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FAMILY PRESERVATION: AN OUTCOME STUDY

Jeff Chandler, B.A.

An Abstract Presented to the Faculty of the Graduate School of Lindenwood College in Partial Fulfillment of the Requirements for the Degree of Master of Art, 12/30/96.

ABSTRACT

Although Family Preservation (FPS) programs have been intensely scrutinized and better evaluated than many other social service programs, more exploration will be required under the demands of managed care. This study examines program outcomes from a FPS program at Edgewood Children's Center in St. Louis, MO. These outcomes included the degree of positive change in family functioning and its' relationship to out-of-home placement, client satisfaction with services and the manner in which they were delivered, and the cost effectiveness of Family Preservation compared to foster care and residential treatment in Missouri. The author makes conclusions and recommendations about future research within the context of satisfying the documentation requirements of managed care, and implications for practice.

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CHAPTER I

INTRODUCTION

In 1980, the Federal government took a step to prevent the growing number of children placed into out-of-home care. This step consisted of PL. (96-272) which stipulated, among other things, that children served by the public welfare system be cared for in the least restrictive environment with a right to permanency. Resulting from this legislation, programs such as Family Preservation Services (FPS) have been initiated in a majority of the 50 states.

Most FPS programs are patterned after the Homebuilders model, which began in 1974 in Tacoma. The program began as an experimental project between Catholic Community Services and a grant from the National Institute of Mental Health (NIMH). The Homebuilders model is described as an "intensive in-home family crisis intervention and education program designed to prevent the unnecessary out-of-home placement of children in state funded foster care, group care, psychiatric hospitals, or corrections institutions" (Kinney, Haapala, Booth, Leavitt, 1990, p. 31). Kinney, Haapala, and Booth (1991) describe how the program began. Initially their idea was to develop foster homes with training and

professional backup. The NIMH insisted that efforts be concentrated on keeping children safe in the home before placement occurred. Efforts were then focused on the development of an intensive in-home counseling program.

The Homebuilders model is based on crisis intervention theory (Rapoport, 1970), which views crises as time limited and opportunities for change. The idea was that if a worker could spend eight to ten hours per week with family members during the peak of their crisis, family members could learn new skills or access resources that may return them to their pre-crisis level of functioning. Critics of the model (Dore, 1993) state that many families, especially those in which primary caregivers are depressed, are unlikely to respond to such an approach when applied in intense, rapid doses. Many of the situations that professionals view as a temporary crisis are seen by FPS opponents as antecedents of the larger societal issue of poverty (Dore, 1993; Halpern, 1990). Halpern (1990) states: "Services cannot alter the social conditions that produce or exacerbate, and ultimately reproduce, individual and family problems" (p. 647).

The goals of FPS are: to protect children, to maintain and strengthen family bonds, to stabilize the crisis situation, to increase family

skills and competencies, and to facilitate the family's use of a variety of formal and informal helping resources (Whittaker & Tracy, 1990). Ideally, the service is offered to families in which one or more children are at "imminent risk" (within 72 hours of referral) of placement. The service is voluntary and requires family members to participate actively.

Family Preservation programs usually contain the following characteristics:

1) Therapist availability 24 hours a day to meet the needs of families whenever they may occur.

2) Flexible scheduling: Families are seen when and where needed for as long as needed. Sessions of two hours or longer are not uncommon.

3) Services are home centered. The worker may help coordinate other services and even provide transportation to appointments or outings, and secure "concrete" services.

4) Services are flexible to meet individual family needs. Services include therapy, support, education and concrete services.

5) Services are intense with some families seen daily.

6) Workers carry only two to three families at one time.

7) Services last four to six weeks.

8) Coordinating after care services is essential (Kinney, Haapala, Booth, Leavitt, 1990).

The State of Missouri has incorporated all of the above noted characteristics into its FPS program with some notable exceptions. Case workers carry only two families at any one time, and families are seen eight to ten hours a week (which translates to four to five days per week with some sessions lasting two or more hours). Otherwise, Missouri's FPS program is fashioned around the homebuilders model to include therapist training conducted by the Behavior Sciences Institute (developers of the homebuilders model). Edgewood Children's Center's FPS program differs only in that one specialist is on-call to all families 24 hours a day, seven days a week on a rotating schedule. As a result specialists are "on-call" for one week at a time approximately three times per year.

The population served by FPS programs comes from a variety of backgrounds and concerns. Common to all families, however, is the imminent risk of a child being separated from the family (Tracy, 1991). The 1994 Missouri Family Preservation annual report prepared by Drainer (1994) offers demographic data for St. Louis City and St. Louis County (Table 1).

Table 1.: Families/Children Served in Fiscal Year (FY) 1994

Families referred FY 1994	519
Families accepted FY 1994	452
Total children accepted FY 1994	1361
At-risk children accepted FY 1994	975

Drainer (1990) also describes the Head of Household characteristics by gender and race as summarized in Charts 1 and 2.

Chart 1. Head of Household by Gender

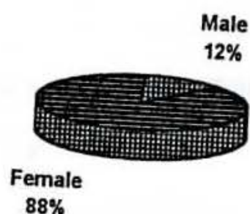


Chart 2. Head of household by Race.

Drainer (1994) also notes that only 11% of heads of household were under the age of 23, 45% were 30 to 39. It also may be significant to note that 66% of heads of household were unemployed at the time of referral and 35% of heads of household had an income below $5,000 per year. Also noted in the Missouri statistics were "At-Risk" child characteristics. These are summarized in Charts 3,4 and 5 for gender, race and age respectively.

Chart 3. At-Risk Child by Gender

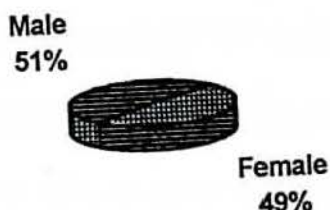
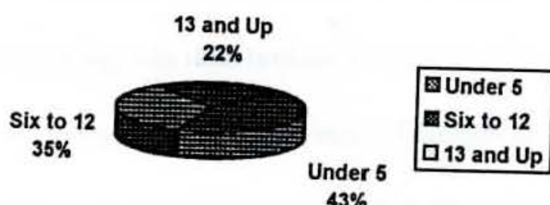


Chart 4. At-Risk Child by Race

Chart 5. At-Risk Child by Age



Additionally, 6% of the at-risk children were learning disabled. If these children had been placed out-of-home, 74% would have been placed in foster homes. During fiscal year 1994, 317 families exited Family Preservation Services (A valid exit is one with a recorded exit date during FY 1994). Upon exiting, 82% of the families were reported intact (Drainer, 1994). Data from fiscal year 1995 was unpublished at the time of this report.

Statement of Purpose

Following the philosophy of FPS, that crisis brings about a temporary lapse in family functioning resulting in a family becoming "at risk", this study is designed to look mainly at the variable of family functioning and secondly at related variables of client satisfaction and cost

effectiveness.

