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National Family
Preservation Network
Safe children. Strong families.

IFPS ToolKit

*A comprehensive guide for establishing & strengthening
Intensive Family Preservation Services*

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Introduction

The year 2009 marks the 35th anniversary of the first Intensive Family Preservation Services (IFPS) program. Within two decades, IFPS programs were operating in 35 states with most of them following the original model known as HOMEBUILDERS®.

The National Family Preservation Network (NFPN) was established in 1992 as the primary national voice for the preservation of families. With funding from the Edna McConnell Clark and Annie E. Casey Foundations, NFPN was equipped to provide the training and technical assistance necessary to implement quality IFPS programs nationwide. In support of NFPN's efforts the Clark Foundation published an information packet on IFPS in 1994. NFPN updated the IFPS packet in 2003 and posted an electronic version. While both of these packets still contain useful information, in the past six years there has been an explosion of knowledge about IFPS as evidenced by the creation of a new assessment tool that pinpoints the effectiveness of services, new research that emphasizes model fidelity and demonstrates the effectiveness of IFPS with a broad variety of families and problems, establishment of new IFPS programs and the strengthening/expansion of existing programs, and additional proof of the outstanding safety record and cost-effectiveness of IFPS.

In order to share the most recent knowledge about IFPS, NFPN held an IFPS Summit in October, 2008. Public child welfare agencies identified as having a statewide IFPS program were invited to attend and 16 of the 20 invited states sent a representative. Two other states wishing to establish an IFPS program also sent representatives. As the Summit participants discussed new information and research about IFPS, it became apparent that a new publication would be needed to capture and disseminate these findings.

Thus, NFPN has produced and is now offering the IFPS ToolKit as a comprehensive resource guide for the development and maintenance of strong and effective IFPS services. The ToolKit includes definitions, history, benefits, standards, performance measures, federal funding sources, payment structure for contractors, latest research, step-down services, evaluation measures, success stories, and resources for IFPS. There is also information on IFPS as it applies to reunification services, including a proposed model for Intensive Family Reunification Services (IFRS).

It is NFPN's desire that the IFPS ToolKit be widely disseminated and used to develop high quality IFPS programs. Please let us know if we can be of assistance to your agency.

What are Intensive Family Preservation Services (IFPS)?

Intensive Family Preservation Services (IFPS) are concentrated, in-home services designed to prevent unnecessary out-of-home placement of children. Families are referred at the point where an out-of-home placement is imminent. Referrals may come from a variety of child and family-serving systems including child welfare, mental health, juvenile justice, and developmental disabilities. In home contact with families occurs within 24 hours of referral. IFPS therapists receive special training to provide 8–10 hours of services per week to families which include a mix of counseling, teaching skills, and help with basic needs. Therapists serve only a few families at a time and are available 24 hours a day, seven days a week. Services are provided for 4–6 weeks.

It is important to state that IFPS is a model of service, not a philosophy to preserve families at all costs. If children cannot be safely maintained at home, then removal is in their best interest. On the other hand, IFPS is not appropriate for families whose children are *not* at high risk of removal. There are less intensive service models that can provide support to these families. IFPS is reserved for families facing imminent placement of a child.

Please note that the professional who provides IFPS services to a family is referred to as a “therapist” throughout the ToolKit in order to differentiate this person from others who also work with the family. As used here, the therapist is expected to have a college degree in social work or a related field and specialized training in IFPS. Individual states determine whether or not a therapist must be licensed.

History of IFPS

An identifiable system of child welfare in the United States may be traced to the mid-1800s when the Children’s Aid Society in New York began shipping trainloads of homeless and destitute children to Midwest rural homes. The roots of family preservation can be traced to the first White House Conference on Dependent Children in 1909 when the policy was explicitly stated that children should be kept with their parents whenever possible and the family provided with the necessary aid to maintain children in suitable homes. This policy was summed up by the Children’s Aid Society in 1923 in an annual report stating that every social agency should be a “homebuilder” and not a “homebreaker.” Nevertheless, it would be 50 years before a systematic family preservation program would be established. In the intervening years, children who were abused and neglected were typically placed in foster or residential care and grew up in out-of-home placement.

