting of systems: individuals, marital and parent-child, which interacts with other systems: extended family, schools, church, and the community (Epstein, Bishop & Baldwin, 1983). Fundamental assumptions about family functioning that stem from systems theory include the following: 1) parts of the family are interrelated and cannot be understood in

isolation from the rest of the system; 2) family functioning is more that the functioning of each of the parts and 3) the structure, organization and transactional patterns of the family strongly influence the behaviour of family members (Epstein, Bishop & Baldwin, 1983).

A general definition of the term "family functioning" is provided by Geismar and Camasso (1993). Geismar and Camasso have defined family functioning as the "performance by family members of socially expected roles and tasks which are aimed collectively at achieving family goals" (Geismar & Camasso, 1993, p.23). For these authors, the adequacy of a family's functioning is determined by the degree to which tasks achieve the goal of family well-being and by the extent to which assigned roles meet individual competence and conform to societal expectations (Geismar & Camasso, 1993). One of the positive features of this general definition is that it provides a flexible understanding of family functioning that allows for the fact that "societal expectations" and "family goals" are relative to different families, in different settings.

Epstein, Bishop and Baldwin (1983) provide a more narrowed definition of family functioning based on their beliefs about what currently constitutes societal expectations about the function of "today's family". The use of the term "family functioning" in this study is based on their conceptualization. Epstein, Bishop and Baldwin (1983) state

that the "primary function of today's family unit is to provide a setting for the development and maintenance of family members on social, psychological and biological levels" (p.118). According to them, in order to fulfil this function, families have to deal with a variety of instrumental, developmental and hazardous tasks. This view is supported by Skinner, Steinhauer and Santa-Barbara (1983) who also state that the goal of the family is the "successful achievement of basic, developmental and crisis tasks" (p. 93).

For these authors, understanding the functioning of a family entails understanding the structure, organization and transactional patterns that affect the family's ability to fulfil instrumental, developmental and crisis-related tasks (Epstein, Bishop & Baldwin, 1983; Skinner, Steinhauer & Santa-Barbara, 1983). Based on this view and their work with families, Epstein, Bishop and Baldwin (1983) developed a clinically oriented conceptualization of family functioning referred to as the McMaster Model of Family Functioning (MMFF). The MMFF describes the structural and organizational features of families and the patterns of transactions among family members, which they state, "have been found to distinguish between healthy and unhealthy families" (Epstein, Bishop and Baldwin, 1983, p.172).

McMaster model of family functioning

The MMFF identifies six fundamental dimensions of family functioning: problem-solving, communication, roles, affective responsiveness, affective involvement, and behaviour control (Epstein, Bishop & Baldwin, 1983). *Problem-solving* refers to the family's ability to resolve issues which threaten its integrity and effective functioning. *Communication* refers to the family's style of exchanging instrumental and affective messages; the focus is on whether these exchanges are typically "clear" or "masked" in regard to content, and "direct" or "indirect" in regard to whether the person spoken to is the one for whom the message is intended. *Roles* refers to the established patterns of behaviour the family has for fulfilling its instrumental and affective functions. Important assessment considerations here include whether family responsibilities are allocated clearly and equitably and whether accountability is maintained. The dimension, *affective responsiveness*, concerns the extent to which family members experience a full range of appropriate emotional responses while *affective involvement* regards the level of interest and importance family members place on each other's activities and concerns. *Behaviour control* refers to the family's style of managing behaviour concerning dangerous situations, psychobiological drives and socialization. The MMFF includes four different patterns of behaviour control: rigid, flexible, laissez-faire and chaotic.

According to Epstein, Bishop and Baldwin (1983), no one dimension of family functioning is more important than another, and all six need to be considered for an adequate understanding of family functioning. But IFPS studies that have used measurement instruments based on the MMFF, have only used the general functioning indexes (Wells & Whittington, 1993) and have not specifically collected information regarding these six dimensions of functioning. Thus, studies may not be providing an adequate understanding of the functioning of families before or after they receive IFPS.

It is important to examine how well families in IFPS are functioning in each of the six dimensions outlined by the MMFF, because IFPS may have a greater effect on some areas of family functioning than on others. Such investigations may improve IFPS screening procedures and assist practitioners to select families who are most likely to benefit from IFPS. It may also assist IFPS practitioners to further refine and develop treatment services for any areas of family functioning where improvement is suspect.

The conceptualization of family functioning based on the MMFF (Epstein, Bishop and Baldwin, 1983) is compatible with the goals and rationale of IFPS. IFPS are generally provided when children are considered to be at risk because families are not adequately fulfilling instrumental, developmental or crisis-related tasks. Depending on the particular family, treatment may focus upon the functioning and role performance

of parents at basic levels: providing food, shelter and safety, or it may focus on helping families to resolve developmental issues related to child welfare concerns. Whatever the particular focus, IFPS treatment goals generally include changes in some or all of the dimensions of family functioning described by Epstein, Bishop and Baldwin (1993). For example, common IFPS treatment goals include improving communication and listening skills, improving problem-solving skills, teaching parents behavioral management skills, encouraging the clear allocation of roles, and increasing family involvement through recreational activities.

In addition to the six dimensions of family functioning included in the MMFF, another important aspect of family functioning concerns the behaviour of children. This is not the same as the MMFF dimension of behaviour control which refers more to the family's style of behaviour management. Examining changes in the behaviour of children, especially referred children, is just as important though. Many of the families who participate in IFPS have come to the attention of child welfare agencies due to children's behavioral problems. Since it is often behaviour problems that put children at risk of placement, it is important for IFPS studies to consider this dimension when examining family functioning.

Summary

A number of studies on the functioning of families in IFPS have failed to provide a conceptualization of family functioning. Consequently, the rationale for its operationalization is not always clear. This is especially troublesome in view of the questions that have been raised about the relevance of certain family functioning measures to the goals of IFPS programs.

In this section, a clinically oriented conceptualization of family functioning referred to as the McMaster Model of Family Functioning (Epstein, Bishop & Baldwin, 1983) was presented. The MMFF is based on the view that the primary function of the family is to provide a setting for the development and maintenance of family members on social, psychological and biological levels. The model includes six dimensions of functioning each of which is considered to be as important as the other. For this reason, it was decided that in addition to obtaining information about general family functioning, data concerning the functioning of families in each of these six areas should also be collected. In addition, it was argued that children's behaviour is another aspect of family functioning that should be examined in IFPS research.

SUMMARY AND RESEARCH QUESTIONS

The paucity of research on the functioning of families in IFPS is a problem that needs to be addressed. The assumption implicit in the rationale and support of these programs is that they prevent placement by improving family functioning, yet few studies have examined changes in family functioning in any detail. The majority of studies have focused exclusively on placement prevention which is not necessarily a good nor sufficient indicator of IFPS treatment success. For this reason, recent IFPS studies and literature reviews have recommended the examination of family functioning variables.

There are a number of questions regarding the functioning of families in IFPS that would be useful to address. First of all, does the functioning of families who receive these services improve? Preliminary findings suggest that family functioning does improve, but there is reason to be cautious since studies have a number of limitations including the use of questionable measurement instruments, the absence of conceptual definitions, inadequate service descriptions and poor study designs (Spaid, Fraser & Lewis, 1991; Wells & Whittington, 1993; Feldman, 1991; Scannapieco, 1993). Secondly, which areas of family functioning change? A number of IFPS studies have only reported general family functioning scores and thus, it is not clear which particular aspects of functioning improve while families receive these

services (Spaid, Fraser & Lewis, 1991; Wells & Whittington, 1993; Scannapieco, 1993). In addition, studies have not collected or factored into their analyses, the perceptions of different members of the same family. This may be a shortcoming as previous studies have found significant differences between parent and adolescent reports of family functioning and have cautioned against assuming that parental reports are more accurate.

The present study, therefore, was designed to address some of these perceived gaps in the literature. The study examined two research questions:

1) Does the general functioning of families who receive IFPS improve from admission to discharge?

2) Does the functioning of families improve from admission to discharge in any of the following areas: problem-solving, communication, roles, affective responsiveness, affective involvement, behaviour control and children's behaviour?

CHAPTER 3

METHODOLOGY

In this chapter, the approach or strategy used to address the research questions is described. The discussion will be limited to six areas: research design, data collection procedures, program description, instrumentation and data analysis procedures. The discussion of study limitations will be included in the final chapter.

RESEARCH DESIGN

The present study used a non-randomized, one group, pretest-posttest design which can be symbolized as follows:

O_1 X O_2

Where:

O_1 = Measurements of family functioning at admission

X = IFPS program

O_2 = Measurements of family functioning at admission

The descriptive design utilized in this study has been used in other studies on IFPS and family functioning (Wells & Whittington, 1993; Spaid, Fraser & Pecora, 1991). The design is limited by several threats to internal and external validity and therefore, study results will not support statements about whether any observed changes in family

functioning would have occurred in the absence of IFPS. Such statements require the use of a comparison or control group, which was not feasible due to difficulties gaining access to comparable families with children at risk of placement. However, the design of the study was considered appropriate because not much is known about the functioning of families in IFPS. In view of the research questions, the design is fitting and enables the study to identify whether improvements in functioning occurred during the time that families received IFPS.

Sample

For this study, nonprobability availability sampling procedures were used. Every family admitted to the IFPS program during the study period of October 1994 to October 1995 was invited to participate. A family was considered appropriate if it had at least one parent who was willing to be involved. Fourteen or 88% of the families admitted to the program during this time period agreed to participate in the study. Of these, 14 (100%) completed the program and the posttest. The level of participation and the lack of attrition in this study stands in contrast to the low participation and high attrition rates observed in almost all of the IFPS studies reviewed by Blythe, Salley and Jayartne (1994). Demographic and other descriptive information about the participants in this study was collected and will be

presented in Chapter Four.

Although a family was considered appropriate for the study if at least one parent agreed to participate, referred children who were between the ages of 10 and 18, were also asked to participate. The term "referred children" denotes children who were considered to be at risk and under whose name the child welfare file was opened. If a family had more than one referred child, the oldest child was invited to participate. The age criterion was necessary given the age restrictions on the measurement instruments used. Nine of the 14 families who participated in the study had children who met the above criteria and eight of these families had one child who agreed to participate. In addition, 6 of the 14 study families had fathers and five of these fathers agreed to participate. Altogether, 27 individuals from 14 families participated in this study: 14 mothers, 5 fathers and 8 children.

PROCEDURES

Ethical issues

Approval to proceed with this study was granted by the Faculty of Social Work Ethics Committee at the University of Calgary and by the Associate Deputy Minister, Saskatchewan Social Services (see Appendix A).