Family functioning measures are unique for each family and were interpreted on an individual basis from case notes, assessments, and closing summaries. Functioning was then broken down into skill areas such as parenting skills, housing, abuse/neglect, etc... Changes in areas, unique for each family were translated to Likert scales in order to have a common ground for statistical comparison/contrast between families experiencing placement and those that did not experience placement. The form developed to gather and rate changes in functioning is presented in appendix A.

Client satisfaction refers to the degree to which the client was satisfied with services provided by FPS. This variable was included for two reasons: 1) Logically speaking, satisfied clients are less likely to file law suits, and 2) To test for a correlation between satisfaction and placement rates. The satisfaction survey developed by the researcher is presented in appendix B. It should be noted that an extremely low response rate made the satisfaction data collected significant only on implications for future research.

Cost effectiveness, as a variable, was operationalized by comparing the cost of FPS with the cost of traditional interventions like foster care and residential treatment.

Although Family Preservation programs have been intensely scrutinized and better evaluated than many other social service programs, more exploration will be required given the demands of managed care.. Managed care is concerned not only with program effectiveness and efficiency, but also with customer satisfaction because a happy consumer is less likely to sue for malpractice. In addition, funding sources and the public are pressuring agencies to demonstrate their money is well spent.

The research sought to answer the following questions:

1) Was there a significant positive change in family functioning pre-intervention compared to post-intervention,

2) Was there a significant difference in placement rates between families in which there was positive change in functioning compared to families in which no change in functioning occurred,

3) Were families happy with the services they received, and

4) Was FPS more cost effective than out-of-home placement?

Therefore, the research hypothesis was that there would be a significant difference in placement rates between families in which there was significant positive change in functioning.

CHAPTER II

REVIEW OF LITERATURE

A variety of home based services exist to help families and prevent out of home placement of children. These services are called by a variety of names, including "home based services", "family based services", and "intensive family preservation services". While these services were first developed in child welfare, they also exist in the mental health and juvenile justice systems. Recently home based services have been developed for families where a child is returning home from an out of home placement, and these services are referred to as "reunification services" (Fein & Staff, 1993). The purpose of reunification services is to help the child and other family members in adapting and adjusting to the return home.

Several typologies have been offered in an effort to understand these various services and how they differ from and are similar to one another. The Child Welfare League of America (CWLA) (1989) describes three service types: 1) family resource, support, and education services, 2) family-centered casework services, and 3) intensive family-centered crisis

services. These are viewed as a continuum of services, with the intensity of services and severity of family need varying for each program.

In 1993 the Family Preservation and Support Services Program was passed as part of the Omnibus Budget Reconciliation Act. This Act defines and differentiates family preservation and family support services. Further description of family support, family-centered casework, and family-preservation, or family-centered crisis services, will differentiate this continuum of services.

Family Resource, Support, and Education Services

Family support or resource services are prevention services available to all families without regard to eligibility criteria. Services are voluntary, that is, families participate if they desire to do so. There is wide variation among these programs, as emphasis is placed on community and parent involvement in the development of these services. Weissbourd and Kagan (1989) note "the goals of family support programs focus on enhancing the capacity of parents in their child-rearing roles; creating settings in which parents are empowered to act on their own behalf and become advocates for change; and providing a community resource for

parents" (p. 21). The recent Family Preservation and Support Services Program Act defines family support services as:

...primarily community-based preventive activities designed to alleviate stress and promote parental competencies and behaviors that will increase the ability of families to successfully nurture their children; enable families to use other resources and opportunities available in the community; and create supportive networks to enhance child-rearing abilities of parents and help compensate for the increased social isolation and vulnerability of families.

These programs differ from traditional social services as their purpose is prevention and parents are actively involved in determining the content and nature of the program. Weissbourd and Kagan (1989) state that family support programs move beyond prevention toward "optimalism". While prevention means there is intervention to prevent a problem, optimalism "extends the concept of prevention because it moves beyond avoiding or preventing a problem to promoting optimal development of children and families" (Weissbourd & Kagan, 1989, p. 22).

Family support services have not traditionally been offered through the child welfare system. However, the Program Instruction compiled by the Administration for Children and Families in relation to the implementation of the new legislation challenges states to not just add services, but to make changes in the child welfare delivery system (with

child welfare delivery being broadly defined). The legislation "offers each State an opportunity to strengthen, reform, and better coordinate and integrate its service delivery system" (ACF, 1994, p. 12); and "encourages States to use the new program as a catalyst for establishing a continuum of coordinated and integrated, culturally relevant, family-focused services for children and families" (p. 5).

The appropriated monies are small, and funding will be based on the number of children eligible for food stamps in each state (ACF, 1994). Despite the vision of family support services being available to all and the move toward optimalism, the realities of funding may limit these services to certain high need target groups.

Family-Centered Casework Services

Family-centered casework services include a range of services that are offered to families with a variety of problems or needs. Services include counseling/therapy, case management, education/skill building, advocacy, and concrete services (the provision of food, housing, clothing, and so on). The purpose of these services is to "promote the protection and well-being of children by helping their parents to increase their patenting abilities, and by furthering a nurturing and stable family

environment to enable the children's healthy growth and development" (CWLA, 1989, pp. 29 - 30). Unlike family support services, family-centered casework services are provided to families who are experiencing problems that are interfering with family life and may even threaten the safety and well-being of the child(ren). Problems may include: 1) problems meeting basic survival needs, such as homelessness, or inadequate housing, or lack of heat or food; 2) family violence; 3) child abuse or neglect; 4) abuse of drugs or alcohol; 5) intellectual, emotional, or physical impairment of adults or children; and 6) child behavior problems or parent-child conflict (CWLA, 1989). Services may by offered in the home or in the office, but the Child Welfare League (1989) encourages services to be provided in the home. Within the guidelines provided by the Child Welfare League (1989), services should be time limited, with services provided beyond six months requiring supervisor approval, and services provided beyond one year requiring the approval of the agency administrator. The maximum case load size recommended by the CWLA is fifteen.

Intensive Family-Centered Crisis Services

The CWLA acknowledges that these services are referred to by a variety of names, including intensive family services, intensive home-based services, and family preservation services. For purposes of consistency, this type of service will by referred to as "intensive family preservation services" (FPS). This is in keeping with the current literature and is the term used in Missouri to describe this type of service. It might be noted that FPS is a model of service delivery as well as the goal of a variety of home and family based services (Dore, 1993).

There are a number of similarities between family-centered casework services and intensive family preservation services. Both are family centered and focus on identifying and building on strengths and developing empowerment. Interventions are individualized to meet the needs of the family, because families enter both types of programs with a variety of problems and needs.

The primary difference between service models is that FPS are crisis oriented, provided to families "in serious crisis" and "no longer able to cope with problems that threaten family stability" (CWLA, 1989, p. 47). Families who receive FPS have a child at "imminent risk of placement". In an attempt to avert placement and meet the crisis, FPS services are intense,

with caseloads ranging two to six families. FPS are short term, usually provided from four to 12 weeks.

