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An Evaluation of Home Based Family Services

Tia L. Liston

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An Abstract Presented to the Faculty of the Graduate School

of Lindenwood University in Partial Fulfillment of the

Requirements of the Degree of

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Abstract

The purpose of this study was to evaluate the effectiveness of home-based family therapy by analyzing existing data from a local agency. Files from the past year containing a complete referral form, a client satisfaction survey and follow-up forms from six months and a year, were evaluated to determine the level of client satisfaction. The data was analyzed to determine the differences in frequency of types of difficulties addressed. Data was also analyzed to determine factors related to successful outcomes. Based on results, it was determined that home-based services were successful. An evaluation of types of services and difficulties were addressed.

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Dedication

To my husband, Nathan, who traded a wife for a researcher, and whose strength, prayers, and support helped me achieve my goals. To my parents, Doyle and Beth Willhite, whose belief and spiritual upbringing gave me the foundation to trust in God and encouraged me that I have the mind of Christ. To my mother and father-n-law, Pam and Danny Liston, whose tenacity and love for Jesus gave me the hope and ability to succeed. To my best friend and sister, Christy, and to my brothers, Todd and Tobin, who believed in me and encouraged me to pursue my dreams. Finally, to my Savior Jesus Christ, who led me and gave me the heart to help others.

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Chapter I

Introduction

Every day hundreds of children are placed outside of their homes. These placements include foster homes, residential treatment centers, psychiatric hospitals, relative care and detention centers, all of which can be highly expensive. Several treatment approaches have been developed in order to prevent these types of out of home placements. Many researchers and professionals believe that if an agency can provide intensive psychological treatment and community support to these families in crisis, that an out of home placement may be prevented (Aronen, Kurkela; 1996. Berg; 1994. Fraser, Downs, York, Belcher, Cook, & Dhooper, 1987-88).

Home-Based Services can provide families with several resources and assist families in exploring options for their future benefit. Helpful resources that may be provided to families through home-based services may include individual and family therapy, utility assistance, medical or psychiatric referrals, housing assistance, transportation and parenting groups. According to Aponte, Zarski, Bixentine and Cibik (1991) "a majority of the families who receive assistance through home-based services are low income, minority and consist of a single-parent" (p. 403).

Violence, illegal drugs, alcoholism, high crime, and child abuse permeate today's society. According to Aponte, et al, (1991), these difficulties are "not just personal failures, but societal defeats, and therapeutic efforts to the poor are rarely limited to the family system" (p. 404). Home based services attempts to assist these families by providing them with future resources and the tools to explore options within the community for future assistance.

According to Fraser and Haapala (1988), over thirty years have passed since Eysenck's exiting report on the effectiveness of intensive psychotherapy, including home-based family therapy. Over the past thirty years, little research has been conducted on the effectiveness of particular strategies within home-based therapy. The advantages of home-based therapy is primarily based on the success rate as a whole, not assessed and dissected as to which particular techniques that were used.

Home Based Therapy was initiated to assist families whose problems became so severe that the known community resources were unable to assist them proficiently. Caseworkers assigned to these families often felt that the children had to be placed outside the home to relieve pressure within the home. According to Kinney, Haapala, and Booth (1991) home-based services gave caseworkers and families another option: "services that are more intense, accessible, flexible, and goal-oriented rather than provided by traditional support programs" (p.3). This innovative focus increased support and relieved pressure by providing and facilitating a safe and nurturing environment for the children within the context of the family.

Inevitably, some families referred to home-based services present multiple problems and therefore may not successfully benefit from the program. Due to the fact that home-based services are primarily established to prevent an out of home placement, the success of home-based services are dependent upon whether or not the child remained in the home after completion of the program. Many professionals have argued that home-based services were not successful because a child was placed outside the home. Minimal research has been conducted on the outcomes of home-based family therapy based upon the client's interpretations of successfulness.

Statement of Purpose and Hypothesis

The purpose of this study is to determine how successful clients rate home based services, common difficulties that are addressed during the intervention, and whether the client's completion of home based services is predictive of child placement outcomes. This study includes three questions. 1) What is the client's level of satisfaction with home-based services? 2) Is there a significant difference of the satisfaction level expressed between families with multiple problems and those who indicate a single problem? and 3) Is client satisfaction predictive of child placement outcomes?

Chapter II

Review of Related Literature

During the 1980's, families were being evaluated due to an increase in poverty, homelessness, child abuse, drug abuse, and alcohol abuse. The combination of these difficulties led parents to be at serious risk of having their children removed from their home (Wells, & Biegel, 1991).

Home-based family therapy began in 1980 after the Adoption Assistance and Child Welfare Act of 1980, P.L. 96-272 was passed on a national level. This national policy was approved after a significant number of federal legislative decided to seek the prevention of unnecessary out-of-home placements of children. Therefore, preventive and reunification programs were developed in support of stabilizing home placements for children (Wells & Biegel, 1991).