A number of procedures were negotiated and implemented in

order to ensure that issues of confidentiality, anonymity and voluntary consent were addressed. To protect the anonymity of families who did not want to participate in the study, IFPS program workers first informed families of the study during their initial meetings and provided them with the following: 1) a letter written by the researcher explaining the study, the time requirements and the assurances of confidentiality (see Appendix B); 2) the consent form for adults and children (see Appendix B); and 3) a letter from the Saskatchewan Social Services outlining its role in the project. If families agreed to participate and signed the consent form, then program workers contacted the researcher and provided the name, phone number and address of the family. Prior to administering any of the measurement instruments, the researcher verbally explained the letter and consent forms to family members in order to personally ensure the information was understood.

Participation in the study was entirely voluntary; families were informed that their decision would not affect their participation in the IFPS program. Families were also informed that they had the right to withdraw at any time. The confidentiality and anonymity of participant responses was ensured; no identifying information left the IFPS program office as all responses were transformed to numbers and the results expressed in aggregate form.

Data Collection

Data were collected from parents and children within 1 week of their admission to the IFPS program and within one week of their discharge. All parents or caregivers and one referred child from each family, were asked to complete the standardized measures of family functioning and children's behaviour employed by the study. Parents and children were administered these measures in their homes by the researcher who was not affiliated with the program. Each family member completed the measure separately, without comparing their responses to each other. Two of the children were administered the tests verbally as they found reading too time consuming. Each family interview took about 1 to 1 1/2 hours to complete.

In addition, data were collected from the four IFPS program workers concerning demographic information and the types of services provided to families. Since each family was assigned only one family worker, a single worker was asked to complete clinical and concrete services checklists for each study family. Workers were asked to complete these checklists at the time each family completed the program. It should also be mentioned that program workers were not informed of the pretest or posttest results until after the family had finished receiving services.

PROGRAM DESCRIPTION

During the literature review, a conceptual framework for describing IFPS programs was presented. This framework, developed by Unrau (1994), includes three main components: program philosophy, service structure and treatment. In general, "program philosophy" refers to the set of beliefs that guide the program, "service structure" refers to the features that support program implementation and "treatment" refers to the clinical and concrete services provided to families in order to reach treatment goals. These three program components form a general conceptual framework that can be used for examining, describing and comparing individual IFPS programs (Unrau, 1994). It is this framework that will be used to describe the IFPS program that participated in the present study.

The Family Builders Program

The IFPS program involved in this study is the Family Builders program located in Regina, Saskatchewan. The Family Builders Program is a part of Saskatchewan Social Services and was designed to complement the mandate of Child Protection, Family Services Division. Although the Family Builder's program coordinator and four family workers are employees of the Department of Social Services, they are not officers under The Family Services Act and thus, do not have the power to

apprehend children. The four family workers involved with this study are referred to as "family preservation therapists" and all of them have university undergraduate degrees: 3 have a Bachelor of Social Work Degree and one has a degree in Rehabilitation. Two of the family preservation therapists were working on their Master's of Social Work degrees during the time of the study.

Program Philosophy

The Family Builder's Policy and Procedures Manual (1993) outlines the fundamental beliefs that guide program staff. Like many IFPS programs, the Family Builders program originally modelled the Homebuilders Program in Federal Way, Washington. As a result, many of the beliefs and values set forth in the Family Builder's Policy and Procedure Manual (1993), are similar to those articulated by Homebuilders.

One of the fundamental principles that guides the Family Builders program is the belief in the integrity of the family unit. The program is supported not only by the belief that families are the best place for children to grow and develop, but also by the view that concentrated efforts should be made to enable children to remain with their own families. Placing children with foster families may be better than placing them in a more restrictive setting, but Family Builders's staff believe that it is preferable to initially work towards resolving child protection issues so that children can remain

with their own families.

While the Family Builders staff are guided by the belief that children should be kept with their own families, they also believe that children have the right to a safe and nurturing home. In most cases, these two beliefs can be upheld as family preservation therapists work with families to resolve protection issues so that children can remain at home. However, in cases where the treatment services and presence of Family Builders staff cannot ensure safety, then the right of children to be safe takes precedence. If this is the case, then protection workers are advised of the exact risks and interim safety measures are undertaken. In sum, the Family Builders Program maintains a belief system that commits them to do whatever is necessary to protect children and preserve families.

The Family Builders program also has a number of beliefs that guide treatment and worker-client relationships. First of all, program staff believe that many family problems occur due to skill deficiencies. In this view, the causes of problems are attributed to learning and the past environment rather than to the personalities of family members. This belief undergirds the program's use of social learning theory and cognitive-behavioral approaches. Secondly, the Family Builder's Policy Manual (1993) states that families are doing the best they can with what they have. Program staff believe that many family problems may be linked to a lack of external

resources. Overall, these two views comprise a belief set that encourages a very non-blaming and non-labelling stance.

Another fundamental view mentioned in the Family Builders Policy Manual (1993) is that positive change stimulates hope and optimism and thereby increases motivation for continued change. Many of the families referred to Family Builders have endured chronic struggles and have tried many other community resources. As a result, program staff believe that family members often feel powerless. Program staff believe it is their responsibility to create hope and optimism for these families by helping families to change and to believe that they have the ability to resolve issues successfully.

The final belief outlined in the Family Builder's Manual (1993) is the belief in an egalitarian relationship with clients. All family members are viewed as colleagues in the helping process and their opinions and views are solicited and respected. The therapeutic relationship is used in a manner conducive to having family members view workers as colleagues, rather than as experts or authorities. This is one reason why family preservation therapists are clearly distinguished from the child protection officers.

Service Structure

The service delivery structure of Family Builders also shares many of the features common to a Homebuilders program.

However, as a result of modifying the program to fit community and client needs, some of the components are different. Service delivery components of the Family Builders Program, as described in various places throughout the program manual (1993), include the following:

- *The duration of services is two months.* The program extended the duration of services over the Homebuilders model because of the perceived need to provide longer term treatment in Regina.
- *Intensity.* The average service hours per family is reported to be 132.5 over a two month period. The intensity of services gradually decreases during the intervention period. During the first two weeks the intensity ranges from 10 to 25 hours, during the third to fifth week from 10 to 15 hours, and during the six to eighth week from 5 to 10 hours.
- *Small Caseloads.* Therapists work with only two families at a time due to the intensity of services.
- *Treatment in the natural setting.* Therapists provide services within the homes of families. They may also provide services in other natural settings such as playgrounds or schools if the need exists, and if families are agreeable.
- *High accessibility and responsiveness.* Therapists give families as much time as they need, when they need it most. Therapists are available to families twenty-four

hours a day, seven days a week. Each therapist carries a pager and an on-call system is utilized.

- *Flexibility*. A variety of treatment techniques are used to address individual needs. Treatment plans address specific issues related to child protection concerns. In addition to providing clinical services, therapists also provide concrete services and are said to teach families basic life skills such as how to use the transportation system, make child care arrangements and so on.
- *Accountability*. The referring child protection worker is advised of the progress of families on a weekly basis. A detailed report of treatment, including recommendations for further service, are provided at the end of services. There is no description of formal evaluation procedures, but treatment goals are described as concrete, specific and measurable, and are aimed at the elimination of referral issues (Family Builder Program Manual, 1993).

Treatment

At a theoretical level, the treatment model for Family Builders is primarily based on psychoeducational, social learning and cognitive-behavioral theories. At a practice level, the treatment strategies used by workers are reported to be borrowed from the Homebuilders Model (Kinney & Haapala, 1991) and from the Teaching Family Model developed in Boystown, Nebraska and used by Alberta Family Support Services

in Calgary, Alberta (Fixsen, Blase, Olivier, Lander, Clark & Adams, 1988).

The assessment process at Family Builders focuses on three main areas. The first part of the assessment process focuses on the present here and now situation. Therapists typically consult with schools, protection workers and others to gain additional perspectives of the family's situation. The second part of the assessment process involves an assessment of the history of the problem. Although treatment focuses on the present, genograms, eco-maps and other techniques are used to understand the context and potential limitations of treatment. The third aspect of assessment focuses on desired outcomes. Therapists attempt to understand what the home would look like if child welfare concerns were resolved. The emphasis here is on developing concrete, behaviourial outcomes that are realistic and directly related to reducing child welfare risks.

As is the case in many IFPS programs, Family Builder's staff attempt to tailor treatment to the unique situations of individual families. Treatment strategies are altered to creatively fit with the family's life styles, values, culture and so on. Different strategies may be selected based on assessment results, treatment goals, and the family's unique situation. However, the treatment menu, from which strategies are chosen, primarily consists of behaviourial and cognitive-behaviourial approaches. As mentioned earlier, a majority of

the treatment techniques used by Family Builders therapists are borrowed from the Teaching Family Model.

During the discussion of the philosophy of Family Builders, it was noted that program staff are guided by the belief that many family problems are due to skill deficiencies. These deficiencies are not perceived to be the result of individual psychopathology, but are attributed to inadequate learning and teaching in past environments. It is in this regard that the Teaching Family model fits with the Family Builders' philosophy.

The Teaching Family Model is a consolidated array of techniques that can be used to teach competent behaviour in areas such as family life skills, vocational skills, social skills and so on. Utilizing techniques from this model, Family Builder therapists teach family members the specific skills they need in order to eliminate the need for placement. The menu of skills that can be taught to children includes basic skills (eg. following instructions, accepting criticism, asking permission), school-related skills (eg. dealing with authority, study skills, peer relations), skills for dealing with feelings (eg. expressing affection), alternatives to aggression (eg. self-control, avoiding trouble) and skills for dealing with stress. Skills that may be taught to adults include effective parenting skills (eg. effective praise), setting clear expectations (eg. chore chart), skills for dealing with feelings, alternatives to aggression, skills for

dealing with stress, job-related skills, and planning skills (eg. goal setting, household organization). Therapists may also teach the matching of these skills. For instance, parents learn to effectively praise a child who follows instructions correctly.

The process of teaching skills involves breaking skills down into specific behaviours. Each one of the skills on the treatment menu has an specific recipe which outlines the exact behaviours that children or parents need to perform. For instance, children are taught to ask permission by looking at the person, asking in the form of a question, waiting for the answer, and saying "okay", if the answer is "yes", or "thank-you", if the answer is "no". Therapists use various methods such as modelling, feedback, support and prompts to aid learning.