Other authors have also defined various models of family centered services. Rzepnicki, Schuerman, and Littell (1991), briefly describe family-based, home-based, and intensive family preservation services, with family-based services similar to the family-centered casework services described above. Home-based services are a type of family-based service, but are provided in the family's home. Finally, these authors state family preservation services are family and home-based services which are short term and intense, with the purpose of preventing out of home placement.

Nelson, Landsman, and Deutelbaum (1990) also specify three models of family-centered services, all with the purpose of preventing placement. These three models are: 1) the crisis intervention model, 2) the home-based model, and 3) the family treatment model. These models were developed based on data from eleven programs, and as such, the authors acknowledge that more work is needed to validate this typology. Within this grouping, FPS is the crisis intervention model.

Excluding family support services, no fewer than 12 labels have been applied to home based services. Other than service duration and

intensity, it is difficult to discern differences between the models, and even to determine whether differences exist.

Theories

Barth (1990) reviews empirical support for the theories or perspectives underlying FPS. Each of these theories is briefly described and empirical evidence for its application to FPS is discussed.

Crisis Intervention

Homebuilders is based largely on crisis theory and the services are directed toward families thought to be in crisis (Haapala & Kinney, 1979; Kinney, Haapala, & Booth, 1991). Barth (1990) states "An implicit acceptance of crisis intervention theory is something of a given by most agencies offering FPS..." (p. 89).

Crisis theory poses that as a result of a crisis, the person is in a vulnerable state and thus is open to help and willing to change. Crisis refers to the "state of the reacting individual who finds himself in a hazardous situation (Lindemann & Caplan, cited in Rapoport, 1962), or an "upset in a steady state" (Caplan, cited in Rapoport, 1962). Usual and typical problem solving procedures do not work, and if there are not adequate internal and external resources for the person to draw upon, then

a state of crisis may develop. Crisis intervention, within FPS, is based on the assumption that either the event that leads to the risk of placement or the risk of placement itself is a crisis, in that it is an event that upsets the usual functioning of the family. Thus, the family is open to help and FPS offers immediate help.

Although crisis intervention is commonly referred to as a theory, Rapoport (1970) states it is "premature to dignify it with the term 'theory' " (p. 267). Rather it might be best viewed as a conceptual framework drawing upon a number of theories, including psychoanalytic, cognitive, homeostasis, and stress theories (Rapoport, 1970; Taplin, 1971). Cohen and Nelson (1983) note that "the assumptions of crisis theory remain highly speculative" (p. 22). Basic assumptions of crisis theory have been implicitly accepted, even though there is no empirical evidence to support these. These include that there is a specified time period (4 - 6 weeks) during which crises are resolved and that individuals in crisis are motivated and open to change (Auerbach, 1983; Barth, 1990).

Fraser, Pecora, and Haapala (1991) tested the hypothesis that the amount of time between referral and therapist response in FPS was related to treatment outcome. If crisis theory is operative, it is assumed that the

shorter the response time between referral and services, then the higher the level of outcome attainment. The hypothesis was not supported, but it must be cautioned that there was little variability in response time across cases.

Barth (1990) notes "there is no forceful theoretical or evaluative argument for drawing on crisis theory or crisis intervention constructs to boost the helpfulness of FPS" (p. 98). Staudt and Drake (1995) outline basic tenets of crisis theory and discuss the consistencies and inconsistencies between the theory and the program model. They find several inconsistencies and suggest the uncritical acceptance of crisis theory may have led to an acceptance of a program model that may not adequately met the needs of many service recipients. Thus, there is a lack of empirical evidence to support crisis intervention as a theoretical base for family preservation services.

Family Systems

The family systems perspective focuses on the family as a system with subsystems and individuals interacting in such a way to keep the whole family in balance. There are several different family therapy approaches, including structural, strategic, and intergenerational. Within

any of these therapies, an individual's problem is viewed as a symptom of something gone awry within the family system. Barth (1990) notes the family system is assessed and intervention applied according to the dimensions of boundary, alignment, and power. Thus, the family systems perspective supports interventions focusing on family structure and communication, such as changing or clarifying family rules and boundaries.

Barth (1990) notes "Family therapy with high risk families is now in danger of becoming handcuffed by an overallegiance to variants of family systems theory which exclude social learning and ecological perspectives. This exclusion is based on skimpy theoretical grounds and overlooks the possibility that those procedures may give a family new tools for self-regulation and sovereignty" (p. 107). He reviews the research evidence in support of family therapies and notes that while evidence exists to support the efficacy of family therapy, little work has been done to determine its effectiveness with families typically seen in FPS. Adherence to only a family systems approach cannot address many issues confronting families seen in the child welfare system. The prime example is family violence, where a systems perspective has been criticized, especially, but not only, by those with a feminist perspective (Bograd, 1984; Merkel & Searight,

1992). Many of the structural and societal arrangements which contribute to family violence or break-down may be ignored if concentration is only upon interactions in the family. Merkel and Searight (1992) note that the notion of looking to a smaller and less powerful spouse or child for behaviors that influence or maintain the abuse is "morally and intellectually repugnant" (p. 42). Friesen and Koroloff (1990) note the need to move beyond a strict family systems approach in mental health, as several factors contribute to the etiology of child emotional disorders. Thus, while the use of family systems may be effective with many populations, its sole use with families seen in FPS does not seem appropriate.

Social Learning

Bandura developed the social learning approach. Social learning encompasses the behavioral approach, but also includes a cognitive component. Within the social learning approach, behavior is viewed as learned, and behavior is maintained by the rewards the behavior brings. Ways to change behavior include the modeling of new behaviors, the provision of rewards, consequences, and/or punishment. Thoughts and feelings also have a role in influencing behavior. If a person thinks he or she will fail, then the person will probably behave in such a way that failure

results. Cognitive approaches focus on changing the person's defeating self-talk.

Barth (1990) states that of the four theories or perspectives underlying FPS, social learning enjoys the most empirical support. Gurman, Kniskern, and Pinsof (cited in Barth, 1990), reviewed studies of family therapy and found a social learning approach to be more effective than structural family therapy. Howing, Wodarski, Gaudin, and Kurtz (1989) note the lack of research about interventions with maltreating families. Recent studies show some promise that the use of social learning theory may be effective in treating neglecting and abusive families (Barth, Blythe, Schinke, & Schilling, 1983; Gaudin, 1993; Szkula & Fleischman, 1985). Fraser, Pecora, and Haapala (1991) found that teaching families how to obtain concrete services was related to outcome.

Ecological Perspective

The ecological approach is concerned with transactions between the person and the environment. It "departs dramatically from the traditional person-in-environment orientation through the concept of transaction" (Pardeck, 1988, p. 137). While traditional casework followed the medical model and focused on the individual and the pathology of the individual,

workers practicing within an ecological framework see problems of the individual as "derived from the complex interplay of psychological, social, economic, political, and physical forces" (Pardeck, 1988, p. 134). Bronfenbrenner (1979) notes "lying at the very core of ecological orientation and distinguishing it most sharply from prevailing approaches to the study of human development is the concern with the progressive accommodation between a growing human organism and its immediate environment, and the way in which this relation is mediated by forces emanating from more remote regions in the larger physical and social mileau" (p. 13).