Since this development research has been conducted to improve and evaluate home-based services, and to determine funding. In 1991 the US House of Representatives Select Committee on Children, Youth and Families estimated, if no major changes by governmental policies had taken place, that over 850,000 children would be in out-of-home placements such as residential treatment facilities, psychiatric hospitals, foster care, group homes and correctional facilities by 1995 (Wells & Biegel, 1991).

Several treatment approaches to prevent out-of-home placements have been developed since the approval of P.L. 96-272. Based on research professionals determined that if an agency could provide intensive, home-based psychological treatment and community support to families in crisis, that an out of home placement may be prevented (Wells, & Biegel, 1991).

Description of Home-Based Therapy

Home-based family therapy focuses on the family as the target of the intervention, rather than the particular parent or child at risk. Home-based therapy uses the basic knowledge and skills developed from family therapy to completely assess and treat the family as a whole, usually conducted during an intensive, specific, time and duration limited period (Berg, 1994). Home-based services may include intensive family counseling and support, case management and community resources on an outreach basis to troubled children and parents/families that are at risk of having one or more children removed from the home (Stroul, & Goldman, 1990).

Home-based family therapy is primarily held in the family's home, and the family is viewed as the client. The services are "ecological" and involve working with the family's particular community to access resources and support. Home-based services focus on reunification and preserving the family, unless it is clearly defined that preservation is not in the best interest of the child. Service to the family is flexible and provides twenty-four hour crisis intervention. Home-based specialists have small caseloads to insure availability and accessibility to families. Goals and objectives of services are individually assigned and offered along a continuum of intensity and duration, based on desired outcomes and needs of the family. Service to families are multifaceted, including family and individual counseling, coordinating community resources and support networks, as well as specific skill training designed to meet each families individual needs (Stroul, & Goldman, 1990).

Goals and Objectives.

Goals and objectives of home-based family therapy focus on services that are strength based and solution-focused. Goals are individually developed based on the families needs. Some goals are determined by the referring

worker, but goals are agreed upon and established individually, based on recognition and desired outcomes.

Each family is given a goal sheet. The goal sheet is developed by the family and an assigned specialist. The family is asked to list areas of difficulty and the home-based specialist assists the family in exploring specific steps and solutions that could lead to the desired outcome. Goals are reviewed weekly and may be changed or altered depending on the families needs.

Insoo Kim Berg, Director of the Brief Family Therapy Center, located in Milwaukee, Wisconsin, reports in her book Family Based Services (1994) that "goals which are unclear in an intervention, will lead to long-term contact" (p. 63). Home-based family therapy is developed to be intense and short-term, therefore clear and precise definition of goals are essential.

Berg has established guidelines for goal setting in home-based therapy. She reports that goals must first be important to the client. It is inevitable that unless someone is ready for change, it is otherwise impossible to enforce it. Goals must be meaningful in order for clients to feel responsible for change. Secondly, goals must be described in social interactional terms. Berg (1994) reports that all clients will benefit when they are helped to formulate specific goals.

Berg (1994) further states that goals must be small, simple, and realistically achievable. The solution-focused approach includes that even extreme difficulties can be solved with simple, small solutions. Goals must be made to be achievable within a specified amount of time. Goals must be described in interactional terms. Berg (1994) states that when negotiating goals with a client, it is the specialists task to help the client state the goals in a way that the client describes with whom, as well as where the changes will happen.

Berg continues by reporting that goals must be described as a beginning of new behavior, not an end of undesirable behavior. Illustrations in Berg's publication include that clients often describe their goals in idealistic terms. She reports it can be a positive sign if clients can acknowledge the possibility of life being different from the present, but that these goals often take a lifetime to achieve. Berg instead, recommends that the client "may need the assistance of the specialist to develop goals which are small and concrete" (p.76).

Goals must be achievable, but also viewed as requiring work from the client. Goals which require work allow clients to feel and take responsibility for their achievements. Although small and simple, the goal may appear difficult to clients. Home-based specialists can encourage clients by approaching the difficulty as a team (Berg, 1994).

Lastly, the goals must be agreed upon by the specialist and client. Both must be working toward the same end result. Priorities may be set if goals do not coincide completely. For instance, a parent decides that he would like to work on communication, but the referral reported alleged physical abuse. The specialist must encourage the parents alternative ways of discipline. Working on what the client perceives as goals will assist in establishing rapport and trust, but Berg urges that the child's safety must precede (Berg, 1994).

Home-Based Therapy Versus In-Office Therapy

David Cottrell, Professor of Child and Adolescent Psychiatry at the University of Leeds in the UK, wrote a short paper titled Family Therapy in the Home. Cottrell reports home-based therapy has advantages over in-office clinic based therapy for some clients. Financially, some families cannot afford in-office counseling. They may have difficulty with transportation or childcare, therefore leading to missed appointments. Cottrell reports that there have been few facts and studies of home-based versus in-office therapy.