In 1974 a model of Intensive Family Preservation Services (IFPS) was established through the HOMEBUILDERS® program in Washington State. Its goal was to strengthen families and prevent unnecessary out-of-home placement. The federal government provided impetus for nationwide replication of IFPS through the Adoption Assistance and Child Welfare Act of 1980. This act required states to provide *reasonable efforts* to prevent or eliminate the removal of children from their homes or make it possible for them to return home. Family preservation services were listed as an essential component of satisfying the reasonable efforts requirement.

The private sector then stepped up to provide key funding for IFPS. In 1986 the Edna McConnell Clark Foundation awarded \$3.3 million for development of model programs, training and technical assistance, and capacity building. In 1992, the Clark Foundation funded 7 existing organizations to promote IFPS. Both the Clark Foundation and the Annie E. Casey Foundation provided funding to establish a new organization, the National Family Preservation Network (NFPN). NFPN is the only national organization whose mission is to serve as the primary national voice for the preservation of families.

IFPS reached its pinnacle in 1993 when IFPS programs existed in 35 states. That was also the year that federal funding first became directly available for IFPS through the Family Preservation and Support Act, later changed to the Promoting Safe and Stable Families Program. By 1994 the Clark Foundation had turned its attention to a new agenda: reform of the child protection system. The Casey Foundation has continued to provide funding for IFPS through various initiatives.

In 1988 HOMEBUILDERS® began an IFPS program in the Bronx. Although many of the parents receiving IFPS were involved with crack cocaine, 88% of the Bronx families remained together three months following intervention. Here's one of the success stories:

The house had no front door. There were bullet holes in the walls. Neighbors gathered on the porch, a sentry at the door; drug traffic was heavy. The only furniture in the small two-story house was a potty seat for the toddler and a run-down couch. There were no beds, no chairs, no appliances. The family preservation therapist came daily to work with the mother and make sure the children were safe and fed. At first the mother didn't want to get up from the floor where she slept. By the second week, she was waiting on the porch for the therapist. Together they found another house. The mother moved, taking her children with her. She left the father of her four daughters; he remained on drugs. She completed a drug treatment program and is getting her GED. Now she says that if the therapist hadn't arrived, she would not have survived.

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What are the Benefits of IFPS?

Better Outcomes for Children

Because IFPS prevents unnecessary out-of-home placement, it's important to first look at what happens when children are removed from their family:

- Children in foster care spend an average of more than two years away from their homes.
- A child is twice as likely to die from abuse in foster care than in his own home.
- Maltreated children placed out-of-home exhibit significant behavior problems in comparison to maltreated children who remain in their homes.
- Maltreated children removed from their homes later experience higher delinquency rates, teen birth rates, and lower earnings than children who remain in their homes.
- Children placed in foster care have 2–3 times higher arrest, conviction, and imprisonment rates as adults than maltreated children who remain in their own homes.
- Post-Traumatic Stress Disorder strikes one in four foster youth after leaving foster care. That is double the PTSD rates of veterans returning from Iraq and over 6 times the rate among the general U.S population.
- In studies that spanned four states, one out of every three youth who aged out of foster care struggled with mental health problems such as major depression, substance abuse, social phobia and anxiety. Almost one quarter of such youth in Texas had a history of suicide attempts.
- Former foster youth are at high risk for a range of other health problems including generally compromised health, substance abuse, sexual risk-taking behaviors, physical and sexual abuse and malnourishment.

With appropriate targeting, IFPS diverts 80–90+ percent of children from out-of-home placement, but it is estimated that states provide IFPS to fewer than 1 in 10 children placed in foster care. Extensive media coverage of deaths of abused and neglected children may result in child welfare caseworkers removing more children from their homes. In turn, caseloads increase, workers are overloaded, and the tragic consequence is more child deaths. Only about half of the children in foster care return home each year. Approximately 50,000 children are adopted each year but at least twice that many are waiting for adoptive homes. Some of these children will grow up in foster care. No state has been able to effectively address child abuse and neglect by focusing primarily on out-of-home placement and adoption. States with effective child welfare systems focus on reducing the number of children entering out-of-home care. IFPS is strategically positioned to assist in this effort and would have far greater impact if every state were to establish or strengthen and expand these services.