An ecological approach implies that children and families do not function in isolation from their environment, and a number of authors have advocated for such a perspective in working with families and children (Hess & Howard, 1981; Vosler, 1989; Whittaker, Schinke, & Gilchrist, 1986). Pelton (1992) notes that child welfare clients usually do not view their problems as personal, but rather as social and environmental in nature.

A number of authors have proposed models and provided frameworks for assessment and intervention based on an ecological perspective. While Brunk, Henggeler, and Whelan (1987) note that there

are no empirical evaluations of treatment based on the ecological model of practice, there are some recent studies of intervention utilizing an ecological perspective.

Gaudin, Wodarski, Arkinson, and Avery (1990/91) studied a social networking package and found it to be effective with child neglect. Social networking consisted of personal networking, mutual aid groups, volunteer linking, using neighborhood helpers, and social skills training. Casework activities, including advocacy and brokering, were also used.

Brunk, Henggeler, and Whelan (1987) found multisystemic therapy to be effective in restructuring parent-child relationships, and in inducing change in behaviors that differentiate maltreating families from non-maltreating families. Multisystematic therapy is described as similar to family therapy in that it stresses the context of behavior, but it also moves beyond the family to a focus on extrafamilial and cognitive variables. Barth (1990) notes that "Family systems theory, social learning theory, and ecological theory--and many of the techniques derived from them--are often complementary and agreeable" (p. 107).

The Integration of Theories

There are similarities between social learning and family systems theories that are sometimes hard to discern in practice (Barth, 1990; Fleischman, Horne, & Arthur, 1983). Barth (1990) states "Under either label, therapists help family members understand how each individual's behavior is contingent on responses from other family members" (p. 101). Kazdin (1988) describes a functional family therapy approach that relies on: 1) a systems approach, 2) an operational behavioral perspective, and 3) cognitive processes.

Barth (1990) notes that neither family systems nor social learning is explicit in clarifying the impact of social resources on family functioning. Thus, while there are also differences between social learning and family systems, he states "The actual practices of therapists working under the guidance of family systems or social-learning based approaches may differ most strikingly according to their theoretical allegiance to an ecological systems model" (p. 104).

Outcomes Research

> "Agencies involved in the delivery of social services increasingly are concerned with assessing the impact of their services on clients. This is due, in part, to the growing awareness that professionals must be accountable to societal and individual

> values as expressed in public policy and in organizational and consumer goals. In addition, the financial support of human service programs by the federal government is becoming contingent on demonstration of effectiveness and assurance of quality. Many studies of the effectiveness of social work intervention have yielded disappointing results, however, and several reviews of these studies have received widespread attention. Thus, although there is increasing pressure on agencies to evaluate their programs, the realistic fear that evaluative research will fail to document any positive effects of services on clients has resulted in the prevailing ambivalence toward evaluation among practitioners" (Coulton, Solomon, 1977).

Nearly 20 years ago, professionals already had a keen awareness that social service research was not only inadequate but at times avoided. While improvement in the amount of research conducted occurred, many professionals remained skeptical of the validity and generalizabiltiy (Dore, 1993; Rossi, 1992; Wells, Biegel, 1992; Blythe, Salley, Jararatne, 1994). As stated earlier, Family Preservation is one of the more widely researched social programs of our time. Initial data on the effectiveness of FPS was positive. In contrast to most child welfare programs, Family Preservation collected follow-up data at set intervals after the interventions. The data collected by the Behavioral Sciences Institute in 1990 touted a 94% intact rate for families (i.e. no children placed outside the home) at the close of services and an 88% intact rate at the 12-month follow-up.

Although these figures seemed impressive, the effectiveness of Family Preservation recently has been under fire. Blythe, Salley, and Jararatne (1994) stated that:

> "Obviously, such evaluation efforts have some notable shortcomings. For instance, the data are subject to several measurement flaws. Because they typically do not consider placements in other systems of care (such as mental health) and do not track runaway children, the follow-up data may underrepresented the number of placements.. Often the sole measure considered is out-of-home placement, which does not tell about family functioning. Also, such follow-up efforts do not allow the determination of the effectiveness of Family Preservation Services compared to traditional child welfare services."

Recently, Rossi (1991, 1992) and Wells and Biegel (1992) discussed some of these studies and made recommendations for future research. On the basis of a review of the major Family Preservation studies completed at the time, Rossi suggested that future evaluations have large numbers of subjects making effects (which are expected to be small) detectable. He noted that many studies tested immature programs and services varied across sites. Also, he observed that simple analysis strategies in experimental designs were simple and lacking in multivariate techniques (Rossi, 1991; Rossi, 1992). Wells, and Biegel(1992) considered three studies in detail and they suggested that future research examine child

and family functioning measures as outcomes in addition to the avoidance of unnecessary placement. In summarizing study findings, Wells and Biegel (1992) noted that placement was averted for about half the children at imminent risk of placement, but that Family Preservation Services did not have lasting effects over the 12-month follow-up period.

Findings from other studies suggest that children in families that enter FPS with more severe problems are likely to have poorer outcomes. Children who have experienced prior placements have a higher likelihood of placements than children with no prior placements (Fraser, Pecora, Haapala, 1991; Yuan, Struckman-Johnson, 1991). Besides having a history of prior placement, neglect, poor housing and drug/alcohol abuse are predictors of placement (Berry, 1992; Fraser, Pecora, Haapala, 1991; Schuerman, Rzepnicki, Littell, 1994), Bath, Richey, and Haapala (1992) found a curvilinear relationship between child age and placement, with infants and older children (aged 10 to 17) more likely to be placed than children aged three to nine.

Spaid and Fraser (1991) present preliminary evidence that suggests Homebuilders- type models may be more effective with families with younger children where parents lack supervisory skills than with families

with older children who display oppositional behaviors. This finding seems to contradict findings that FPS is not as successful with families that neglect. However, studies that reported less success with neglect compared families with young children to similar families where other types of abuse took place. Spaid and Fraser compared children referred for abuse and neglect compared to families with "ungovernable" or "incorrigible" children without regard to child age (Fraser, Pecors, Haapala, 1991). It is difficult to compare across studies due to this type of variability in study populations.

Recent studies from Utah, Alabama and Michigan appear to show that Family Preservation is cheaper and significantly related to reduction in foster home placements (Cooper, 1996). In Alabama, after a court-mandated switch to a Family Preservation model, the foster care population dropped 30% over a two-year period (Cooper, 1996). Conversely, in Illinois placements increased 30% and child deaths due to abuse increased from 78 to 91 in the two years after Family Preservation was abandoned (Cooper, 1996). Additionally, a Michigan study estimated that the annual per-child cost for a year of foster care was $11,000 compared to $3,930 for a six-week Family Preservation intervention (Cooper, 1996).