Creating Competence from Chaos, a comprehensive guide to home-based services written by Lindbland-Goldberg, Dore and Stern (1998) suggests that "a mental health home-based approach is valuable" in order to strengthen vulnerable families and can be "embedded in ecosystemic thinking and practice" (p.xvi). Golberg et al states that "the values that underlie this treatment model is shared by other professionals who believe that a family's needs are best met through individually tailored, family-centered, community (home) based, culturally competent and outcome-oriented services" (p.xvi).

Cottrell recommends in-home therapy. He reports that in other fields, it is proven that in-home services may be more effective than those carried out in clinics. For example, Cottrell quotes that Herbert (1988) advocates the use of home-based behavioral treatments in the management of aggressive children. Statistical reports have demonstrated that home-based treatment is more effective than clinical-based methods in the management of behavioral problems in autistic children (Cottrell, 1994).

Cottrell also found that, regardless of statistics, less in-home therapy is being carried out than clinic work. He has devoted his short paper to common difficulties raised with in-home therapy, as well as strategies for dealing with these difficulties. His reports state that many professionals view families as being "unmotivated if they cannot find means of getting to therapy". However, many families may be very motivated to change, but lack transportation. Cottrell (1994) further states that some families may have a member with a disability or small children and alternative childcare or transportation must be arranged in order to leave the home for an in-office session. Some clients have difficulty leaving the home due to mental health issues. For example, a ten year old boy had not been attending school and his mother suffered from

agoraphobia. In-home therapy was necessary to assess the situation and help this mother with her son's truancy.

Friesen and Koroloff (1990) agree that child-focused therapy should begin to move toward family-centered in-home care. They report that "the lack of emphasis on support for families whose children have serious emotional problems is not accidental, but related at least in part to secure beliefs about the nature and cause of emotional disorders in children". And furthermore, that "until recently, many professionals, parents and members of the public shared a belief that children's mental and emotional disorders were always a result of inadequate, inappropriate or malignant parenting" (p.14).

Cottrell acknowledges that in-home therapy may cause anxiety, loss of power and structure among therapists. However, therapists benefit from gaining insight about families by working in their living environment and community (Cottrell, 1994). He reports that it is often not safe for therapists to visit their clients at home. He suggests to enforce definite rules and regulations, including that a co-worker attend sessions, adequate seating for those participating in sessions, attendance be regulated and decided upon by the parents, to regulate disruptions, such as televisions and radios be turned off, and to define the duration and time limit for each session.

Cottrell (1994) balances the argument, including that home-visits can be intrusive and deny the family of the option to miss appointments. He concludes his paper by the fact that home-based family therapy is not easy, but offers the possibility of working with families that might not otherwise receive help.

Multiple Problem Families Versus Single Problem Families

Families referred to home-based services vary in regards to presenting problems and underlying issues and concerns. Many families have multiple problems that need to be addressed, as well as several children at risk of placement. Some families having only one child at risk of placement, may have fewer difficulties to address during the intervention. Families consist of a single parent, an intact family, blended families, or children in relative care (Borrine, Handal, Brown, & Searight, 1991).

Most multiple and single problem families require additional services beyond in-home therapy. Families need aftercare, or referrals to additional specialty agencies to address ongoing issues and to maintain stabilization of the family.

Berg (1994) reports that certain therapists believe that "multiple problem" families may thrive on the idea of a crisis. She states that these therapists believe families "live from crisis to crisis" and do not know how to handle their lives without difficulty. Berg (1994) reports in her studies that this misconception is due to the fact that the families relationship with programs and social workers are short-term and focus only on the crisis, therefore leading to a "crisis orientation". Berg suggests that the worker focus instead on what is different and suggest a relationship between the event and the reaction.

Types of difficulties addressed may include severe situations. An adolescent or parent with suicidal or homicidal thoughts would require a twenty-four hour safety plan and intervention (Lothian, 1991). These types families may require additional services and safety contracts, as well as twenty-four hour supervision.

Some families may need assistance with a delinquent adolescent. Alexander and Parsons (1972) of the University of Utah initiated a study on the impact of family process and recidivism on families with delinquent adolescents. Their intervention was based on "prior family interaction studies, along with a systems conceptualization of deviant behavior" (p.219). Alexander and Parsons (1972) evaluated a short-term behaviorally oriented family intervention program that worked with families to help them improve communication and increase family mutuality. The results of their study indicated that out of forty-six families who completed the program, all demonstrated significant changes in at least three family interaction measures at the end of therapy. These were compared to thirty families who received alternative forms of family therapy, as well as fifty-two families who received no professional treatment. Alexander and Parsons (1972) reported that the "study marked the utility of a therapy evaluation theory that includes a precise portrayal of intervention techniques, a description of expected process changes, strict nonreactive outcome measures, and controls for growth and attention placebo" (p.219).

Other types of difficulties addressed included assisting parents with alternative discipline techniques (implementing "hands-on" exercises during sessions), homelessness or severe financial difficulties, drug and alcohol abuse, assisting with referrals for psychological and psychiatric evaluations, establishing rapport and communication with schools through staffings and assisting families with marital and communication problems. Families may require assistance with several difficulties at one time, or the focus may be on a particular problem with a child or adult within the family system.