Other treatment techniques commonly used by Family Builders therapists include changing the family view, active listening and empathy, teaching "I" and "You" statements, rational problem solving (SODAS-F) and guided self-discovery. Therapists also engage in networking activities designed to link families with personal and community support systems. Therapists may also adopt the role of advocate and become involved in legal or education issues. In addition, although it may not be clinical per se, therapists provide concrete services and help families with food, housing, medical and dental services, financial assistance, recreational

activities, nutritional meal planning and so on.

INSTRUMENTATION

Family Functioning

In this study, family functioning was defined as the performance by family members to provide a setting for the development and maintenance of family members on social, biological and psychological levels as measured by the Family Assessment Device 3 (FAD-3) (Epstein, et al., 1983), Child Behaviour Checklist (CBCL) and Youth Self-Report (YSR) (Achenbach & Edelbrock, 1983). More specifically, the areas of family functioning that were examined in this study were operationally defined - based on the McMaster Model of Family Functioning (Epstein et. al. 1983) - as follows:

- *Problem-solving.* A family's ability to resolve instrumental and affective problems to a level that maintains effective functioning as measured by the corresponding FAD-3 subscale.
- *Communication.* The exchange of instrumental and affective information within a family as measured by the FAD-3 subscale.
- *Roles.* The repetitive patterns of behaviour by which family members fulfil family functions as measured by the FAD-3 subscale.

- *Affective Responsiveness*. The ability of a family to respond to a given stimulus with the appropriate quality and quantity of emotion as measured by the corresponding FAD-3 subscale.
- *Affective Involvement*. The extent to which family members show interest in and value the activities and interests of individual family members as measured by the FAD-3 subscale.
- *Behaviour Control*. The pattern a family adopts for managing behaviour in physically dangerous situations, in situations that involve the meeting and expressing of psychobiological needs and in situations involving interpersonal socializing behaviour as measured by the FAD-3 subscale.
- *Children's Behaviour* as measured by the CBCL and YSR.

FAD-3

The FAD-3 contains sixty statements about family life to which a person is asked to rate how well the item describes his or her family by selecting among four responses: strongly agree, agree, disagree, strongly disagree. The FAD-3 is based upon the McMaster Model of Family Functioning (MMFF) (Epstein et al., 1983) which postulates that a family's ability to fulfil its instrumental, developmental and crisis-related tasks is affected by the first six dimensions of functioning mentioned above. The FAD-3 has six subscales which correspond

to these dimensions, as well as, a General Functioning Index that measures the general health/pathology of a family. One total score ranging from 1 to 4 is produced for each sub-scale with a lower score indicating greater health.

Relevance. The FAD, which is essentially the same as the FAD-3, has been recommended as an instrument that is relevant to the goals of intensive family preservation programs (Jones, 1991). IFPS treatment is commonly directed to facilitating change in one or more of the areas of functioning measured by the FAD. The General Functioning Index of the FAD has been used in previous evaluations of IFPS programs (Jones, 1991; Wells & Whittington, 1993).

Reliability. Reports to date have consistently provided psychometric data that supports the reliability of the FAD. The development of the FAD utilized a sample of 294 people who had one family member in an adult psychiatric hospital and 209 students enroled in an introductory psychology class (Nelson & Utesch, 1990). Internal consistencies for each of the scales have been reported as follows: Roles & Behaviour Control (.62), Problem-solving (.74), Communication (.75), Affective Involvement (.78), Affective Responsiveness (.83) and General Functioning (.92) (Epstein, Bishop & Baldwin, 1983, p.177). As for the stability of the FAD, test-retest reliabilities over one week were as follows: Problem-solving (.66), Affective Involvement (.67), Communication (.72), Behaviour Control (.73), Roles (.75), Affective Responsiveness

(.76) and General Functioning (.71) (Miller et al., 1985).

Validity. The FAD has been reported to discriminate between clinical and nonclinical families and to correlate significantly with other measures of family functioning (Epstein et al, 1983; Miller et al, 1985; & Sawyer, et.al., 1988). In addition, a factor analysis applied to the six subscales indicated that over 90% of the items loaded the highest on factors as hypothesized (Kabacoff et al. 1990).

Child Behaviour Checklists

In addition to the FAD-3, the Child Behaviour Checklist (CBCL) and Youth Self Report (YSR) were used to measure changes in the behaviour of children (Achenbach & Edelbrock, 1983). These measures were included in the study because child behaviourial problems are interconnected with family functioning and are often cited as the presenting problem for families referred to IFPS programs. Both the CBCL and YSR have been used in other evaluations of the functioning of families in IFPS programs (Kinney et al, 1991, Wells & Whittington, 1993).

The CBCL was completed by parents, while the YSR was completed by the children. The CBCL and YSR are each comprised of 112 items, each one representing a problem behaviour. The YSR is essentially the same as the CBCL except it is worded in the first person. Parents and children are asked to rate the frequency of the behaviour "now or within

the past six months" according to a three-point Likert-type scale ranging from "not true" to "very true or often true". As has been done in other IFPS studies, instead of six months, family members were asked to rate the frequency of behaviours within the past month in order to measure change in an program that only lasts two months (Wells & Whittington, 1993). The CBCL and YSR produce scores on several subscales, but only the total behaviour problem T scores were used. The total behaviour problem T score is a standardized score based largely on percentiles, which accounts for differences in the ages and gender of children. For both the CBCL and the YSR, higher T scores indicate greater problems.

Reliability. Inter-rater and test-retest reliability have been demonstrated for the CBCL, while test-retest reliability has been demonstrated for the YSR (Achenbach, 1983). For individual items on the CBCL, intraclass correlations were reported to be in the .90's. For scale scores and total problem and competence scores, the median Pearson product moment correlation for 1 week test-retest reliability of was .89 for the CBCL and .81 for the YSR. The median Pearson correlation between mother's and father's ratings on the CBCL was .66. Test-retest correlations for CBCL scores over a three month period averaged was .74 for parents.

Validity. The content validity of the CBCL and YSR was evaluated in terms of whether test items were related to the

clinical concerns of parents, adolescents and mental health workers (Achenbach, 1983). Over 98% of the behaviour problem items were demonstrated to be significantly associated with clinical status ($p = .01$), as established independently of the CBCL and YSR. The CBCL and YSR have been reported to discriminate between clinical and nonclinical samples (Achenbach, 1983).

IFPS program

In order to ensure the program that participated in this study was an IFPS program, data were obtained concerning program participants and the intensity, duration and types of services. Some of the information about family, child and program characteristics was obtained from case files and interviews with family workers. Workers at Family Builders routinely complete a Family Characteristics Questionnaire for each family at termination In addition, workers normally record data concerning the amount and intensity of service hours. Information obtained about the risk of placement was determined by the child protection worker at the time of referral. It should be mentioned though, that the determination of placement risk has been shown in other studies to be questionable (Blythe, Salley and Jayartne, 1994).

In order to measure the types of services provided to study participants, family workers were asked to complete

Clinical and Concrete Services Checklists (Kinney et al, 1991). These checklists were developed by Homebuilders staff and include the following main service categories: Child Management/Parent Effectiveness Training, Emotional Management, Interpersonal Skills, Assertiveness, Miscellaneous Clinical, Advocacy, Other Services and Concrete Services (Appendix C). Workers were asked to check off the specific services provided during the course of the intervention. Although no information is available regarding the reliability or validity of these checklists, they have been utilized in a number of other studies on intensive family preservation services (Feldman, 1991; Fraser et al, 1991).

DATA ANALYSIS PROCEDURES

Data in this study were analyzed using both descriptive and inferential statistics. Raw data pertaining to sample and program characteristics were organized and summarized through the use of descriptive statistics. The family functioning data collected from different members of the same family were averaged to get one family mean score. Since differences in parents and children's reports of family functioning may have made the use of family mean scores imprudent, these scores were first compared. In cases where differences between parents and children's scores for family functioning dimension were found, changes in pretest and posttest scores were

analyzed separately for each group. In cases where no differences were found, the comparisons of pretest and posttest scores were based on family mean scores.

Since certain assumptions for the use of parametric tests could not be met given the small size of the study sample, the analysis of family functioning data was based on the use of a nonparametric statistical test. The Wilcoxon Matched-Pairs Signed Ranks Test was used to compare differences in family functioning scores. This test is appropriate for the case of two related small samples when the measurement scale allows one to determine the amount of any difference between paired observations, as well as the direction of difference (Daniel, 1990; Neave & Worthington, 1988). The Wilcoxon Matched Pairs Signed Ranks Test ranks differences between paired scores and determines the probability of the occurrence of the observed differences. The .05 level of significance was used for all comparisons.

CHAPTER 4

ANALYSIS AND FINDINGS

In this chapter, the data collected for the study is analyzed and presented. The chapter is divided into three main sections. The first section provides a description of the families and children who participated in this study according to a number of social and demographic characteristics. The second section presents descriptive statistics concerning the amount and types of services provided to these families. Finally, the third section provides the analysis of the family functioning data and presents the findings for the two research questions.

SAMPLE CHARACTERISTICS

In order to better understand the families and children who participated in this study, sociodemographic and other data was obtained from the case files. Such information may be useful in comparing participants in this study to participants in other IFPS studies. This sociodemographic data is simply presented in this section and will be discussed in the next chapter.

Family and Parent Characteristics

Information about the size and structure of the 14 families involved in this study was obtained. As indicated in Table 4.1, the average size of study families was 4.5 with a standard deviation of 1.22. The mean number of children in these families was 3.05 (SD = .91). In terms of family structure, 8 (57.1%) of the families were headed by a female single parent, 4 (28.65%) were parented by the birthmother and a male steparent and 2 (14.3%) were headed by the two birthparents.

Data pertaining to the ethnicity, ages, education and economic status of parents and families were also collected and included in Table 4.1. In terms of ethnicity, the vast majority of mothers (85.7%) and all of the fathers (100%) were Caucasian. The mean age of mothers was 37.9 (SD = 7.1), while the mean age of fathers was 33.6 (SD = 4.59). At least 50% of the mothers and fathers did not have a high school diploma and none of the parents had a university degree. The gross annual family income for nearly 80% of the families was less than $20,000 with almost 40% of the families reporting an income of less than $10,000 per year. The main source of income for 50 percent of the families was employment, while for 42.9 percent of the families, it was financial assistance.

In addition to basic demographic data, information about the presenting problems and prior agency involvements for study families was also obtained and included in Table 4.1.