Most of these studies are limited because the intervention is defined only in the most general terms. For example, the general approach (cognitive-behavioral, ecological, empowerment and strength, etc.) might be stated, but further specification is not provided. Only a few studies have specified the FPS intervention in more detail. Fraser and Haapala (1987/88) studied specific components of FPS and their relationship to placement. They found that the provision of concrete services (directly providing transportation, food or clothing) and treatment interruptions (e.g. visiting neighbors, phone calls, disruptive child behavior, etc.) were related to placement avoidance. They suggest that treatment interruptions were related to placement avoidance because the worker could use these opportunities to teach problem solving and other skills (Fraser, Haapala, 1987; Fraser, Haapala, 1988).

Several child welfare studies have examined intermediate outcomes. Goal achievement or treatment gains have been found to be associated with placement avoidance (Berry, 1992; Fraser, Pecora, Haapala, 1991; Schwartz, AuClaire, Harris, 1991). Family functioning has been used as an intermediate outcome (Fraser, Pecora, Haapala, 1991; Thieman, Fuqua, Linnan, 1990). Thieman, Fuqua, and Linnan (1990) used the Family Risk

Scales (FRS) and stated that their "analysis shows dramatically that improvement in family functioning was associated with avoidance of placement" (p.27). The analysis consisted of calculating the degree of change in family functioning for each group--families who experienced placement and those who did not (Thieman, Fuqua, Linnan, 1990). Families who avoided placement showed differences on 19 of 26 FRS scales compared to no significant scale changes for families who experienced placement (Thieman, Fuqua, Linnan, 1990). The conclusion was that family functioning may be closely related to placement (Thieman, Fuqua, Linnan, 1990).

Outcomes research has increased over the past 10 years and there is more research being completed each year. Most research, however, still is considered flawed in many respects. The flaws include:

1) Lack of control groups: Only a handful of studies have used control groups (Fraser, Pecora, Haapala, 1991; University Associates, 1993; Wood, Barton, Schroeder, 1988). There continues to be a rich debate about whether it is ethical to withhold treatment from one group in order to form a control group. Rossi (1992) states that the ethical argument is moot as it assumes that the withheld treatment is effective without having enough conclusive data to make such a determination.

2) Threats to validity: It is difficult to determine the impact of services versus changes (maturity, natural change, etc.) that may occur in the absence of services (Rossi, 1992).

3) Imminent risk as an admission criteria: This is a subjective judgment that can vary from agency to agency and from worker to worker (Rossi, 1992).

4) Placement as an outcome measure: Rossi (1992) states:"...the goal of preventing placement is not completely independent of the actions of child protective agencies or of FPS programs. Indeed, a critical feature of the latter is that entry into the program involves a moratorium on placement. Hence, the fact that a child is not placed while under Family Preservation Services is not an outcome of treatment but a part of treatment itself. Furthermore, placement during treatment may be a positive outcome, signifying that the best way to preserve the safety of the child was to remove that child from its home" (p.90).

There is a consensus throughout the literature that the use of placement as an outcome by itself is not valid. This study hopes to follow in the path of Thieman, Fuqua, and Linnan by using a pretest/posttest assessment of family functioning to determine whether there is a correlation between family functioning and avoidance of placement.

CHAPTER III

METHODOLOGY

In order to formulate some research questions, a working research hypothesis was developed. The goal of the Family Preservation program at Edgewood Children's Center is to have an impact on family functioning in such a way that placement of a child can be averted while maintaining child safety in the home. The underlying assumptions include:

1) Families may lack the skills/knowledge to effectively raise their children,

2) Families may be lacking needed resources to effectively raise their children,

3) Families are capable of creating and sustaining change if they so desire,

4) Families are the best place for children to be raised,

5) Safely maintaining children in their homes in cheaper in financial and emotional costs compared to out-of-home care (Kettner, Moroney, Martin, 1990).

From these assumptions, a hypothesis was formulated which assumes that:

1) Families are able to learn new skills and/or enhance the use of existing skills,

2) *then* a significant difference in placement rates should be seen between families in which there was significant positive change in functioning. Additionally, it should be demonstrated that Family Preservation Services are more cost effective than out-of-home placement (Kettner, Moroney, Martin, 1990), and that client satisfaction is high among customers.

Design

To answer these questions, terms needed to be defined and demonstrate consistency and measurability. The two major concepts to be considered are "family functioning" and "client satisfaction." Because it is believed that changes in family functioning are related to placement avoidance, change in functioning is conceptually defined as the observable change in skill attainment or usage proficiency (Thieman, Fuqua, Linnan, 1990). The other concept, client satisfaction, is viewed as the degree to which clients report that services were helpful and delivered in a professional and respectful manner.

Operationalizing these concepts gives us the variables to be measured. Family functioning was measured by reviewing case files and by using a Likert scale prepared by the researchers (Appendix A) to rate the pre-intervention level of skill attainment/use to post-intervention skill

attainment/use. The scale ranged from one to ten with ten being no skill attainment/usage, and one being complete mastery of the skill. The skill to be evaluated was taken from goals set by the family as being areas needing improvement in order to prevent placement. Skill areas were unique, although common themes developed: parenting, anger management, drug abuse, etc. One researcher reviewed all files to ensure consistent ratings. To ascertain client satisfaction with services, a staff-developed client satisfaction survey (Appendix B) was used as a guide for telephone interviews. For families that could not be reached by phone, the survey was sent to their last known address. Questions were targeted to determine what aspects of program services and delivery helped families keep their children in the home. Suggestions for program improvement were also requested.

In order to answer the research questions, a research design that included the use of qualitative and quantitative data was employed. The research design is known as the one-group, pretest-posttest design (Rubbin, Babbie, 1993). Data from before the intervention is compared to data after the intervention to see whether there is any observable change (Rubbin, Babbie, 1993).

Subjects

The study sample consisted of all participating families in fiscal year 1994 and 1995 who completed an intervention (four or more weeks of FPS). To obtain a sample of this population, a random sample of 150 families was drawn using case numbers. Forty cases were dropped from the sample due to incomplete interventions or file data bringing the total sample to 110 cases. Of this sample, children who participated, 76% (n= 242) were African American, 21% (n= 67) were Caucasian, 2% (n= 6) were Hispanic and 1% (n= 3) were Asian (N=318). Sixty-six point two percent (n= 73) of the adults who participated were African American, 33% (n= 36) were Caucasian and 0.8% (n= 1) were Hispanic. Of the adults, 6% (n= 7) were age 20 or younger, 32% (n= 35) were 21 to 30, 43% (n= 47) were age 31 to 40 and 19% (n= 21) were 41 or older. Of the children, 6.1% (n= 19) were one or younger, 30% (n= 95) were two to five, 26% (n= 83) were six to 10, 29% (n= 92) were 11 to 15 and 8.9% (n= 28) were 16 or older. The total number of people in a household are shown in Table 3.1 and the number of children in a household are shown in Table 3.2.