Safety

In over three decades of IFPS nationwide with thousands of families served, there has been less than a handful of child deaths that can be directly linked to IFPS, either during or after the intervention. Recent research indicates that safety is the strongest area when families are assessed following an IFPS intervention.

To what can this strong safety record of IFPS be attributed?

- The safety of the child is the highest priority.
- IFPS therapists respond immediately to family crises. Workers generally see families within 24 hours of referral.
- IFPS therapists meet with families in the home which allows for a more thorough assessment and opportunities for effective intervention.
- IFPS therapists see families frequently, sometimes for hours at a time in order to provide a quick response to emergencies and to teach skills during a crisis when families are most willing to learn new behaviors. Workers are available 24/7 and carry only a few cases at a time in order to be readily available.
- Prior to terminating the intervention, IFPS therapists connect families with other community services to reinforce gains. Families are not abandoned at the end of the IFPS intervention.
- Therapist training, supervision, and ongoing monitoring and quality assurance provide additional measures to ensure the safety of families.

Improvement in Family Functioning

The North Carolina Family Assessment Scale is an assessment tool used in conjunction with IFPS services. The tool measures family functioning at intake and at case closure. Research indicates that most families show improved functioning in all areas that the tool measures: environment, parental capabilities, family interactions, safety, and child well-being. Only 6–9% of families deteriorate in functioning following an IFPS intervention. With those families, the assessment at case closure may result in out-of-home placement for the child. Although placement is not prevented, the safety of the child is ensured, and that is the top priority.

Cost Savings

Far more federal, state, and local funds are spent on out-of-home care and services than are spent on in-home services. For example, Child Trends reports that states spent at least \$4 billion in federal Title IV-E funds on foster care in FY 2006. In contrast, states spent \$363 million in Title IV-B funds (Subpart 2—Promoting Safe and Stable Families) on family preservation and support as well as time limited reunification and adoption promotion. While there are other sources of funding for both foster care and in-home services, the overall ratio is about ten dollars of out-of-home care funding (entitlement) for each dollar of in-home funding (capped).

The financial incentive to increase funding for IFPS is that for each child who receives in-home services and safely remains at home rather than entering out-of-home placement, there can be substantial savings. The Washington State Institute for Public Policy (WSIPP) found that

Intensive Family Preservation Services programs adhering to the HOMEBUILDERS® model are very cost-effective. WSIPP calculated \$2.54 of benefits for each dollar of cost due to reduced out-of-home placements and lowered incidence of abuse and neglect.