Table 4.1

Characteristics of Study Families (N = 14)

Variables	Number	Percent
Mean Number of Family Members (SD)	4.50 (1.22)	
Family Structure		
Two parents - natural	2	14.3
Birthmother with stepparent male	4	28.6
Single parent - female	8	57.1
Ethnicity of Mothers (N = 14)		
Caucasian	12	85.7
Aboriginal	2	14.3
Ethnicity of Fathers (N = 6)		
Caucasian	6	100.0
Aboriginal	0	
Mean Age of Mothers (yrs) (SD)	37.9 (7.1)	
Mean Age of Fathers (yrs) (SD)	33.6 (4.6)	
Level of Education - Mothers		
Less than Grade 12	8	57.2
High School Diploma	3	21.4
Technical Institute Diploma	3	21.4
University Degree	0	0.0
Level of Education - Fathers		
Less than Grade 12	3	50.0
High School Diploma	1	16.7
Technical Institute Diploma	2	33.3
University Degree	0	0.0

(continued)

Table 4.1 (continued)

Characteristics of Study Families (N = 14)

Variable	Number	Percent
Gross Annual Family Income		
9,999 & under	5	38.5
10,000 - 19,999	5	38.5
20,000 - 29,999	2	15.3
30,000 - 49,999	1	7.6
Missing Data	1	
Major Source of Family Income		
Employment	7	50.0
Financial Assistance (SAP, SIP)	6	42.9
Unemployment Insurance	1	7.1
Presenting Problems for Families		
Child Behaviour	13	92.8
Parenting Issues	12	85.7
Physical Violence	5	35.7
Child Neglect/Abuse	4	28.6
Mental Health	4	28.6
Spousal Abuse	3	21.4
Severe Financial Hardship	3	21.4
Previous Agency Involvements		
Mobile Crisis Services	7	50.0
Mental Health Clinic Services	4	28.6
Child Outpatient Services	4	28.6
Family Therapy Services	4	28.6
Parent Aid Services	3	21.4
None	3	21.4
Women's Shelter	2	14.3

In terms of presenting problems, the categories were not mutually exclusive. Thus, many families were reported in the case files as having multiple presenting problems when the issues were essentially the same. Based on the case files, the two most commonly cited presenting problems for study families were children's behaviour (92.8%) and parenting

issues (85.7%). Children's behaviour included problems like juvenile delinquency, violence towards family members or others, parent-child conflict and other out-of-control behaviours such as truancy or running away. Parenting issues not only included parenting skill deficits and issues of abuse and neglect, but also parent emotional, mental health and substance abuse problems. Other presenting problems reported for families were physical violence (35.7%), child neglect and abuse (28.6%), mental health (28.6%), spousal abuse (21.4%) and severe financial hardship (21.4%).

The vast majority of study families had received some services from other agencies prior to their referral to Family Builders. Only three or 21.4% of the families had not received any services prior to their referral. The most common form of service previously received by families was short-term mobile crisis services. The next most common types were mental health services, child outpatient services and family therapy services.

Child characteristics

Data was also collected concerning the one referred child within each of the 14 study families. As indicated in Table 4.2, approximately fifty-seven percent of the referred children in this study were male. The mean age of study children was 11.2 years (SD = 2); the youngest child was 8, while the oldest was 15. As for their family position, the

majority of referred children (64.3%) were the eldest.

Although determinations of placement risk have been shown in the past to be questionable, the data was available and should be considered. According to the assessments of risk completed by child welfare workers prior to the family's referral to Family Builders, 10 (76.9%) of the study children were at imminent risk of an out-of-home placement. Imminent risk was defined as placement within one week in the absence of services. The remaining children were considered to be at risk of being placed within one month. None of the children were identified as being at no risk of future placement.

Table 4.2

Characteristics of Study Children (N = 14)

Variable	Number	Percent
Gender		
Male	8	57.1
Female	6	42.9
Mean Age	11.2	
(SD)	(2.0)	
Position in Family		
Oldest Child	9	64.3
Youngest Child	3	21.4
Other	2	14.3
Risk of Placement		
Imminent Risk: within one week	10	76.9
Placement within one month	3	23.1
No risk	0	0.0
Missing Data	1	

PROGRAM CHARACTERISTICS

Information was collected from the case files and through the use of instruments concerning the amount and types of services provided to families. The data is summarized in this section.

Structural features

Service duration. The mean number of weeks of service for study families was 8.46 with a standard deviation of 2.29. In terms of intervention days, the medium number of days that families received services was 52.25 with a range of 33 to 95.

Service hours. For Family Builder workers, the mean number of hours of direct or face-to-face contact with families was 70.44 with a standard deviation of 30.23. The mean number of total service hours, which includes direct and indirect contact such as face-to-face, phone calls and collateral contacts, was 102.07 with a standard deviation of 43.86. Although data was not available concerning the distribution of service hours for study families over the intervention period, it is reported in the Family Builders Policy Manual (1993) that services average 25 to 10 hours during the first two weeks, 15 to 10 hours during the third to fifth week, and 10 to 5 hours per week thereafter.

Service goals. Information pertaining to the number and type of service goals set by study families and IFPS workers

was obtained from the case files. In this study, the mean number of treatment goals set by families and workers was 7 (SD = 2.7). The frequency that various service goals were chosen is shown in Table 4.3. As indicated, the six most commonly set goals were improving parenting skills, improving communication skills, improving anger/fighting management, receiving therapeutic forms of support and increasing the self-esteem of parents or children. These particular six goals were set by more than sixty percent of the study families.

Table 4.3

Service Goals Set By Study Families and Workers (*N* = 14)

Service Goal Category	Number	Percent
Improve parenting skills	11	78.6
Improve communication skills	11	78.6
Anger/fighting management	10	71.4
Provide support	9	64.3
Increase self-esteem	9	64.3
Basic skills/Home management	9	64.3
Improve school-related skills	6	42.8
Stress/emotion management	5	35.7
Advocacy (ie. school, legal issues)	3	21.4
Alcohol issues	2	14.3

Clinical services

Data were collected from IFPS workers regarding the types of clinical services provided to study families. Although the duration of IFPS services is relatively short, based on the data collected, IFPS workers in this study

provided an extensive and eclectic array of clinical services. The IFPS workers reported an average use of 39.35 (SD = 15.23) different clinical activities per case.

Table 4.4 displays the frequencies of service activities provided to study families. The data is organized according to the service categories contained on the Clinical Services Checklist (Kinney et. al. , 1991). Of the 81 clinical services examined, 10 were provided in more than 85% of the study cases. Five of these ten activities can be described as conducive to the process of engagement, assessment and contracting: relationship building, providing support or understanding, clarifying family rules, clarifying problem behaviours and setting treatment goals. The other five can be described as treatment activities: teaching parents the use of natural or logical consequences, teaching children to accept "no", building the self-esteem of parents and children, teaching problem-solving skills and role playing.

Many of the other clinical services commonly provided to study families also appear to be psychoeducational/behavioral in style and relevant to the types of service goals commonly set by families. For instance, clinical services provided in more than 70% of the cases include teaching the use of time-out, teaching child management skills, teaching active listening, teaching the use of "I" statements, providing literature, providing information about child/adolescent development, teaching impulse management, de-escalating and

teaching rationale emotive therapy concepts. All of these activities are germane to the common treatment goals of improving parenting, communication and anger management skills.

Table 4.4

Clinical Services Provided to Study Families (N = 14)

Clinical Services	Number	Percent
Child Management/Parenting Items		
Natural/logical consequences	14	100.0
Time-out	11	78.6
Teaching skills	10	71.4
Active listening	10	71.4
"I" statements	10	71.4
Use of reinforcement	9	64.3
Tracking behaviours	9	64.3
No lose problem solving	7	50.0
Problem ownership	5	35.7
Environmental controls	3	21.4
Emotion Management Items		
Building self-esteem	14	100.0
Impulse management	11	78.6
Rational Emotive Therapy concepts	10	71.4
Anger management	8	57.1
Pleasant events	7	50.0
Tracking emotions	7	50.0
Handling frustration	7	50.0
Self-criticism reduction	6	42.8
Depression management	5	35.7
Relaxation	5	35.7
Use of crisis cards	3	21.4
Interpersonal/Assertiveness Skills		
Accepting "No"	14	100.0
Problem-solving	13	92.8
Negotiation skills	9	64.3
Improving compliance	8	57.1
Giving/accepting feedback	7	50.0
Fair fighting	7	50.0
Territoriality concepts	7	50.0

(Continued)

Table 4.4 (continued)

Clinical Services Provided to Study Families (N = 14)

Clinical Services	Number	Percent
Advocacy Items		
Educational system	8	57.1
Referral to counselling	7	50.0
Consultation	5	35.7
Court hearings	1	7.1
Other Clinical Services		
Setting treatment goals	14	100
Relationship building	14	100
Support/understanding	14	100
Clarifying family rules	13	92.8
Role playing	12	85.7
Clarifying problem behaviours	12	85.7
Providing literature	11	78.6
Deescalating	11	78.6
Structure/routine	11	78.6
Reframing	10	71.4
Clarifying family roles	10	71.4
Child/adolescent development info	10	71.4
Listening	9	64.3
Encouraging hope	9	64.3
Monitoring client	9	64.3
Reframing	9	64.3
Defusing crises	8	57.1
Family council	6	42.8
Money management	5	35.7
Time management	5	35.7
Link to informal support systems	5	35.7
Social skills	5	35.7
Paper/pencil tests	5	35.7
Process of change	4	28.5
Use of journal	2	14.2

Concrete services

Data were collected concerning the concrete services provided to families as this is considered an important feature of IFPS. In this study, 14 or 100% of the families were provided with some type of concrete service. However,

only three concrete services were provided in more than 50% of the cases and two of these services had to do with recreation: providing recreational activities for families (71.4%), providing transportation to family members (64.3%) and arranging for recreational activities (57.1%). Concrete services related to basic needs such as providing food or shelter were provided less often as families were already meeting these needs.

Table 4.5

Concrete Services Provided to Study Families (N = 14)

Concrete Services	Number	Percent
Provide recreational activities	10	71.4
Provide transportation	9	64.3
Arrange for recreational activities	8	57.1
Help client get food	5	35.7
Help client obtain financial assistance	3	21.4
Help client obtain medical/dental services	3	21.4
Help client obtain childcare/babysitting	2	14.2
Help client get transportation	2	14.2
Provide toys or recreational equipment	2	14.2
Do housework/cleaning with client	1	7.1
Help client obtain housing	1	7.1
Help client to find a job	1	7.1
Arrange for lifeskills classes	1	7.1
Help client get utility services	1	7.1
Help client obtain household goods	1	7.1

FAMILY FUNCTIONING

Comparison of parent and child reports

Since previous studies have found significant differences in the reports of family functioning obtained from parents and children, it was considered important to first compare parent and child reports (Sawyer et. al., 1988). Such information was used to determine the wisdom of later using family mean scores to compare pretest and posttest family functioning scores.