Treatment Approaches

Due to the extensive variety of difficulties addressed, the specialist who provides home-based family therapy uses alternative styles of treatment approaches. A particular approach that has proven successful with one family may not be as successful with another. Several approaches that are utilized by home-based therapists include solution-focused therapy, systematic integration and multi-family approach. Treatment approaches used in home-based family therapy include using the entire family or individual members of the family separately, but it is important to note that the entire family is responsible for change and adhering to the treatment approach designated by the therapist.

Many home-based service providers have adopted the "solution-focused" approach. The solution-focused approach does just that, focuses on solutions to the problem versus dissecting the specific problem. Families have specific goals which are assigned or developed by the members of the system, and each do their part in completing the goals. The therapist or specialist can act as a "mediator" in helping the family decide on specific goals of the intervention. Solution-focused approach is based on family strengths and is goal oriented.

Some controversial studies and therapists do not believe in the solution-focused approach and make references such as the "Band-Aid" theory, or the "quick-fix". However, evidence has yielded the solution-focused approach to be successful. Berg (1994) introduces a step-by-step description, for those who are unfamiliar with the theory and concepts known as brief therapy. The focus remains on what the client is doing right, rather than what they are doing wrong.

Another type of family therapy introduced by Raphael and Dorothy Becvar (1996) is the systemic integration approach. The Becvar's

acknowledge that the systemic/cybernetic approach does consume some bias, but they do not convey that this approach is the "right way, the only way, or the best way to think", but it "is a way to think" (p.1).

The Becvars (1996) further describe the systemic/cybernetic approach as being compared to a "psychological pie". This pie can include using elements of behavioral, psychodynamic, experiential, structural, communications, and strategic approaches. The Becvars (1996) report that the "systemic approach is based on a foundation of assumptions about reality and an appropriate description, including asking the question "what?", reciprocal causality, wholistic, dialectical, subjective/perceptual, freedom of choice/proactive, patterns, focus on here and now, relational, and contextual" (p.8).

The Becvars (1996) note the importance that through systemic thinking, family therapy is "probably a misnomer, and should be labeled as relationship therapy" (p.8).

Alternatively, studies by Zarski, Aponte, Bixentine, and Cibik (1992) report that a multi-family approach can be successful in producing change. Their study was based on reviewing the use of multi-family therapy group components for families who are at risk and are receiving home-based services. The studies include the advantages and disadvantages of using this alternative approach to treat families.

The method used in the study included using seven families over a period of fifteen weeks. These families, all receiving home-based services, were to attend a group session that was held at a Midwestern university. The emphasis on the group included that the families would benefit within the group sessions due to all receiving home-based services and therefore could assist one another by sharing helpful resources and identifying strengths.

Zarski et al (1992) describe advantages and disadvantages of the multifamily group therapy sessions. Advantages included that families experienced a sense of validation from interacting with one another, they enjoyed a sense of acceptance, alternative resources, community supports and additional sources of feedback. Disadvantages included vulnerability of families' sharing areas of struggles and inconsistency of attendance.

Rate of Success

The rate of success regarding home-based therapy is measured by figures that indicate whether the services prevent out of home placements for children at risk. Wells and Biegel (1991) report that intensive home-based therapy has been successful towards preserving families. The most accurate way of measuring success is utilizing follow up studies that focus on the children at risk of an out of home placement, as some families consist of children who are, and are not at risk of placement. Wells and Biegel (1991) state that there is precise evidence, from their own studies, that home-based therapy is effective. It is further stated that because of careful client tracking and program evaluations, "findings from this project contribute to the growing confidence and optimism characterizing intensive home-based family preservation programs" (p.24).

The rate of success of home-based therapy can also be measured by client satisfaction. McCrosky and Meezan (1997), both professors at the School of Social Work, University of Southern California, report that client satisfaction can be measured in two different ways.

First, a client satisfaction survey can be administered with the client. The survey can be completed together, or sent in by the client. The survey should consist of questions relating to how helpful the services were, what was addressed during the intervention, and whether anything changed during the

intervention. The survey should be short, easy to complete, measured for internal consistency and appropriate for use with various ethnic and racial groups.

Client satisfaction can also be rated with a closing session, asking the client brief questions regarding his or her feelings of accomplishment and assistance throughout the services. Because client satisfaction can only be rated by the client, it is important to provide the best environment so the client feels able to report his or her feelings precisely and honestly (Wells, & Biegel, 1991).

Client satisfaction can also be rated with a closing session, asking the client brief questions regarding his or her feelings of accomplishment and assistance throughout the services. Because client satisfaction can only be rated by the client, it is important to provide the best environment so the client feels able to report his or her feelings precisely and honestly (Wells, & Biegel, 1991).

Rate of success has not proven to be dependent upon the nature of the referral for home-based services. Both multiple and single problem families report significant success with home-based services.

An independent study was conducted by Cherniss and Herzog (1996). This study, The Impact of Home-Based Family Therapy on Maternal and Child Outcomes in Disadvantaged Adolescent Mothers, evaluated one-hundred sixteen high-risk, urban, disadvantaged teenage mothers and their children.