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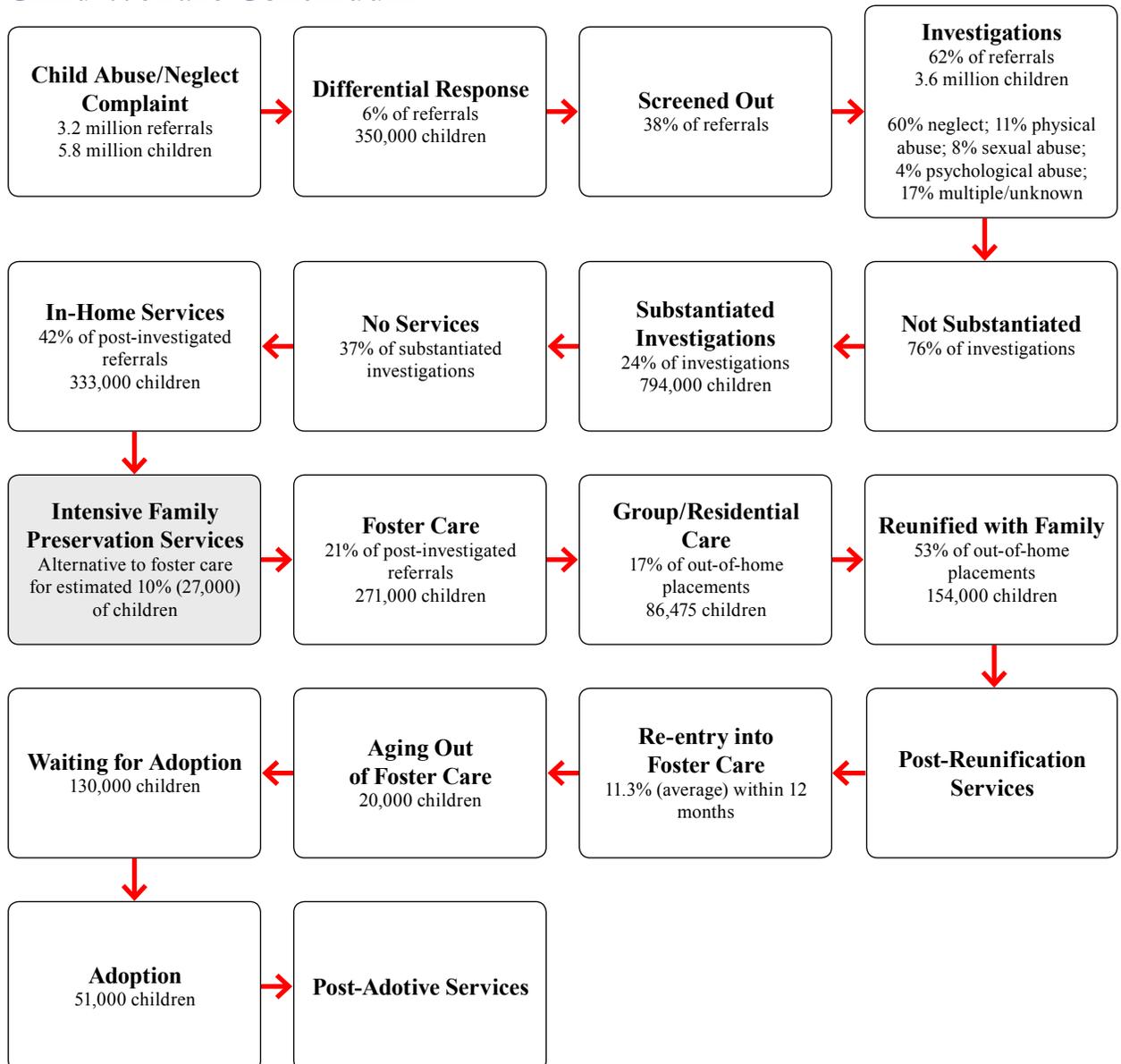
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Where does IFPS fit into the Continuum of Services?

Intensive Family Preservation Services are sometimes categorized as prevention services because IFPS prevents out-of-home placements. However, IFPS is more appropriately categorized as a tertiary prevention service in the sense that it is a final effort to avert out-of-home placement. It is helpful to see where IFPS fits into a system of services—the chart below portrays the place of IFPS in the Child Welfare System Continuum of Services:

Child Welfare Continuum



Sources

Child and Family Services Review, First Round; AFCARS Report, fiscal year 2006; AFCARS Report, fiscal year 2007; Child Maltreatment 2007; U.S. Department of Health and Human Services, Administration on Children, Youth, and Families

Essential Components of IFPS

There are two types of essential components for IFPS: Program and Intervention.

IFPS Program Components

□ Focus on a Specific Target Population

The primary goal of IFPS is to serve as an alternative to the unnecessary placement of children into foster, group, or institutional care. The program serves *only* those families whose children are in imminent danger of placement or cannot return home without intensive services.

□ Twenty-Four Hour Availability for Intake

The IFPS program is available to receive referrals 24 hours a day, seven days a week.

□ Immediate Response to Referral

IFPS therapists meet with each client family within 24 hours of referral unless the family is unable to meet.