In contrast to other studies, this study did not find many statistically significant differences between the reports of family functioning obtained from parents and children. Based on the use of a Wilcoxon Matched Pairs Signed Ranks Test, no statistically significant differences were found among the scores obtained from parents and children at the time of admission or discharge, for any of the following dimensions of functioning: problem-solving, communication, roles, affective involvement, affective responsiveness, behaviour control or general family functioning. For these dimensions of family functioning therefore, family mean scores were used to compare pretest and posttest scores.

The only difference found to be statistically significant based on the Wilcoxon Matched Pairs Signed Ranks Test, involved the reports of child behaviour problems obtained from parents and children at the time of admission ($T_+ = 0$, $n = 7$,

$p = .0078$). At the pretest, the Total Child Behaviour Problem scores obtained from children ranged from 52 to 71 with a median of 61.5, whereas for the parents of these children scores ranged from 65 to 85.5 with a median of 73.75. In other words, at admission, study children did not perceive their behaviour to be as problematic as did their parents. At the time of discharge though, no statistically significant differences were found between Total Child Behaviour Problem scores for parents and children. Nevertheless, it was considered prudent not to use family mean scores when comparing pretest and posttest scores for this dimension of family functioning. Instead, parents' and children's scores were analyzed separately.

In the next sections, the findings for the two research questions are presented. For the sake of clarity, the study questions are restated in italics at the head of each section.

Study question 1:

Does the general functioning of families who receive intensive family preservation services improve from admission to discharge?

As indicated in Table 4.6, the general functioning of study families appears to have improved while they were involved with the Family Builders program. Family scores for general family functioning at the pretest ranged from 1.75 to

3.00, with a median of 2.29. At the posttest, general family functioning scores ranged from 1.58 to 2.61, with a median of 2.04. An analysis based on the Wilcoxon Matched Pairs Signed Ranks Test, indicates a statistically significant difference between the pretest and posttest scores for general family functioning ($T_+ = 5.5$, $n = 14$, $p = <.001$). The data analysis supports the view that the general, overall functioning of study families improved during the time they participated in the IFPS program.

Table 4.6

Median Scores for Dimensions of Family Functioning at Pretest and Posttest ($N = 14$)

Family Functioning Dimension	Pretest	Posttest	p^a
General Family Functioning	2.29	2.04	< .001
Problem Solving	2.30	2.00	< .001
Roles	2.64	2.38	< .005
Behaviour Control	2.07	1.86	< .005
Affective Responsiveness	2.24	2.16	< .005
Affective Involvement	2.64	2.31	< .05
Communication	2.38	2.24	< .05

[a]Statistics for 1-sided Wilcoxon Matched-Pairs Signed-Ranks Test

Study question 2:

Does the functioning of families improve from admission to discharge in any of the following areas: problem-solving, communication, roles, affective involvement, affective responsiveness, behaviour control and children's behaviour?

Problem-solving. As indicated in Table 4.6, this dimension of family functioning showed improvement in families while they were involved with the Family Builders program. At the pretest, scores on the FAD problem-solving subscale ranged from 1.67 to 2.83, with a median of 2.30. At the posttest, scores ranged from 1.67 to 2.42, with a median of 2.00. The analysis based on the Wilcoxon Matched Pairs Signed Ranks Test, indicates a statistically significant difference between the pretest and posttest problem-solving scores ($T_+ = 3$, $n = 13$, $p = <.001$). The findings suggest that problem-solving improved for study families during the time they participated in the IFPS program.

Communication. Improving communication skills was one of the most commonly set treatment goals and it appears that this area of functioning also improved for families while they were in the IFPS program. The median pretest communication score for families is 2.38, with a range of 1.16, while the median posttest score is 2.24, with a range of .75. Analysis using the Wilcoxon Matched Pairs Signed Ranks Test, indicates that communication scores improved to a statistically significantly degree from the pretest to the posttest ($T_+ = 12$, $n = 12$, $p = <.05$).

Roles is another dimension of functioning that families reported improvement in from admission to discharge. The scores for role functioning reported by study families at the pretest ranged from 2.16 to 3.18, with a median of 2.64. At the posttest, scores ranged from 1.77 to 2.90, with a median of 2.38. There is a statistically significant difference between pretest and posttest scores for role functioning (T_+ = 7, n = 14, p = <.005), which supports the view that the ability of study families to allocate tasks and monitor role performances, improved while they were involved with the Family Builders program.

Affective responsiveness and affective involvement are two more areas of functioning that also appear to have improved for families while they participated in the Family Builders program.

The median pretest score for families on the Affective Responsiveness FAD subscale was 2.24 with a range of 1.49, while the median posttest score was 2.16, with a range of 1.49. In relation to affective involvement, the median pretest score is 2.64 with a range of 1.79, while the median posttest score is 2.31, with a range of 1.04. The comparison of pretest and posttest scores by the Wilcoxon Matched Pairs Signed Ranks Test, indicates that scores improved to a statistically significant degree for both affective responsiveness (T_+ = 8.5, n = 13, p = <.005) and for affective involvement (T_+ = 10.5, n = 12, p = <.05).

Behaviour Control. Out-of-control behaviour on the part of children was the most commonly cited presenting problem and so it is especially interesting that study families appear to have improved in the area of behaviour control. Behaviour control refers to the way that families express and maintain standards for the behaviour of its members (Epstein et. al., 1983). The median pretest score for behaviour control is 2.07, with scores ranging from 1.16 to 2.55, while the median posttest score is 1.86, with scores ranging from 1.11 to 2.11. The Wilcoxon Matched Pairs Signed Ranks Test indicates a statistically significant difference between the pretest and posttest behaviour control scores ($T_+ = 9$, $n = 14$, $p = <.005$). Thus, the data analysis supports the view that families improved in the area of behaviour control while they participated in the IFPS program.

Children's behaviour. Since pretest reports for this area of functioning differed between parents and children, family mean scores were not used in the analysis. Instead, reports obtained from parents and children were analyzed separately.

As indicated in Table 4.7, parents reported improvements in the overall behaviour of "at-risk" children. The median total child behaviour problem (CBCL) T score reported by parents at the pretest was 71.5, with a range of 35.5, whereas at the posttest, the median score was 63.75, with a range of 40. There is a statistically significant difference between the pretest and the posttest scores ($T_+ = 8.5$, $n = 13$, $p =$

<.005), which indicates a decrease or improvement in problem behaviours.

Table 4.7

Median Scores for Children's Behaviour at Pretest and Posttest

Measure	*N*	Pretest	Posttest	*p*[a]
Total behaviour problems				
Parents' reports (CBCL)	14	71.5	63.75	< .005
Children's reports (YSR)	8	61.5	56.0	< .05
Internalizing behaviours				
Parents' reports (CBCL)	14	67.5	59.5	< .005
Children's reports (YSR)	8	56.5	53	NS
Externalizing behaviours				
Parents' reports (CBCL)	14	73.75	65	< .001
Children's reports (YSR)	8	61.5	59.5	< .05

[a]Statistics for 1-sided Wilcoxon Matched-Pairs Signed-Ranks Test

More specifically, parents reported improvements in children for internalizing behaviours: somatic complaints, withdrawal, anxiety, and depression, (T_+ = 10, n = 14, p = <.005) and for externalizing behaviours: delinquency and aggression, (T_+ = 1, n = 13, p = <.001). The median parent pretest T score for internalizing behaviours is 67.5, with a range of 26, while the median posttest score is 59.5, with a range of 30. As for externalizing behaviours, the median pretest T score is 73.75 with a range of 28, while the median posttest score is 65, with a range of 36.5. Overall, the

analysis indicates that study parents perceived less withdrawal, anxiety, delinquency, aggression and other behaviour problems in their children at the time of discharge, than they did at the time of admission.

Study children also reported improvements in their overall behaviour. The median total behaviour problem (YSR) *T* score at the pretest was 61.5, with a range of 19, while the median posttest score was 56, with a range of 29. Analysis based on the Wilcoxon Matched Pairs Signed Ranks Test, indicates a statistically significant difference between the pretest and posttest Total Behaviour Problem scores ($T_+ = 3$, $n = 8$, $p = <.05$). According to the study children therefore, their behaviour improved during the time they participated in the IFPS program.

Like their parents, study children reported a decrease in aggressive, delinquent and other externalizing behaviour problems. The median pretest externalizing *T* score was 61.5 with a range of 22, while the median posttest *T* score was 59.5, with a range of 25. The comparison of pretest and posttest scores indicates that the externalizing behaviour problem scores decreased or improved to a statistically significant degree ($T_+ = 3$, $n = 8$, $p = <.05.$).

The analysis of children's scores for internalizing behaviour problems though, yields a different result. In contrast to parent scores, the pretest and posttest internalizing behaviour scores obtained from children, are not

different to a statistically significant degree. The median pretest *T* score for children on this subscale was 56.5, with a range of 26, while the median posttest *T* score was 53, with a range of 29. Thus, unlike the analysis of parent data, the analysis of child data does not support the view that there was a decrease in child behaviour problems like withdrawal, anxiety and somatic complaints, while families participated in the IFPS program.

CHAPTER 5

DISCUSSION AND CONCLUSION

This study was designed to examine changes in the functioning of families who received IFPS. There was interest in not only determining whether the general functioning of families improved during the course of services, but also in identifying what particular areas of functioning may have improved. Family functioning was conceptualized in a multidimensional manner and was measured through the use of standardized instruments. In addition, a number of sample and program characteristics were examined in order to provide some context for the interpretation of study findings.

Although the study findings are based on a descriptive design and limited by a number of factors, they indicate that improvements in family functioning occurred while families participated in the IFPS program. Consistent with other IFPS studies, improvements were observed in the general functioning of families and in the behaviour of at-risk children. One of the more unique aspects of this study though, is that improvements were also observed in particular areas of functioning. Based on the conceptual model of family functioning that was used, the following six dimensions of functioning showed improvement in families: problem-solving, roles, communication, affective involvement, affective responsiveness and behaviour control.

The discussion in this chapter is divided into four sections. The first section presents a discussion of notable study sample and program characteristics. The second section provides the discussion and conclusion of the main findings for the two research questions regarding family functioning. The limitations of this study are addressed in the third section, while the implications for policy, practice and research, as well as future considerations, are discussed in the fourth and final section.