Obviously multi-problem clientele, these families received home-based services including family therapy, case management, supportive counseling and resource coordination. Cherniss and Herzog (1996) reported that, at a twelve month follow-up, those who received family counseling, along with other

services offered, were "less dependent on welfare and had improved more on all three of the parenting dimensions evaluated" (p. 72).

According to Lindblad-Golderg et al (1998), in Pennsylvania, the Division of Children's Services in the State Office of Mental Health prevented a decrease in state funds for home-based services by demonstrating results from ongoing evaluations on home-based services in the 1990's. Results from their study indicated that only "twenty-five percent of children in families receiving home-based services had experienced a psychiatric inpatient placement within the year following treatment", as compared to "eighty-percent from the year prior to the home-based intervention" (p.265-266).

Lindbland-Golberg et al. (1998) established in their book, Creating Competence From Chaos, the purpose of evaluating client satisfaction and outcomes. The purpose is listed as an "element to demonstrate the relationship between goals and objectives of treatment, the treatment model employed, and the outcome results from clients" (p.266). According to Lindbland-Goldberg et al., "policy makers, financial assessors, program evaluators and planners, administrators, and clinicians must have a precise understanding of program goals, the outcomes recommended for families and children, and some agreement as to how those goals are to be accomplished" (p.266).

Aftercare

Many agencies offering home-based services have added protocol to establish appropriate aftercare for each individual family member. Aftercare was designed to assist families in maintaining following through with goals completed during the intervention, or new goals that were recognized and developed toward the end of the intervention.

Aftercare is identified as an important element to home-based services. Friesen and Koroloff (1990) report that "families must have the necessary supports in order to cope with effectively raising their children" (p.13). In the field of mental health, "these developments are accompanied by new concepts about the system of care for children with severe emotional disorders, as well as new propositions about the participation of family members that have important implications for mental health policy and administration" (p.13).

Aftercare may be implemented within home-based services due to ongoing, intensive needs of clients. Due to the short duration of home-based therapy, certain families may request ongoing services, such as parenting classes, and individual or marital therapy, not otherwise offered or addressed during the intervention.

Goals of aftercare are individually developed, based on the clients needs. The therapist may establish a termination meeting where family members recognize which goals they did not complete, or new goals that they feel would further improve their lives. The therapist assists the family in locating appropriate resources to follow up with the family goals, such as a parent aid to be assigned to those who want to learn and implement new parenting techniques. Resources are coordinated appropriately by the therapist and a supervisor, then brought to the family at a termination meeting. At the six and twelve month follow-ups the therapists documents new agencies which are providing services to the family, as well as those agencies established by the therapist at termination.

Funding for aftercare, as well as home-based services, may not be included in most family's insurance policies. As mentioned before, most families who receive home-based services tend to be lower-class and

minorities, therefore the state provides access to home-based services for those who cannot afford it.

According to Stroul and Goldman (1990), "the cost for home-based services ranges from $1,000 to $10,829 per family across all types of services available" (p.68). They report that two major conclusions can be made regarding the cost. First, "the reported costs are including the entire family system". This is recognized as an investment, as the entire family is treated, rather than supporting the cost of an out-of-home placement for one child. Secondly, "the cost for an out-of-home placement per child far outweighs the average cost of home-based services" (p.68).

Stroul and Goldman (1990) report that the primary funding source for home-based services is state government and the second funding source is the state mental health departments. In this study, they also concluded that some agencies who provide home-based services receive funding from the "juvenile justice programs, independent grants from United Way, private funding sources and educational funds"(p.68).

Many ambient factors of home-based services have been evaluated and studied. Although treatment approaches and aftercare are only a few important elements of home-based services, one must continue to evaluate successfulness. The following chapters contain methods and results found concluding an evaluation of an independent agency that offers home-based family services in a large Midwestern city.

Chapter III

Method

Subjects

Subjects included in this study were drawn from existing data of 202 families who received home-based services within the year 1998 from a local not-for-profit agency in a large town in the Midwest. Subjects may be referred to home-based services through the Missouri Division of Family Services, family court systems, schools, private mental health organizations, concerned friends or family members, or by self-referral.

Subjects included in the study were 272 at-risk children, 124 being male (45.6%) and 148 being female (54.4%). The children were from a total of 138 families for whom the agency had six and twelve month follow-up information. Since there were 64 families whom did not have six and twelve month follow-up information, these were excluded from the study. Racial composition of the 272 subjects included 76.1% African American, 22.4% Caucasian and 1.5% being categorized as other. Statistics revealed that the majority of families served tended to be minority, low-income, and consist of a single parent home. The data indicated that 44.5% of the subjects came from households earning less than $10,000 per year. Table 3.1 indicates percentages and frequency of subjects from each of the yearly household income groups.