□ Services Provided in the Natural Environment

IFPS services are delivered in clients' homes and other settings in their day-to-day life. Although the bulk of interventions occur in the clients' homes, therapists go where the problems are occurring.

In-home services can be inconvenient for therapists and increase service delivery costs. These factors are more than offset by the benefits of serving clients in their own environment.

It is possible to reach much more seriously troubled clients by seeing them in their own home. Many families are too disorganized to schedule and transport themselves to office visits. Cancellations and dropouts are very rare if services are brought to the client. In-home interventions also increase the likelihood that all family members will participate in the counseling.

In-home services allow IFPS therapists to make more accurate assessments and more useful treatment plans because they see processes in action. They observe family members using new behaviors, revise plans as needed, and provide support until clients experience success. In-home services also increase a therapist's credibility. Clients know that the therapist has directly witnessed the family's problems instead of just hearing about them and possibly making incorrect assumptions about what happens.

Generalization of learning is greatly facilitated when services are provided in the natural environment of the client. Ultimately, families need to be able to use new skills at home. If they learn them in the office, it is often difficult to carry the knowledge to their home life.

Finally, family members appreciate in-home services. It is more convenient for them, and many say it helps alleviate their embarrassment at having to receive services.

❑ **Intensive Services**

IFPS is an intensive service, with caseloads averaging only two families at a time. Hours of contact with family members are allocated according to the needs of the family. Total time per family usually varies between eight and ten hours per week, about half of which is face to face and telephone contact with the family members. Service intensity is often greatest during the first week.

The intensity of IFPS allows IFPS therapists to serve very high-risk families, who may need frequent contact to ensure child safety. High intensity also facilitates rapid change in families. It creates the capacity for a timely, comprehensive response to severe family problems. It allows the time to provide a range of psycho-educational interventions as well as help provide “hard services” to meet basic needs of the family. With low caseloads, therapists are able to be flexible about the length of client sessions and take advantage of times when the family is most open to change.

❑ **Time Limited Services**

IFPS is time-limited, averaging four to six weeks, with the option of service extension if the risk of placement is still high and it is likely further service will lower that risk.

Four to six weeks seems like a very short time. It is important to remember that up to 40 hours or more of face-to-face services are delivered in this time. Although therapists, clients, and referring workers often express a wish for a longer time frame, success at averting placement does not appear to be influenced by the length of the intervention. Informal data indicate that if a family has not been able to profit from four to six weeks of intervention, it is unlikely their situation will improve with additional intensive services

There are advantages to an intensive, short-term intervention. Paramount is the expectation that change can occur rapidly. The IFPS therapist discusses the service time frame with the family. The expectation that change can occur rapidly is positive for clients, and helps motivate them to participate in services.

The brief time frame also helps keep the therapist and clients focused on the service goals and on what interventions are or are not working. Furthermore, when everyone knows there is a defined time period, it is more likely that they will use the time productively.

The four to six week intervention period should be considered a guideline, not an absolute limit. It is important to recognize that some families need more time and some need less. This guideline must always remain secondary to the basic goal of helping families avoid placement by learning new skills to cope with their problems.

❑ **Twenty-Four Hour a Day Availability to Clients**

IFPS therapists ask family members to contact them whenever a crisis occurs, or whenever the therapist could be most helpful. Therapists are available to their clients 24 hours a day, seven days a week. Family members can contact their therapist by telephone or pager. When a family’s therapist is not available, another therapist or a supervisor immediately responds to the family’s needs.

❑ **Use of a Single Therapist with Team Back-Up**

IFPS services are provided to client families by a single therapist. Utilizing a single therapist, rather than a team approach as is used in some service models, creates a stronger relationship with the family and enhances therapist accountability. In rare circumstances, a supervisor or second therapist may also assist the family.

❑ **Accountability**

The IFPS program routinely utilizes a variety of methods to ensure it is accountable. Placement prevention rates are tracked. Data are collected on adherence to all aspects of the program model. Clients and referring agents are asked to give written feedback about their satisfaction with services.