SAMPLE AND PROGRAM CHARACTERISTICS

Based on the population served, the intensity and duration of services, the treatment goals and the types of services provided, it is reasonable to conclude that the Family Builders program is an IFPS program. Since not all IFPS programs are the same though, it is important to compare the Family Builders program with IFPS programs in other studies.

In general, the families who participated in this study appear to be quite similar to the populations observed in other IFPS studies. As reported in other studies, the vast majority of children in this study were considered to be at imminent risk of placement by child welfare workers: 76.9%. This percentage can be directly compared to the 62% reported to be at imminent risk in Wells and Whittington's (1993)

study. Like other IFPS studies (Feldman, 1991; Fraser, Pecora & Haapala, 1991), the most common presenting problem for study families was children's out-of-control behaviour. Consistent with the studies by Feldman (1991) and Fraser, Pecora and Haapala (1992), the majority of families in this study were single-parent in structure. None were headed by males. Also consistent with studies by Wells & Whittington (1993) and Fraser, Pecora & Haapala (1992), the annual income for more than 75% of the families in this study was less than 20,000 with the majority of parents having less than a grade 12 education.

Despite the similarities, there are some differences between the families in this study and those in other IFPS studies. Apart from nationality - Canadian families as opposed to American families - this study sample contains far fewer minority families than Feldman's (1991) study. In Feldman's (1991) study, 49% of the families who received IFPS were non-caucasian, compared to only 14.3% in this study. Since ethnicity and cultural values may influence the use or usefulness of certain service approaches, the results of this study may be limited by ethnicity. It should be noted though, that only 16.9% of the families in Pecora and Fraser's study (1991) were non-caucasian, which is much closer to the percentage observed in this study.

Another notable difference is that the at-risk children who participated in this study were, on average, slightly

younger than those who participated in other studies. The mean age of children in this study was 11.2 years (SD = 2.0), with the ages ranging from 8 to 15. This compares to a mean age of 12.97 years (SD = 3.64), in Feldman's (1991) study and a mean age of 13.7 years, with a range of 10 to 17, in Wells and Whittington's study (1993). What bearing this may have on the study results is difficult to determine. There is little reason to doubt though, that many of the issues facing families with younger at-risk adolescents or preadolescents, are different than those confronting families with older at-risk adolescents. This may be reflected in the fact that two of the most common skills taught to parents in this study were time-outs and use of behaviourial charts; skills which are likely more effective with younger than older adolescents.

In terms of service structure characteristics, a number of features are worth discussing. First of all, compared to other IFPS study programs, the Family Builders program provides services to families for a relatively long period of time. In this study, the mean number of weeks that families received services was 8.46 (SD = 2.29) compared to a mean of 5.5 weeks in Fraser, Pecora and Haapala's (1991) study, 5.3 weeks in Feldman's (1991) study, and 12 weeks in Wells and Whittington's (1993) study. Secondly, the Family Builders program provided more direct contact service hours per family, on average, than other IFPS study programs. The average number of direct contact hours per family in this study was

70.44, compared to 36.81 hours in Feldman's (1991) and 37.01 hours in Fraser, Pecora and Haapala's (1991) study. Although this is likely related to the longer duration of services, the Family Builders program also averaged more direct service hours than the IFPS program in Wells and Whittington's (1993) study (60.1 hrs.) which was, on average, almost 4 weeks longer.

The longer duration of services and the higher amount of face to face contact with families, may have had an effect on the changes in family functioning that were observed in this study. It may have meant that workers had more time to work on more goals, using more service technologies. For example, the average number of treatment goals for families in Fraser, Pecora and Haapala's (1991) study was 4.6, compared to an average of 7 goals per family in this study. In addition, the mean number of clinical services provided per case in Fraser, Pecora and Haapala's (1991) study was 31.8, compared to a mean of 39.35 (SD =15.83) in this study. Coupled together, the longer duration of services and the higher amount of direct contact may help to explain some of the changes in family functioning that were observed in this study, that were not observed in Fraser, Pecora and Haapala's (1991) study.

FAMILY FUNCTIONING

Overall, the findings of this study indicate that the functioning of families who received IFPS improved from the time of admission to the time of discharge. The improvements observed in relation to the general functioning of families and in the behaviour of children are consistent with the findings of other IFPS studies (Wells & Whittington, 1993; Feldman, 1991; Spaid, Fraser, & Lewis, 1991). One of the more unique features of this study though, is that improvements were also observed in particular areas of functioning previously unidentified in IFPS research. These areas include problem-solving, communication, roles, affective involvement, affective responsiveness and behaviour control.

Although the data analysis indicated that the differences in functioning before and after IFPS were statistically significant, it is important to discuss the clinical significance of the findings. Two issues seem important in this regard. One is whether the reported improvements in functioning are sufficient enough, while the other is whether the types of changes in functioning are relevant to the goals of IFPS and the problems facing families.

Based on the clinical cutting scores developed for the FAD by Epstein and colleagues (1985), many of the changes in family functioning observed in this study appear to be clinically significant. Using theory and clinician interview

ratings as criteria, Epstein and colleagues (1985) developed these cut-off scores in order to differentiate between healthy and unhealthy functioning on each of the FAD dimensions. One way to determine the clinical importance of the study findings therefore, is to compare the median pretest and posttest functioning scores to these health/pathology cutting scores.

At the pretest, of the seven dimensions of family functioning measured by the FAD, the median scores were in the unhealthy range for the following five areas: problem-solving, roles, affective involvement, communication and general functioning, and was borderline for affective responsiveness. At the posttest however, the median scores were in the healthy range for four areas of functioning: problem-solving, affective involvement, affective responsiveness and behaviour control. This suggests that the amount of change in at least three areas of family functioning - excluding behaviour control which improved, but was in the healthy range at the pretest - was clinically important. Study families had, on average, reported clinically significant improvement in the areas of problem-solving, affective involvement and affective responsiveness.

Two of the other functioning dimensions that were measured: communication and general family functioning, had median posttest scores right at the clinical cutting mark. While these posttest scores may not indicate healthy functioning for these dimensions, in contrast to the pretest

scores, they do not indicate unhealthy functioning. In view of this, these improvements can be cautiously interpreted as clinically significant.

Roles was the only area of functioning at the posttest with a median score, which after being rounded up to the nearest tenth, was above the clinical cutting mark and thus, in the unhealthy range. Nevertheless, the median score for this dimension was closer to the healthy range at posttest, than it was at the pretest, even though this amount of change may not be clinically significant.

The clinical significance of changes in the behaviour of at-risk children is more difficult to determine. This is partly because the reports by parents and children differed and were analyzed separately. For parents, the pretest and posttest median scores for total behaviour problems were both in the clinical range, which indicates that significant child behaviour problems still existed at the time of discharge. However, the reports obtained from children yield a different result. For children, the pretest median total behaviour problem score was in the borderline range, while the posttest median score was in the nonclinical range. This indicates a clinically significant level of improvement in behaviour. However, given the discrepancy in reports and the smaller sample of children who completed the YSR, it is reasonable only to conclude that the behaviour of study children improved during the course of IFPS services, but the amount of

improvement was not clinically significant.

In addition to whether the amount of change in various areas of functioning can be considered clinically sufficient, the relevance of some of the changes also needs to be discussed. The remainder of this section focuses on the importance of the findings in some of the functioning areas examined.

Problem-solving was one area of functioning which significantly improved for families during the course of IFPS. This is an important finding because problem-solving is one of the most common areas targeted for change by IFPS workers. In this study, the vast majority of families (92.8%) were taught problem-solving skills according to the clinical services data that was collected. Since problem-solving refers to a family's ability to identify and communicate problems, generate possible solutions, choose a course of action and carry it out, these skills are generalizable. Thus, improvements in this area may mean that families will be able to resolve their own future difficulties without the need for formal external resources like child welfare agencies.

Affective responsiveness. The significant improvement found in the area of affective responsiveness is also important. According to Epstein and colleagues (1983), this dimension refers to a family's ability to respond to a given situation with the appropriate quality and quantity of feelings. Based on the pretest data, many of the families

referred to the IFPS program had a narrowed range of emotional expressiveness; many reported difficulties expressing tenderness, love, joy or affection, and overresponded to situations with anger, fear or depression. These problems are reflected in the percentages of study families who set treatment goals related to the management of anger/fighting (71.4) and stress/emotion (35.7) and who received services concerning impulse management (78.5), deescalation (78.5), anger management (57.1), and depression management (35.7). How common these problems are to other families referred to other IFPS programs may be unclear, but the positive change in affective responsiveness reported by families in this study, should be considered a relevant finding.

Affective involvement. The improvements reported in the area of affective involvement are interesting. This dimension refers to the value and extent of interest family members give to the activities of each other (Epstein et al., 1983). The range of functioning goes from a lack of involvement or disengagement, to overinvolvement or enmeshment. Some IFPS researchers have questioned whether change in fundamental areas of functioning such as this, should be expected during the course of short-term IFPS (Spaid et al., 1991; Wells & Whittington, 1993). Based on these study results, it appears that such change is possible, at least in the short-term. Some of the clinical services that may have influenced changes in affective involvement include the teaching of

territoriality concepts, active listening, family council and problem ownership. In addition, the most common concrete service provided to families involved assisting them to participate in recreational activities so as to encourage them to spend more enjoyable time together.

Communication. Improving communication was one of the most common treatment goals set by families and IFPS workers in this study. Hence, the vast majority of study families received a variety of clinical services designed to improve communication. Since clearer and more direct styles of communication are thought to enhance family functioning, the improvements observed in this area are important. However, despite the recorded improvement, communication scores were still, on average, at the clinical cutting mark, which may indicate that the IFPS program needs to continue developing services in this area.

Roles. Although the role functioning of families improved during the time of IFPS, the median score for study families remained in the unhealthy functioning range at the time of discharge. Relevant clinical services that were provided to the majority of study families included clarifying family roles (71.4%) and establishing family structures and routines (78.5%). However, since unhealthy role functioning - where basic instrumental and affective tasks are not being met - may increase the risk of placement, the IFPS program in this study may need to further develop and target services in

this area.

Behaviour control and children's behaviour. Behaviour control improved for study families during the course of IFPS, but families had, on average, already reported effective functioning in this area at the time of the pretest. This may seem confusing given that the number one presenting problem for families was children's out-of-control behaviour. However, the behaviour control dimension of the FAD refers to the style of behaviour management a family uses, whereas the CBCL and YSR were used to measure children's actual behaviour. The results in this regard indicated that children's behaviour improved, but not to a clinically significant degree.