Table 3.1
Yearly Household Income

Income	Frequency	Percent
<$5,000	60	22.10%
$5,000-$9,999	61	22.40%
$10,000-$14,999	39	14.30%
$15,000-$24,000	38	14.00%
$25,000-$34,000	10	3.70%
$35,000-$49,000	4	1.50%
unknown	60	22.10%
Total	272	100.00%

Instruments

Instruments in this study include three separate forms. All forms were taken from existing files within a particular agency. Data was evaluated from those families who had received home-based family therapy in the year 1998 and had completed all three forms within their file.

The first instrument used was the initial referral form, which included the family's composition, initial problems for the referral, socioeconomic status, race, date of birth and sex. This form was used in order to gather demographic information.

The second instrument used was a client satisfaction survey. This survey was mailed to clients along with the closing letter at the end of treatment. It includes a self-addressed postage paid envelope and asks that clients complete and return it upon their earliest convenience. It is used to evaluate the client's perception of how helpful the intervention was. The client satisfaction survey is a pencil-paper questionnaire that is divided into three sections. The first section includes twelve yes/no questions with the option of commenting, that are focused on the direction of treatment and relationship

with the therapist. The second section asks the client to discuss difficulties addressed within the treatment. A list of difficulties is given and the client checks appropriate options. This section then asks that the client to comment on the helpfulness of the therapy in addressing the most difficult and most important issues. The third section includes two questions with a Likert scale (1-10) that measures the overall helpfulness of the therapist and services, along with additional comments.

The third instrument used was a follow-up questionnaire. The follow-up questionnaire is completed by the therapist at six months and one year after termination. Follow-up forms include any changes of treatment within the family, additional agency involvement's (past and present), and any other pertinent information (such as moving, children placed outside of the home, new schools, doctors, etc.).

Follow-ups are completed by calling the family, a home visit, or by a computer search at the Division of Family Services. However, sometimes this fails to yield results. The families report all changes with the exception of those families who cannot be located. As this is an agency-constructed instrument, there is no existing validity and reliability data. Reliability may be altered by experimenter effects, as different therapist within the agency fills out forms. Some families may be difficult to locate, and the information from the computer is vague. Practicum students contact some families when the therapist of a specific family is no longer employed by the agency.

Procedures

Procedures included gathering all completed files from 1998. Only those families whose files contained the initial referral form and follow-up information from six and twelve months were included in this study. These instruments were evaluated and compared in order to determine successfulness

of the program . Weaknesses would include that attrition may result due to incomplete files. Only 22.77% of the families had completed the client satisfaction survey, these were analyzed separately.

Chapter IV

Results

Results indicated that a total of 259 families with children at risk were referred for home-based services in 1998. Out of those families referred for services, 57 were assessed out, leaving a total number of 202 families served. Only those families who could be tracked at six and twelve months were used for this study, including 138 families total (272 at-risk children).

Findings indicated that at the six month follow up, approximately 84.9% of children were intact with their families and at twelve months after home-based services, approximately 80.5% of children were intact with their families. The tables below indicate the placements of children at the six and twelve month follow-ups.

Table 4.1

Follow-Up at Six Months

Outcome	Frequency	Percent
family intact	231	84.50%
unknown	2	0.70%
moved out	1	0.40%
relative care	4	1.50%
court ordered rel. care	5	1.80%
foster care	14	5.10%
residential	12	4.40%
juvenile detention	1	0.40%
other	2	0.70%
Total	272	

Table 4.2

Follow Up at Twelve Months

Outcome	Frequency	Percent
intact	219	80.50%
unknown	10	3.70%
moved out	7	2.60%
relative care	10	3.70%
court ordered rel. care	11	4%
foster care	10	3.70%
residential	2	0.70%
juvenile detention	1	0.40%
other	2	0.70%
Total	272	

The Client Satisfaction Surveys were collected and analyzed separately in order to determine the effectiveness of the program, difficulties addressed and how satisfied clients were regarding the services offered. The response rate was low, therefore attrition rate was very high. Findings from the surveys are considered biased due to less than 25% return rate. Over 86% of clients completed Section II, with only one person reporting that the services were not helpful. Included in Section II, the client was asked to discuss types of difficulties addressed. Clients reported an average mean of 7.6 difficulties addressed. Clients reported no distinction of satisfaction based on types or number of difficulties addressed.

Despite the variety of difficulties addressed, all clients were equally satisfied with the services. Based on the clients responses, over 80% of the families stated that parenting skills, problem solving and anger management were addressed during home-based interventions. Table 4.3 shows the distribution of the number of problems addressed during home-based

interventions. Table 4.4 indicates distribution of the types of difficulties addressed. Findings indicated that over 90% of those who completed Section II gave a rate of 90% on client satisfaction of home-based services. An analysis of the survey comments from Sections I and II indicates that overall, the clients reported a high level of satisfaction with the services provided. See Table 4.5 and Table 4.6 in Appendix C for a complete list of client satisfaction survey comments from Sections II and III.