❑ **Training and Quality Assurance**

IFPS therapists ideally have a master's degree in social work or counseling. The alternative is a bachelor's degree in a related field with two years of experience working with families.

Specialized IFPS training and ongoing quality assurance processes are utilized. The minimum recommended training on IFPS for clinical staff includes 5 days initial training, and 6–8 days of advanced training. Program supervisors and managers receive an additional 7 days of specialized supervisory training. The recommended ratio of supervisors to staff should not exceed 1:6. Program replication and quality assurance activities include quarterly 2–3 day site visits, file reviews, and weekly or bi-weekly telephone consultation during the initial years of implementation.

IFPS Intervention Components

❑ **Flexible Scheduling**

IFPS therapists have a flexible schedule, serving only two families at a time, which allows them to give clients as much time as needed, when they need it. Intake visits may be several hours in duration; therapists stay long enough to be sure clients are calm and safety plans are in place. After the initial visit, appointments are scheduled as often as needed, at times most convenient to the client, including weekends, evenings and holidays. Making services available at the convenience of clients also increases the chances that all family members will participate in the intervention.

❑ **Individually Tailored Services**

In addition to flexibility in scheduling and length of sessions, IFPS programs offer flexible service packages, individually tailored to the needs of each family. Clients may need help with parenting skills, communications skills, self-control, problem solving, depression, drug or alcohol use, and other life skills. They may request help in meeting such basic needs as food, clothing or shelter. They may work on building a social support network or relating to school or other social service personnel. Therapists are expected to have a wide array of treatment options and approaches available to them.

In some family preservation models, paraprofessionals rather than professionals are used to help families meet their hard service needs. In IFPS, the therapist is responsible for addressing all the needs of the family. Providing hard services, such as helping clean an apartment or driving a client to the grocery store, is a powerful way to engage clients. Clients are grateful for the help, and are often the most willing to share information when they are involved in doing concrete tasks with their therapist.

□ **Engagement and Motivation**

The IFPS therapist takes responsibility for engaging clients and helping them increase their motivation for change. Therapists use a collaborative approach to treatment. Engagement strategies include Reflective Listening, Motivational Interviewing, showing respect, acting as a guest in the family's home, meeting individually with family members as well as the family as a group, and meeting at times and places convenient to the family.

□ **Assessment and Goal Setting**

Workers conduct a client-directed assessment across the family's life domains, including safety assessment and safety planning, domestic violence assessment, suicide assessment, and crisis planning. Behaviorally specific and measurable goals and outcomes are developed and evaluated with the family.

□ **Behavior Change**

Perhaps the most critical aspect of the IFPS intervention is the use of cognitive and behavioral research-based practices. Therapists directly employ these practices with family members, and also teach members how to use these strategies. These practices include:

- Motivational Interviewing,
- Cognitive Behavior Therapy (CBT),
- Rational Emotive Behavior Therapy (REBT),
- Relapse Prevention, and
- Harm Reduction Strategies,

Teaching families new skills lies at the heart of the intervention, as this empowers family members and allows them to continue to improve their family functioning after IFPS has ended:

- The most common skills taught include parenting, communication, assertiveness, bargaining and negotiation, anger management, depression management, time management, and household management.
- Therapists follow specific protocols for teaching skills including presentation of the skill to be learned, modeling, behavioral rehearsal, corrective feedback, coaching, praise, and encouragement, and generalization/maintenance training.
- Therapists break new skills into small steps to simplify the change process and help family members experience success.

- Therapists recognize and take advantage of unplanned opportunities (i.e., “teachable moments”) to use or teach behavior change strategies with family members.
- Therapists provide written materials to reinforce rationales and discussion regarding skills introduced during sessions, and assign homework and encourage frequent practice of new skills so family members have many opportunities to strengthen and integrate behavior changes.

❑ **Skills Development**

Therapists teach family members a wide variety of “life skills” including: parenting, decision-making, mood control and self-management, relapse prevention, resisting peer pressure, interpersonal relations, developing daily routines, and household management. Teaching methods include provision of educational materials, coaching, practice, feedback, and homework.