For families in this study, much attention was given to teaching parenting and behaviour management skills because the risk of placement was usually connected to child behaviourial problems. For this reason, it is difficult to interpret whether the study results are positive enough. While the reported decreases in behaviour problems may have been sufficient for families to avert the need for future placements, clinically significant child behaviour problems remained and thus, the risk of placement may not have been sufficiently reduced. This may be another area where further program improvement is required.

STUDY LIMITATIONS

This study has a number of limitations which restrict the conclusions that can be drawn from the findings. In general, interpretations of the study findings are largely limited by the pretest-posttest, one group design, that was used. First, study families were not randomly assigned to a treatment or control group and therefore, it is not possible to state with any reasonable level of certainty, that the observed improvements in family functioning were due to their participation in the IFPS program. Second, since a comparison group was not even used, it is not known whether the observed changes in functioning were related to the effects of factors such as maturation, statistical regression, or selection.

Maturation is a particularly troublesome issue for this study given the population served by the IFPS program. Families who participate in IFPS programs are often considered to be in a state of crisis at the time of referral. It was very possible therefore, that the functioning of study families at the time of the pretest was uncharacteristically low. Thus, the improvements in functioning that were observed in this study may be related to normal maturation or coping processes as families and children moved out of a temporary state of crisis. Without being able to compare the findings to another equivalent group of families who did not receive IFPS, it is difficult to eliminate this explanation of the

results.

Regression to the mean is a somewhat similar concern for this study. It is commonly recognized that extreme scores have a tendency to move toward the mean. It is possible therefore, that the low pretest scores became less extreme at the posttest due to the effects of regression. Once again, without a comparison or control group, this explanation cannot be eliminated.

In addition, the degree to which the results of this study are generalizable to a larger population or to settings outside of this study, is also limited. This is because the families in this study were not randomly selected from a larger population. In addition, the size of the sample in this study is relatively small at 14. The families who participated in this study may differ in some significant ways from families who are involved with child welfare agencies in this or other regions, provinces or countries. For instance, the families who agreed to receive Family Builder services and participate in this study, may have been more motivated to improve family functioning than other families who are involved with child welfare agencies. It was hoped though, that by collecting demographic and other data for study families, the effect of selection may have been partly addressed so that some comparisons between this and other studies could be made.

The results of this study may also not be generalizable

to other settings due to the specificity of variables in this study. Although the majority of study families were considered to be at imminent risk of experiencing the placement of a child, the determination of risk likely varies from worker to worker, let alone region to region. Child welfare workers in Regina may use different criteria for determining risk than child welfare workers in other regions, provinces or states. Furthermore, the resources available or unavailable to families in a city of 180,000, may differ from those available to families in a smaller rural setting or larger urban center.

In sum, interpretations of the findings of this study are limited. Many of these limitations stem from the pretest-posttest, one group design, upon which the study is based. Nevertheless, the design of the study does allow the conclusion to be drawn that the functioning of study families improved while they participated in the Family Builders program.

STUDY IMPLICATIONS AND FUTURE CONSIDERATIONS

This study was designed to examine changes in the functioning of families who received IFPS. The results of the study may have several implications for social work policy, practice and research. In this section, some of the important implications will be discussed and suggestions will be made

concerning future IFPS research.

In terms of policy, child welfare legislation in Saskatchewan and other places already encourages the development and implementation of IFPS programs. In fact, one of the concerns that motivated this project was that family preservation services may be expanding too quickly and that the rapid expansion of these programs throughout North America was driven more by their potential cost-savings, than by their efficacy. This concern was bolstered by the fact that the majority of IFPS research to date had focused on examining and documenting placement prevention rates. Placement prevention though, is not necessarily a good indicator of treatment success. This is why recurrent recommendations are made in the literature for a broader evaluation of IFPS outcomes (Wells & Biegal, 1990; Rossi, 1991).

Since an assumption implicit in the rationale for IFPS programs is that they prevent placement by improving family functioning, it is important to examine changes in the functioning of families who receive these services. The results of this study, in conjunction with the findings of other studies, suggests that the functioning of families in IFPS programs does improve. These findings may provide some support for the current policies in place which support the use of IFPS. On the other hand, as Pecora, Fraser and Haapala (1991) argue, the implementation of IFPS needs to proceed carefully and thoughtfully, as many problems and risks have

been identified with the rapid growth of these programs (p.290).

In Saskatchewan, there appears to be less reason for concern about IFPS programs expanding too rapidly. At the onset of this study, the Family Builders program was reported to be the only IFPS program in the province. The question of whether IFPS are replacing needed placement services like foster care and residential treatment therefore, may not be as much of an issue in this province. Given the disproportion of IFPS to placement services in this province, the careful development of more IFPS programs may simply represent an effort to meet the mandate of the Child and Family Services Act (1989 -90) by providing a broader range of family service alternatives.

In terms of IFPS research, the results of this study may contribute to the IFPS knowledge base. While the findings do not support any causal claims, they do show that the functioning of families improved during the time of IFPS. Thus, the findings are consistent with previous studies which, overall, provide increasing evidence as to the efficacy of IFPS and lay the groundwork for future explanatory research.

Consistent with previous IFPS studies, this study found improvements in the general functioning of families and in the behaviour of at-risk children. As mentioned though, one of the more unique aspects of this study is that improvements were observed in the following particular areas of family

functioning: problem-solving, communication, roles, affective involvement, affective responsiveness and behaviour control. These findings are interesting because much less is known about the extent of change that can be expected in the functioning of families in IFPS.

In their studies, both Wells and Whittington (1993) and Spaid, Fraser, and Lewis (1991) appear to conclude that IFPS programs should not be expected to effect extensive changes in the functioning of families. For instance, Wells and Whittington (1993) state, "they (IFPS) are not designed to effect major changes in the ways in which families function" (p.77), while Spaid and his colleagues (1991) state, "the items on the FACES 3 represented more enduring types of family traits that would be difficult to change as part of a 30-60 day intervention" (p.148). Although these statements are prudent and perhaps accurate, the results of this study would indicate that it is too soon to draw final conclusions about the extent of possible change in the functioning of families who receive IFPS.

Many of the areas of functioning that families in this study reported as having improved have not been previously identified in IFPS research. Previous research studies have identified improvements in areas such as child well-being, parent-child conflict, parenting skills, children's behaviour, home conditions and social support, but not in other fundamental areas of family organization. Feldman's (1991)

study, which used the full Family Environment Scale (Moos & Moos, 1981), was one of the few studies that identified improvements in areas such as family cohesion, organization, expressiveness and independence. While some of these variables may seem abstract and not as relevant to child welfare agencies as home conditions or children's behaviour, it is important to examine multiple dimensions of family functioning in order to develop a broader understanding of how families in IFPS change.

In addition to examining multiple dimensions of family functioning, the perspectives of multiple family members may also need to be examined in future IFPS research. Previous studies have found, using the FAD, that adolescents rate their families as significantly less healthy than their parents and caution researchers from assuming that parental reports are more accurate (Sawyer, et. al. , 1988). In contrast to Sawyer's (1988) study though, this study did not find significant differences in the reports of functioning obtained from parents and children on the FAD (Epstein et. al., 1983). Some children rated their families as less healthy than the parents, while other children rated their families as more healthy. An obvious difference between the two studies is that not all of the child respondents in this study were adolescents. Whether this accounts for the discrepancy though, is unknown.

In contrast to the reports collected through the FAD

(Epstein et al., 1983), significant differences were found between parent and child reports of children's behaviour as measured through the CBCL and YSR (Achenbach & Edelbrock, 1983). Children consistently rated their behaviour as less problematic than their parents. Future IFPS researchers may need to consider how they will weigh discrepant reports in order to interpret the clinical significance of findings. For instance, in this study it was difficult to interpret the clinical significance of the findings when study children reported their behaviour to be in the nonclinical range at discharge, while parents did not. However discrepant reports are handled in future IFPS research, it appears to be important to collect reports from more than one family member. As Wells and Whittington (1993) noted in their study, the views of one family member cannot be substituted for the views of another.

An interesting trend in IFPS research is that while studies are finding that family functioning improves during the course of services, it is not clear that it improves to a clinically significant degree. In Wells and Whittington's (1993) study, improvements in functioning were observed, but families and children were still functioning at a lower level than nonclinical samples at discharge. In Feldman's (1991) study, the functioning of treatment families improved, but it did not improve to a greater degree than it did for the control families. In Spaid, Fraser and Lewis's study (1991),

family adaptability and cohesion scores improved, but not as much as expected. The findings in this study are consistent with this trend in that family functioning was found to have improved in all of the areas examined, but the amount of improvement was considered to be clinically significant for only some areas.

The determination of clinically significant change is difficult however, and expecting families to be functioning at so called "healthy" levels at discharge may be inappropriate. As Wells and Whittington (1993) argue, the fact that studies may show that families are functioning at a lower level than nonclinical families does not mean that IFPS programs are failing. The circumscribed goals of IFPS need to be remembered when determining program effectiveness; these services are designed to help families achieve basic skills considered necessary to keep children at home (Wells & Whittington, 1993). Clinically significant change therefore, is probably best indicated by whether family functioning has improved to a degree that eliminates the risks associated with the need for placement.

How much improvement is needed in various areas of functioning though, in order to be confident that the risk of placement has been significantly reduced? Are improvements in areas of family functioning such as problem-solving, communication, affective responsiveness and affective involvement, actually related to placement prevention? These

are the types of questions that need to be addressed in order to better understand what constitutes clinically significant improvement in the functioning of families in IFPS.

Given the diminishing resources and increasing service demands facing child welfare agencies, knowledge of factors associated with successful placement prevention efforts is critical. If future IFPS research could begin to identify the areas of family functioning where improvement is associated with placement prevention, then programs could become more efficient by targeting these areas for change. Through detailed examinations of the services activities of IFPS programs a better understanding may be developed as to what treatment interventions tend to produce the types of functioning changes associated with placement prevention. Such research would no doubt aid IFPS practice and program development.

Although this study, in collaboration with others, suggests that the functioning of families improves while they receive IFPS, the results are difficult to interpret given the study's design. In the absence of a control group, it is not possible to determine whether the observed improvements are due to the IFPS program or to other factors such as the maturation of families or statistical regression. It would be best to employ a control group of at-risk families and to assess family functioning at multiple points of time before and after IFPS. Although the feasibility of such research is

extremely difficult since the population consists of families in crisis with children at risk, it is the only way to more truly determine the effect of IFPS programs on the functioning of families.