Table 4.3

Comparison of Single and Multiple Problems Addressed

Number of Difficulties Addressed	Percent
1-2	10.80%
3-4	15.20%
5-6	23.90%
7-8	26%
9-10	13%
11-12	10.80%

Table 4.4

Types of Difficulties Addressed

Areas of Improvement	Percent
Alcohol/Drug Abuse	33%
Anger Management	80%
Budgeting	37%
Communication	34%
Couples Issues	28%
Housing, Utilities	37%
Medical/Mental Health	50%
Parenting	91%
Problem Solving Skills	80%
Safety	41%
School Issues	67%
Other	22%

Chapter V

Discussion

This study hypothesized that a six and twelve month follow-up of home-based services would reveal successful outcomes in that at-risk children would remain intact with their families. The study also hypothesized that client satisfaction surveys would indicate that clients were overall, very satisfied with home-based services.

Results from the study supported the first hypothesis at the six month follow-up, 84.5% of at-risk children treated remained intact with their families, and at the twelve month follow-up, 80.5% remained intact. However, this was based on the 138 families of the original 202 who could be located for the follow-up study. Hence, the high attrition rate make those findings a little suspect.

While data available supported the second hypothesis studied, however, as only 22.77% of surveys were returned the results remain inconclusive. Those surveys which were returned did indicate a high level of client satisfaction but the return rate was quite low and hence may reflect voluntary bias, as only those who were satisfied or had successful outcomes may have returned the survey. A major limitation of this study was that the client satisfaction surveys were mostly returned anonymous, therefore one could not predict whether or not satisfaction was based on child placement outcomes.

As stated in the literature review, success of home-based family therapy is measured by figures that indicate whether the services succeed at what it claims to accomplish - preventing out of home placements. Wells and Biegel (1991) reported that intensive home-based family services appear to be successful. They further stated that one must take into account that the most

accurate way of measuring success includes follow-up studies that focus on only those children who where at risk of out of home placement, as some families consist of both children at risk, and some who are not. They further state that because of careful client tracking and program evaluations, "findings from our projects contribute to the growing confidence and optimism characterizing intensive home-based family preservation programs" (p.24).

Another limitation of the study was the disappointing return of client satisfaction surveys. Surveys were predominately given to the client at the time of termination, along with a self-addressed stamped envelope. Clients were asked to fill out the questionnaire at their earliest convenience and to return it in the envelope provided. Some surveys were mailed to clients, along with a letter and self-addressed stamped envelope. Regardless to conveniences given to the client, a very small number of surveys were returned. The agency from which this study was produced, however, reports that the successfulness of the program is determined through the follow-up examination, not the client satisfaction surveys.

Unfortunately due to the high attrition rates, many families could not be contacted for the follow-up, so one needs to view the follow-up outcomes with caution. The study revealed types of families served, including the finding that over 58% of the children served came from homes that earn less than $15,000 per year. Further studies are recommended on the types of families served, and how to address the financial difficulty of those families who receive home-based services. Most families who are hurting financially are probably unable to focus on behavior and parenting difficulties, but more likely to need financial assistance (such as rental assistance, employment connections, problem solving skills, etc.).

Limitations of this study would include the low return rate of satisfaction surveys and the high attrition rate at the follow-up phase of the study. Agencies who value their client's level of satisfaction, and not just base their evaluation on placement outcomes, must increase their return rate by adding incentives or asking for the survey to be completed prior to the termination meeting and given a sealed envelope to return the survey to a designated person.

Overall, findings did indicate the successfulness of home-based services, as the program is designed to prevent out-of home placements of children at risk. However, future research must make concerted efforts in reducing attrition rate during follow-up studies by employing a more effective tracking system.

Appendix A

Follow Up Questionnaire

Family Name: Due Date:

Address/Phone: Case#

Children(s) Name/ DOB: Therapist:

Follow up at:

_____ 1 month _____ 6 months _____ 12 months

Contact was: _____ in person _____ by phone

1. Is the child residing in the home: _____ yes _____ no

If no, where?

How long? Date of placement: _____

Reason for placement:

2. Have there been any other placements? _____ yes _____ no

If yes, where?

How long? Date of Placement: _____

3. Are you still receiving services from.....

_____ _____ yes _____no

_____ _____ yes _____ no

Agency referred to _____ Contact Person_____

4. Are you receiving new services from other agencies?___ yes ___ no

If yes, where?

Type of services? Dates received?

Comments:

Appendix B

Client Satisfaction Survey

Section I

1. Did the therapist explain the program fully? yes no
Comment:

2. Did the therapist/specialist make it clear that the program was voluntary? yes no
Comment:

3. Were all family members who wished to participate included in the intervention? yes no
Comment:

4. Did the therapist/specialist encourage all family members to participate in setting goals and completing the family goals sheet? yes no
Comment:

5. Did your therapist/specialist treat you with respect? yes no
Comment:

6. Did your therapist/specialist listen and understand what you told him/her? yes no
Comment:

7. Did you feel that the therapist/specialist allow you to work at your own pace? yes no
Comment:

8. Did the therapist/specialist schedule appointment times that were convenient for you? yes no
Comment:

9. Did the therapist/specialist work with you sand your family to obtain the services your needed? yes no
Comment:

10. Did the therapist/specialist discuss options for aftercare with your family? yes no
Comment:

11. Would you recommend our program to a friend or family member? yes no
Comment:

12. Did you feel the co-pay amount was affordable for your family?
yes no
Comment:

Section II

Please check all items addressed during the intervention:
___ Alcohol/drug abuse
___ Anger management
___ Budgeting
___ Communication
___ Couples issues
___ Housing/utilities
___ 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")

1 2 3 4 5 6 7 8 9 10

2. On a scale of 1 to 10, please rate the services. (with 1 being "not helpful at all" and 10 being "very helpful")

1 2 3 4 5 6 7 8 9 10

Additional Comments:

Demographic Sheet

Family Composition: Single Two-Parent Blended

Number of Children 1 2 3 4 5 6 7 8 9 10+

Ages of Parent (s) Mother Father

Race: Caucasian Hispanic African American Asian Other

Socioeconomic Status (yearly): $ 0 - $5,000

$6,000 – $10,000

$11,000 – $20,000

$21,000 – $35,000

$36,000 – $50,000

$51,000 - $100,000 +

Difficulties Addressed: (see referral) 1 2 3 4 5 6 7 8 9 10

11 12 13 14 15 16 17 18 19 20

Aftercare: yes no

Appendix C

Table 4.5

Client Satisfaction Survey Section II B

Client Comments

"The most difficult area worked on included communication with my teenage daughter".

"Helping us see each person in our family as an individual was the most helpful".

"Cleaning my house was the most difficult area, and the most helpful. I knew is was unsafe for the children, but needed help".

"Finding housing for my family"

"Alcohol, and drug abuse issues were the most helpful, and difficult to admit"

"Problem solving and anger management".

"Parenting issues were most helpful"

"Parenting and budgeting were very needed within my home"

"Trying to get my son to attend school, finding out why he was afraid to go"

"Budgeting, how to spend my money more wisely"

"Communication is the key"

"Helping my daughter to respect me was the most helpful;, following through with consequences was the most difficult"

"I messages and learning how to communicate effectively"

"Learning the true meaning of listening, and how to actually listen to my children".

"Helping me through EMDR and how to cope with my past".

"Learning about ADHD and how to parent my children effectively"

"My daughter is mentally handicapped, the therapist helped me to deal with the stress of raising her"

"The most difficult thing to talk about was my past of sexual abuse. The therapist listened and helped my feel like a survivor".

"Coping skills were helpful".

"Learning how to be a single parent"

"Uncovering deep, hidden, stress factors was the most difficult, but the most helpful".

"Medical issues, a poor person has no legal support when it comes to court orders".

"Sorry to say, but none of the things worked that we tried, I have tried everything with my son and believe he is better off somewhere else"

Safety and couples issues were difficult to address , but very helpful".

Table 4.6

Client Satisfaction Survey Section III

Client Comments

"We loved our Therapist"

Another week or two would have been helpful, as making schedules and a daily agenda were on our list of things to do"

"Please call for comments"

"I really appreciate the extra effort I felt my Therapist put toward helping me and my family, he was very kind and considerate"

"I would like to thank each of you for participation in helping make my family more better and a loving family"

"I am pleased with the services"

"I think your program is great and I hope you have many people like the therapist that I worked with, thank you very much."

"The services were great, they helped me and my son a lot."

"I thank everyone for your help and understanding for me and my children to start over again to a new beginning"

"The services were very helpful, I would recommend to you all"

"My therapists were excellent, I have nothing but the best to say about the program , thank you for taking time to help us"

"I am really going to miss my therapist because he was very nice to me and it makes me feel sad to know that he will not be working with me anymore"

"I still feel like I need more help"

"Thanks for coming out and talking with us, Many people know the answers to their problems, it just helps to have a third party there to talk them

out. Having a neutral person listen and give their opinion and ideas is a great idea. I believe everyone needs counseling, not just bad people"

"Out therapist was there for us, most of all he was there to help me through some very difficult times, dealing with abuse and what happened with my family"

"The services were very helpful and professional"

"Helping me with Lawyer expenses was an absolutely timely and much appreciated"

"We think the program went very well, especially working with people like our therapist, she made the rough times bearable, thank you all and thank God for your services"

"I am very pleased with the help we received, the difficult issue now is to try and find counseling help later at the same caring and quality level"

"We will miss our therapist"

"My therapist was very compassionate, something we appear to lose in our professionalism"

"School issues, budgeting, tutoring services and medical attention are other areas that would have been helpful to my family"

"Some families need more time than six weeks"

"At the beginning, I didn't think that this was going to be helpful, but I was wrong. I have become a very different, calm, patient person. I would like to thank each and every one of you for a program such as this"

"I hope the next person that receives your help are happy with your services, I am and I think you guys do a good job"

"I have written a letter to the executive director expressing my deepest gratitude"

"My daughter is still unwilling to follow the house rules"

"Out therapist was a God-sent to our family, we probably would have gotten a divorce without the services"

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