Table 3.1 (n= 110) Family Size

Number of People in Household	Percentage of Sample with that Number
2	12.0%
3	26.0%
4	22.0%
5	26.0%
6	8.0%
7	5.0%
8	0.5%
9	0%
10	0.5%

Table 3.2 (N=110) Number of Children

Number of Children in Household	Percentage of Households w/that Number
1	16.0%
2	28.2%
3	25.0%
4	18.0%
5	8.2%
6	3.6%
7	0.0%
8	1.0%

Of the 110 families in the sample that were included in the study, 32% (n= 35) had an income below $400 per month, 23% (n= 25) had an income of $401 to $800 per month and 13% (n= 14) had an income of $801 to $1200 per month. Twenty-four percent (n= 26) of the families had an income that could not be estimated. The greatest source of income for families (60%, n= 66) was a combination of AFDC and Food Stamps. The second most common source of income was Social Security Disability (15%, n= 17) and employment comprised the income for the remainder (25%, n= 27).

Families in the sample were referred to the program for a variety of reasons as summarized in Table 3.3.

Table 3.3 (N=110)

REASON FOR REFERRAL	PERCENT WITH THAT REASON
Physical Abuse	27.0% (n= 30)
Homelessness	22.0% (n= 24)
Parent/Child Conflict	19.0% (n= 21)
Neglect	12.4% (n= 14)
Mental Illness	6.2% (n= 7)
Drug Abuse	4.4% (n= 5)
Educational Neglect	4.0% (n= 4)
Sexual Abuse	3.0% (n= 3)
Alcohol Abuse	1.0% (n= 1)

School Problems	1.0% (n= 1)
Physical Illness	0.0% (n= 0)

Instruments

In order to collect the required data, two instruments were used. One instrument (Appendix A) was used to gather demographic information and file information including placement status and changes in family functioning as noted in progress notes. The other instrument used was the client satisfaction survey (Appendix B) currently used by Edgewood Children's Center. Both instruments were evaluated and revised by the Family and Community Services staff at Edgewood.

Procedure

Ethical safeguards were employed to protect the clients. The researcher made every effort to minimize risk by:

1) Allowing only the researcher to examine records,

2) Ensuring the report would not include identifying information about participants,

3) Ensuring research records were kept in a locked file and in a password-secured computer,

4) Ensuring that only the researcher had access to the research records which will be destroyed by December 15, 1996.

Additionally, subjects were interviewed over the phone in the privacy of a locked office and files were reviewed in this manner. Participants also had the right to decline to respond to the phone or mail survey.

Four types of data were collected and measured in this study. The datum was the change in family functioning from the start of the intervention compared to family functioning at the completion of the intervention. The second factor was the degree of relatedness between a change in family functioning and the rate of placement. The third measurement was of family satisfaction with services rendered and the manner in which they were provided. The final element was a comparison of cost between a six-week FPS intervention and foster home placement for one year. The questions that naturally followed were: Are these changes important? Are they significant? Were they caused by the intervention(s)?

To answer these questions, the data were analyzed in several ways. The percentage of families that showed a change in family functioning scores was determined. Descriptive statistics about the mean and standard deviation in these scores pre to post intervention also were determined. Data also were subjected to the Wilcoxson Rank Sign Test, and the T-test to determine whether the change levels were:

1) Significant,
2) Attributable to the program,
3) The result of chance.

Data collected from the client satisfaction surveys were evaluated by searching for norms of behavior that could indicate universals, as well as deviations from the norm (Rubbin & Babbie, 1993).

CHAPTER IV

RESULTS

Measurements in the four areas of concern were conducted:

1) Family functioning,

2) Relatedness to placement or avoidance of placement ,

3) Family satisfaction with services and the manner in which they were delivered,

4) Financial cost of FPS intervention compared to out-of- home placement.

With regard to change in family functioning and its relatedness to placement or placement avoidance, 85 (77.3%) of the 110 families included in the study showed improvement in family functioning scores while 15 (22.7%) families showed no change. Sixty-six (85.7%) families that averted placement showed improvement in the family functioning score while 11 (14.3%) did not. Of the 18 families that experienced placement, five (27.8%) showed no change in their family functioning score and 13 (72.2%) showed an improved score.

Descriptive statistics describing pretest and posttest scores in family functioning for both placing and non-placing families are summarized in

Table 4.1. The Likert scale used one to represent complete mastery of a skill and ten to represent complete lack of a skill.

Table 4.1 Family Functioning Scores

	N = 77		N = 18	
	Non-Placement		Placement	
	Pretest	Posttest	Pretest	Posttest
Min	4.00	1.700	7.00	2.50
Max	10.00	10.00	10.00	10.00
Mean	9.10	4.82	9.26	6.40
SD	1.28	2.19	0.98	2.74

When these scores were subjected to the paired samples T-test, the change in score was found to be significant for both placing and non-placing families as summarized in Table 4.2.

Table 4.2 Paired Samples T-test Pretest vs Posttest

N = 77 for Non-placing families	N = 18 for placing families
Mean difference = 4.27	Mean difference = 2.86
SD Difference = 2.44	SD Difference = 2.36
T = 15.35 DF = 76	T = 5.15 DF = 17
Prob. = .000	Prob. = .000

Finally, data regarding change in family functioning were subjected to the Wilcoxon signed ranks test to determine whether the improvement could be attributed to the program. It was found that the change could not be directly attributed to the program for either placers or non-placers ($z = -7.29$, $p = 3.65$).

Data related to the satisfaction survey were evaluated by searching for norms of behavior that could indicate universals, as well as deviations from the norm. Surveys were sent to all 150 families from the randomly drawn sample. Data from 15 surveys were collected by phone or mail. This produced a response rate of 10% (n= 11). Families reported that they felt the therapist fully explained the program to them, made it clear that the program was voluntary and included all family members who wanted to participate. Families also felt that the therapist encouraged all family members to participate, their therapist listened to them and that they were treated with respect by their therapist. Therapists also received high marks for flexibility. Fourteen of the 15 respondents reported they would recommend the program to a family member or a friend.

Criticisms of the program included statements about the program being too long, too short and too intense. One respondent found the

program to be not helpful at all. The remaining respondents rated the program as very helpful.

With regard to a financial comparison, it was found that an average FPS intervention in Missouri costs $3,200 while a year of foster care costs approximately $8,000. A year of residential care costs approximately $40,000.

CHAPTER V

DISCUSSION

To evaluate the relevance of the research findings to the research questions, a reiteration of the questions is appropriate. The research sought to answer the following questions:

1) Was there a significant positive change in family functioning pre-intervention compared to post-intervention,

2) Was there a significant difference in placement rates between families in which there was positive change in functioning compared to families in which no change in functioning occurred,

3) Were families happy with the services they received and

4) Was FPS more cost effective than out-of-home placement?