Effective treatment services for families with children at risk of placement are greatly needed. IFPS programs have an exceptional feature in that they are designed to ameliorate child welfare concerns, while keeping families together. The findings of this study, in conjunction with previous studies, suggest that the functioning of families improves while they receive IFPS. However, further explanatory research is required. Such research may produce a more accurate understanding of the value of IFPS for child welfare agencies and the families they serve.

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Appendix A

ETHICAL APPROVAL
FACULTY OF SOCIAL WORK, UNIVERSITY OF CALGARY
SASKATCHEWAN SOCIAL SERVICES

THE UNIVERSITY OF CALGARY

2500 University Drive N.W., Calgary, Alberta, Canada T2N 1N4

Faculty of SOCIAL WORK

Telephone (403) 220-5942
FAX (403) 282-7269

CERTIFICATE OF APPROVAL

by

THE RESEARCH ETHICS COMMITTEE
FACULTY OF SOCIAL WORK

The PROJECT/THESIS entitled:

Family Functioning and Home-based, Family Preservation Services

of David Rivers (student)

in the judgement of this Committee, has met The University of Calgary ethical requirements for research with human subjects.

94-06-13
Date

Michael Rothery, Ph.D
Research Services, Faculty of Social Work

Saskatchewan

Saskatchewan
Social Services

Deputy Minister

1920 Broad Street
Regina, Canada
S4P 3V6

(306) 787-3491
Fax: (306) 787-1032

August 5, 1994

Mr. David Rivers
#4, 3511 15A St. S.W.
Calgary, AB
T2T 4C2

Dear Mr. Rivers:

I am replying to your recent request to study **Family Builders** as part of your MSW thesis. The question of how attitudes and behaviour change as a result of this type of intervention is important, and I hope that your study can help add to our knowledge of intensive in-home services.

Social Services would be willing to participate in your study, given conditions can be met to ensure the confidentiality and anonymity of responses, voluntary client participation and the least imposition on program staff. Prior to the study, we would also need to see a copy of all data gathering instruments that you will be using.

I would suggest the following procedure for collecting the sample and administering the questionnaires:

- we will contact the families and provide them with: (1) the letter from you explaining the nature of the project, the time requirements, and assurances of confidentiality; (2) the consent form for adults and children; and (3) a letter from Saskatchewan Social Services explaining our role in the project.

- we will ask those clients who agree to participate to send us the consent form, and we will then provide you with their names and addresses.

- you will be responsible for administering the questionnaires to those families who have consented to participate.

If you want to discuss this protocol, or suggest other methods that would safeguard the principles of confidentiality and voluntary participation, please contact David Rosenbluth, Director of Research and Evaluation, at (306) 787-7354. If these procedures are acceptable to you, please let me know and we can start the arrangements for your study.

Sincerely,

Neil Yeates
Associate Deputy Minister
Saskatchewan Social Services

cc. D. Halabuza
D. Rosenbluth

APPENDIX B

Letter of Explanation
Participant Consent Forms

UNIVERSITY OF CALGARY
M.S.W. Thesis Study

Dear Parent:

My name is David Rivers and as a part of my M.S.W. thesis for the University of Calgary, I am studying home-based programs like Family Builders. I am trying to find out how families and the behaviours of children change while families participate in these programs.

The way I have planned to do this is to ask parents and the referred child to complete questionnaires before and after they participate in these programs. One questionnaire consists of a number of statements about families to which you will be asked how well each statement describes your family. The other questionnaire consists of a number of statements about children's behaviour to which you will be asked how well it describes your child's behaviour. Your child will also be asked to complete a similar questionnaire about his or her own behaviour. It will take about 30 to 40 minutes to complete all the questionnaires. By combining the results of many families, it will be possible to study the overall group data and provide home-based programs with helpful information.

It is important for you to know that your responses to the questionnaire will be kept strictly confidential according to the policies and procedures of the Family Builders program. Completed questionnaires with identifying information will be kept in a locked room at the Family Builders' office and will be destroyed at the end of the study. In addition, all names and questionnaire responses will be changed to numbers. No names or identifying information will leave the Family Builders' office or be reported in any publication.

Your decision of whether to participate in the study or not will not affect your participation in the Family Builders program in any way. You have the right to withdraw from the study at any time. If you have any questions about this study, please phone me at 585-1074 or Donalda Halabuza, the Family Builders coordinator at 787-9613. Thank you for your assistance. Your help in this research will be greatly appreciated.

Sincerely,

David Rivers
M.S.W. student
Faculty of Social Work
University of Calgary

CONSENT FORM

I agree to participate in the study of home-based services to be completed by David Rivers as part of his M.S.W. thesis for the Faculty of Social Work, University of Calgary. My signature indicates that I have understood to my satisfaction the information regarding my participation in the study. In no way does this waive my legal rights nor release the researcher or the involved institutions from their professional responsibilities. I understand that if I have any questions about participating in this study I may contact the Faculty of Social Work, University of Calgary at (403) 220-5942 and ask for Dr. Michael Rothery, Chair of the Research Ethics Committee.

Parent's signature _____ Date: _____

Parent's signature _____

Child's signature _____

PARENTAL CONSENT FOR CHILDREN

My signature below indicates that I have also decided to allow my child to participate in the above mentioned study. I am satisfied that my child's signature above indicates that he or she understands the study and agrees to participate. I realize that I may withdraw my child or my child may withdraw, at any time after signing this form without affecting my family's participation in the Family Builders program.

Parent's signature _____ Date: _____

APPENDIX C

CLINICAL SERVICES CHECKLIST
CONCRETE SERVICES CHECKLIST

Family name _____

Homebuilder Clinical Services Checklist

Please record the services you provided any family member, or the family as a whole, by indicating with a check mark whether ther service was provided. Service categories not utilized with the family shoud be left blank.

1. Child Management/Parent Effectiveness Training

____ Use of reinforcement (1.1)
____ Tracking behaviors (1.2)
____ Environmental controls (1.3)
____ Natural/logical consequences (1.4)
____ Time-out (1.5)
____ Active listening skills (1.6)
____ I statements (1.7)
____ No lose problem solving (1.8)
____ Problem ownership (1.9)
____ Other (eg. teaching skills) (1.10)

_____
_____
_____

2. Emotion Management

____ Anger management (2.1)
____ Depression management (2.2)
____ Anxiety/confusion (2.3)
____ Self-criticism reduction (2.4)
____ Building self-esteem (2.5)
____ Handling frustration (2.6)
____ Impulse management (2.7)
____ Use of crisis cards (2.8)
____ Rational emotive therapy concepts (2.9)
____ Rational emotive therapy techniques (2.10)
____ Pleasant events (2.11)
____ Relaxation (2.12)
____ Tracking emotions (2.13)
____ Other (2.14)

_____
_____

3. Interpersonal Skills

____ Conversational/social skills (3.1)
____ Problem solving (3.2)
____ Negotiation skills (3.3)
____ Giving/accepting feedback (3.4)
____ Appropriate sexual behaviour (3.5)
____ Accepting "no" (3.6)
____ Improving compliance (3.7)
____ Other

_____
_____

4. Assertiveness

____ Territoriality concepts (4.1)
____ Fair fighting (4.2)
____ General concepts/skills (4.3)
____ Other

_____
_____

(over)

5. Miscellaneous Clinical

_____ Use of journal (5.1)
_____ Listening (5.2)
_____ Encouraging hope (5.3)
_____ Monitoring client (5.4)
_____ Building hope (5.5)
_____ Relationship building (5.6)
_____ Family council (5.7)
_____ Clarifying family roles (5.8)
_____ Process of change (5.9)
_____ Child/adolescent development (5.10)
_____ Social skills (5.11)
_____ Clarifying problem behaviors (5.12)
_____ Defusing crises (5.13)
_____ Reframing (5.14)
_____ Setting treatment goals/objectives (5.15)
_____ Proving reinforcers (5.16)
_____ Counseling referral (5.17)
_____ Treatment plans (5.18)
_____ Deescalating (5.19)
_____ Values clarification (5.20)
_____ Support/understanding (5.21)
_____ Structure/routine (5.22)
_____ Clarifying family rules (5.23)
_____ Tracking/charting behavior (5.24)
_____ Role playing (5.25)
_____ Providing literature (5.26)
_____ Paper pencil tests (5.27)
_____ Multiple impact therapy (5.28)

6. Advocacy

_____ Referral to counseling (6.1)
_____ Referral to social services (6.2)
_____ Consultation (6.3)
_____ Utility companies (6.4)
_____ Educational system (6.5)
_____ Social service providers (6.6)
_____ Court hearings (6.7)
_____ Other (6.8)

_____
_____
_____

7. Other

_____ Money management (7.1)
_____ Time management (7.2)
_____ Leisure activities (7.3)
_____ Job hunting/interviewing (7.4)
_____ Academic skills (7.5)
_____ Linking with informal support systems (7.6)
_____ Recognizing potential suicide (7.7)
_____ Protective skills (7.8)
_____ Other (7.9)

_____
_____
_____

Family name _____

Homebuilder Concrete Services Checklist

Please record the concrete services you provided any family member, or the famiy as a whole, by indicating with a check mark whether the service was provided. Also, if possible, please indicate the number of hours spent providing this service for this family.

Concrete services not provided to this family should be left blank.

	Check or leave blank	Hours spent
1. Provide transportation (eg. drove a client somewhere)	_____	_____
2. Do housework/cleaning with client	_____	_____
3. Help client obtain housing	_____	_____
4. Help client get transportation	_____	_____
5. Provide childcare/ babysitting	_____	_____
6. Give financial assistance to client	_____	_____
7. Provide furniture or other household goods	_____	_____
8. Help client obtain utility services	_____	_____
9. Help client obtain medical or dental services	_____	_____
10. Provide toys or recreational equipment	_____	_____
11. Help client obtain clothing	_____	_____
12. Help client obtain legal aid	_____	_____
13. Arrange for lifeskill classes (eg. driver education)	_____	_____
14. Provide recreational activities	_____	_____
15. Provide food	_____	_____
16. Help client obtain childcare	_____	_____
17. Arrange for recreational activities	_____	_____
18. Help a client find a job	_____	_____
19. Help client get food	_____	_____
20. Move client to new dwelling	_____	_____
21. Provide a job	_____	_____
22. Provide clothing	_____	_____
23. Help client obtain financial assistance	_____	_____
24. Help arrange homemaker/ cleaning services	_____	_____
25. Help client obtain furniture or other household goods	_____	_____