The first question involving significance of change in family functioning seems to be answered in the affirmative. Evaluating the mean change, using the T-test, for families that averted placement and the families that experienced placement, significant change was found to occur for both groups. The minimum initial score for the non-placing groups (4.00) was higher than the minimum initial score (7.00) for the placing group. These findings were consistent with previously cited literature in

which results indicated that initial scores on family functioning were the most reliable predictors of program success. Following this simple logic, families with higher initial scores (hence lower functioning) are less likely to have as much of a positive change in post intervention scores. The literature points to several factors that may contribute to the differences between the initial scores of the two groups such as:

1) Families having chronic multiple problems may not perceive themselves as being in crisis and therefore may not be motivated to make changes in accordance with the Homebuilders values,

2) Families being referred inappropriately for such issues as housing and/or drug abuse, and

3) Certain families may be experiencing such an extreme crisis and lack the appropriate coping skills therefore making the expectation of change unrealistic.

Addressing the question of relatedness of change in functioning to placement, the results show that 66 (85.7%) families that averted placement showed improvement in functioning while 13 (72.2%) placing families showed improvement in functioning, a margin of 13.4%. Eleven (14.3%) families that averted placement showed no change in family

functioning while five (27.8%) placing families showed no change in functioning. Fewer families that placed children showed improvement in functioning compared to families who averted placement by a margin of 13.5%. More families that placed showed no change in function compared to families that averted placement by the same margin.

Therefore it could be argued that the second research question (Was there a significant difference in placement rates between families in which there was positive change in functioning compared to families in which no change in functioning occurred?) can be answered in the affirmative. It appears as though families showing a positive change in functioning are less likely to have their children placed into out-of-home care, and families that show no change in functioning are more likely to experience placements. This is consistent with findings cited in the literature.

It may be difficult to draw conclusions about overall consumer satisfaction with FPS because the response rate was only 10%. But of that 10%, the overwhelming response was "yes." Consumers appear to be happy with the type of services they received and the manner in which they were delivered. Although this may provide indicators to managed care

providers that the risk of expensive lawsuits resulting from consumer dissatisfaction is low, it is unclear whether consumer satisfaction in any way relates to program success.

With regard to FPS being more cost effective than out-of-home placement (foster care and residential care), FPS is less expensive than residential placement. At an average cost of $3,200 for a six-week FPS intervention, the per diem cost is $76.19. The per diem cost of one year of traditional foster care is $21.92 and the per diem cost of one year of residential treatment is $109.60. Because of the complexities of determining real financial costs due to some families utilizing all of these types of services or other wraparound services, per diem, or even annual cost comparisons may not be valid (since these services are usually used in varying combinations, and rarely independently). Also, the human cost of removing a child from his/her home is difficult to calculate when deciding which option is most cost effective.

The findings of this study are congruent with the current literature (Dore, 1993; Fraser, Pecora, & Haapala, 1991; Kinney, Haapala, & Booth, 1991; Rossi, 1992; Thieman, Fuqua, & Linnan, 1990) that states changes in family functioning are related to placement avoidance. These findings also

seem to support the notion that Family Preservation Services may not have a strong impact on families whose level of functioning is lower upon the initiation of services. Also supported is the notion that families showing the smallest positive changes in family functioning are most likely to experience out-of-home placements.

The current literature is enhanced, however, as past studies have not incorporated client satisfaction with services and the financial cost effectiveness of Family Preservation compared to other options (namely out-of home placement, such as foster care or residential treatment). Studies have made efforts to address these other areas, but not in the context of family functioning and placement aversion rates.

As with all studies, there are limitations to the conclusions that can be drawn. The capacity to generalize the results of this study are questionable as a researcher-developed instrument, not a standardized tool, was used to evaluated family function changes. Also, the researcher was an employee of the program examined rather than an independent contractor.

A control or comparison group was not used so conclusions about the programs' effect on family functioning change and placement aversion

could be credited to maturation, the natural resolution of crisis within the intervention time frame and factors other than the independent variable.

CONCLUSIONS AND RECOMMENDATIONS

Limitations not withstanding, important implications for social work practice and future research can be extrapolated. Overall, the researcher was satisfied with the use of the Likert scale tool to assess changes in family functioning. Because detailed progress notes were kept and goals were explicitly recorded and relevant to the reason for referral, it is believed that a fairly accurate assessment of change in family functioning (especially as it relates to placement aversion) is represented by the presented data. Although much of the literature calls for a standardized tool for researchers to provide a scale to measure family functioning congruent with the individualized nature of the philosophy behind the strengths model. This allowed the researcher to look at each case individually and utilize the detailed notes hence utilizing the judgment and expertise of the line staff who worked with each individual family.

Difficulties in making conclusions about consumer satisfaction stand out in this study. When using phone calls and mailings, a response rate of only 10% was achieved. It may be important to note that the number two reason for referral of the study sample was homelessness (22% of all sample referrals). Also, 55% of the sampled families had a monthly

income of under $800 per month ($9600 per year). Homeless and low-income families tend to frequently change address making follow-up data collection problematic. Agencies could consider using monetary or other incentives, or staff and volunteers to complete door-to-door follow-ups in order to improve the response rate. As managed care companies will require documentation of consumer satisfaction, new methods and perhaps more labor intensive methods for collecting such data will need to be considered.

Another recommendation would be to develop longitudinal studies to follow-up with families who have used Family Preservation Services. The literature is lacking in this area. One question that cannot be addressed in a cross-sectional study but could be in a longitudinal one is whether FPS simply delays the inevitable with regard to placement. Do families involved with FPS eventually place anyway sometime in the future? If so, is delaying placement a positive or a negative outcome for children? Is time in placement for families that used FPS shorter than time in placement for families that did not use FPS? And how long can changes made by families during FPS be expected to be sustained? Because Family Preservation as a model is based on crisis intervention theories, it may be

unrealistic to expect that services will create long-term or permanent effects. The goal as stated in the Homebuilders model is to bring families back to a pre-crisis level of functioning, not to move them beyond that level (Kinney, Haapala, Booth, 1991). Expecting such a program to create long-term, sustainable change therefore may be unrealistic.

Other questions that could be asked concern the number of second time referrals, and the types of services families already are receiving when FPS is brought into the family. Knowing the number of families that previously used FPS within a sample could be important as they may show more (or less) change than would be expected from families using FPS for the first time. The effect of other services on a pre-intervention level of functioning and the degree of change of post-intervention could be significant.

It seems important to note that for programs such as Family Preservation where a very specific model with a specific theoretical orientation has been developed, it is counter-productive to serve families that do not fit the model criteria. Families that do not perceive a crisis, that are homeless or that are chronically multi-problem do not fit the model as described by the Homebuilders (Berry, 1992). By offering services to all,

including the most inappropriate referrals, Family Preservation programs will continue to come under fire for lack of effectiveness as changes in family functioning likely will continue to be smaller for these families than for more appropriate referrals.

Future studies should screen and separate families who are referred for physical abuse or neglect from families who are homeless or chronically multi-problem, to see whether significant differences in results occur to support the notion that FPS works best for the population it is intended to serve. This is not to imply Family Preservation is unhelpful to inappropriately referred families, but it may be unfair to judge a program based on its' ineffectiveness with unintended populations.

Such research also would help to ameliorate the current "all or none" thinking with regard to social service/welfare programs. Programs are either deemed a complete success or a total failure with few shades of gray to describe the complexities of delivering services to a diverse population of consumers.

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Appendix A

Desired Outcomes Instrument

DESIRED OUTCOMES
Family Preservation

Case #:___________

1. Reduce or eliminate the risk of unnecessary placement:

Ask the former therapist, or the former therapists former supervisor:

On a scale of one to ten, with one being no risk and ten being placement, what was the risk of placement for this family upon referral?

1	2	3	4	5	6	7	8	9	10
No risk									Placement

On a scale of one to ten, with one being no risk and ten being placement, what was the risk of placement for this family upon closing?

1	2	3	4	5	6	7	8	9	10
No risk									Placement

1. Initial lickert scale rating:______(1 -10 or ND for No Data)
2. Follow up lickert scale rating:______(1-10 or ND for No Data)
3. Difference (+/-):______(0, +/- 1-9, or ND for No Data)
4. Family intact at exit? Y or N or No Data
5. Was placement recommended by the therapist? Y or N or ND
   a. If "YES", did placement occur? Y or N or ND

2. New Skills taught:

Ask the former therapist or the former therapist supervisor:

Skill #1:____

On a scale of one to ten with one being possession of the skill and ten being no possession of the skill, what was the skill functioning of the family at referral?

1	2	3	4	5	6	7	8	9	10
Possession									No Possession

On a scale of one to ten with one being possession of the skill and ten being no possession of the skill, what was the skill functioning of the family upon closing?

1	2	3	4	5	6	7	8	9	10
Possession									No Possession

Skill #2:____

On a scale of one to ten with one being possession of the skill and ten being no possession of the skill, what was the skill functioning of the family at referral?

1 2 3 4 5 6 7 8 9 10
Possession No Possession

On a scale of one to ten with one being possession of the skill and ten being no possession of the skill, what was the skill functioning of the family upon closing?

____
1 2 3 4 5 6 7 8 9 10
Possession No Possession

Skill #3: ____
On a scale of one to ten with one being possession of the skill and ten being no possession of the skill, what was the skill functioning of the family at referral?

____
1 2 3 4 5 6 7 8 9 10
Possession No Possession

On a scale of one to ten with one being possession of the skill and ten being no possession of the skill, what was the skill functioning of the family upon closing?

____
1 2 3 4 5 6 7 8 9 10
Possession No Possession

Skill #4: ____
On a scale of one to ten with one being possession of the skill and ten being no possession of the skill, what was the skill functioning of the family at referral?

____
1 2 3 4 5 6 7 8 9 10
Possession No Possession

On a scale of one to ten with one being possession of the skill and ten being no possession of the skill, what was the skill functioning of the family upon closing?

____
1 2 3 4 5 6 7 8 9 10
Possession No Possession

1. Skill #1 initial likert scale score:______(1-10, or ND for No Data)
2. Skill #1 follow up likert scale score:_____(1-10, or ND for No Data)
3. Skill #1 +/- change in score:_____(1-10, or ND for No Data)
4. Skill #2 initial likert scale score:______(1-10, or ND for No Data)
5. Skill#2 follow up likert scale score:_____(1-10, or ND for No Data)
6. Skill #2 +/- change in score:_____(0, +/- 1-9, or ND for No Data)
7. Skill #3 initial likert scale score:_____(1-10, or ND)
8. Skill #3 follow up likert scale score:_____(1-10, or ND)
9. Skill #3 +/- change in score:_____(0, +/- 1-9, or ND)
10. Skill #4 initial likert scale score:_____(1-10, or ND)

11. Skill #4 follow up likert scale score:_____(1-10, or ND)
12. Skill #4 +/- change in score:_____(0, +/- 1-9, or ND)
13. Total number of goals set:_________
14. Total number of goals achieved:_________
15. Number of goals directly related to referring issue:_________
16. Number of directly related goals (to referring issue) achieved:_________

3. Family stays together:

1. Family together at one month follow up?: Y or N or ND
2. Family together at six month follow up?: Y or N or ND
3. Family together at one year follow up?: Y or N or ND
4. Number of unplanned out of home placements since closing?:_________
5. Number of planned out of home placement since closing?:_________

Appendix B

Client Satisfaction Survey

Therapist/Specialist: ______________________
Date: ______________

Family and Community Services
Edgewood Children's Center
CLIENT SATISFACTION SURVEY

In our effort to provide you with the best possible services, we need to know how well we did and if the services we provided met the needs of you and your family. Please take a few minutes to complete the survey and return this survey to us in the envelope provided. Thank you!

SECTION I

Please check yes or no to the following questions. Comments are welcomed and appreciated.

1) Did the therapist/specialist explain the program fully?
Yes_____ No_____ Comments: ______________________

2) Did the therapist/specialist make it clear that the program was voluntary?
Yes_____ No_____ Comments: ______________________

3) Were all family members who wished to participate included in the intervention?
Yes_____ No_____ Comments: ______________________

4) Did the therapist/specialist encourage all family members to participate in setting goals and completing the family goal sheets?
Yes_____ No_____ Comments: ______________________

5) Did your therapist/specialist treat you with respect?
Yes_____ No_____ Comments: ______________________

6) Did your therapist/specialist listen and understand what you told him/her?
Yes_____ No_____ Comments: ______________________

7) Did you feel that the therapist/specialist allowed you to work at your own pace?
Yes_____ No_____ Comments: ______________________

8) Did the therapist/specialist schedule appointment times that were convenient for you?
Yes_____ No_____ Comments: ______________________

9) Did the therapist/specialist work with you and your family to obtain the services you needed?
Yes_____ No_____ Comments: ______________________

10) Did the therapist/specialist discuss options for aftercare (follow up counseling, resources, etc...) with your family?
Yes_____ No_____ Comments: ______________________

11) Would you recommend our program to a friend or family member?
Yes_____ No_____ Comments: ______________________

Question 12 for Families First and Extended Families First only

12) Did you feel the co-pay amount was affordable for your family?

Yes_____ No_____

Comments: ____

____

SECTION II

Please check any area that you and your specialist/ therapist addressed:

_____ Alcohol/ drug abuse
_____ Anger Management (stress management, self care, etc.)
_____ Budgeting
_____ Communication ("I" messages, listening, fair fighting)
_____ Couples issues
_____ Housing, utilities, etc.
_____ Medical/ Mental Health
_____ Parenting
_____ Problem Solving
_____ Safety
_____ School issues
_____ Other (please specify)____________________________

Of all the areas on which you and your therapist/specialist worked, which was the most helpful and useful to you and your family and why?

____

____

____

Which was the most difficult area and why?

____

____

____

If the program was not helpful, why not?

____

____

____

SECTION III

1) On a scale of 1 to 10, please rate the helpfulness of your therapist/specialist overall. (with 1 being "not helpful at all" to 10 being "very helpful")

Not helpful Very helpful
1 2 3 4 5 6 7 8 9 10

2) On a scale of 1 to 10, please rate the services.

Not helpful Very helpful
1 2 3 4 5 6 7 8 9 10

Please write any additional comments:

____

____

____

Thank you for taking the time to fill out the survey.

3/96 BB