Social services should make clients strong instead of dependent. Helping clients learn new life skills empowers them. Even when helping clients meet their basic needs, the goal is to teach them to access what they need for themselves.

❑ **Personal Scientist Approach**

Therapists and families are taught to behave as personal scientists. Scientists gather data, conduct experiments, analyze the outcomes of the experiments and conduct more experiments. The family and therapist assess family strengths and problems, (gather data), design and implement change strategies (experiment), evaluate the effectiveness of the change strategies, (evaluate outcomes) and modify the intervention (conduct more experiments). There is as much to learn from failures as from successes.

❑ **Concrete and Advocacy Services**

The IFPS therapist provides and/or helps the family access concrete goods and services that are directly related to achieving the family’s goals, while teaching them to meet these needs on their own. Flexible funding is available for concrete needs.

❑ **Community Coordination and Interactions**

Client families often experience difficulty interacting with others in the community. IFPS therapists coordinate and advocate with other service and support systems including schools, health and mental health providers, juvenile justice, and other social service organizations. At the same time, therapists are teaching family members how to advocate and access these services and supports for themselves.

Source

Institute for Family Development

Performance Measures for Essential Components

The following chart lists the Program and Intervention Components as standards and provides a performance measure for each. The chart is based on the *HOMEBUILDERS*® model of IFPS and is used by permission of the Institute for Family Development.

Program Structure Standards (*HOMEBUILDERS*® Fidelity Measures—Abridged)

<i>Indicators</i>	<i>Performance Measures</i>
Standard: Specific Target Population	
Families referred for <i>HOMEBUILDERS</i> ® services have one or more children at imminent risk of placement OR in need of reunification that will not occur without intensive services in place.	<ul style="list-style-type: none"> • 90% of accepted referrals meet eligibility criteria.
Standard: Values-Based Orientation	
The therapist is behaviorally descriptive, uses value-neutral language, and avoids the use of labels and inference when communicating with or about family members.	<ul style="list-style-type: none"> • Therapists use behaviorally specific, value neutral language in all communication. • Therapists avoid the use of labels and inferences.
Standard: Immediate Availability and Response to Referrals	
Referrals are made and accepted 24 hours a day, 7 days a week.	<ul style="list-style-type: none"> • Provider agency makes at least 20% of all openings available to after-hours referents.
Therapists meet with families within 24 hours of referral.	<ul style="list-style-type: none"> • 75% of families receive their first face-to-face visit within 24 hours of referral from DCFS; 85% of families receive their first face-to-face visit no later than the end of the day after the referral.
Standard: Twenty-Four Hour Availability	
Therapists, supervisors and other team members are available and accessible to families 24 hours a day, seven days a week.	<ul style="list-style-type: none"> • Provider agency policies specifically allow a flexible work schedule, with work hours varying from week to week based on the needs of families. • 100% of clients have information about 24-hour availability and how to access therapist. • On the <i>HOMEBUILDERS</i>® <i>Client Feedback Survey</i>, 95% of family members answer “Yes” to the question: “Was your therapist available and responsive to you?”

<i>Indicators</i>	<i>Performance Measures</i>
Standard: Services Provided in the Family's Natural Environment	
Sessions primarily occur in the family's home or natural environment.	<ul style="list-style-type: none"> • 95% of sessions occur in the home or natural environment.
Standard: Service Intensity and Caseload	
Therapists typically work with 2 families at a time; periodically therapists may work with 1 or 3 families for a short period of time.	<ul style="list-style-type: none"> • Full-time (1.0 FTE) therapists serve 18–19 families per year.
Therapists typically meet with each family 3–5 times per week, and provide 40 or more hours of face-to-face service.	<ul style="list-style-type: none"> • 95% of families meet with their therapist at least 3 times per week. • 85% of families receive at least 40 hours of face-to-face service per intervention.
Standard: Brevity of Services	
Therapists typically provide services for 4 weeks. Services may be extended up to 6 weeks when an extension will substantially decrease the chance of placement.	<ul style="list-style-type: none"> • 95% of all interventions close by the end of 6 weeks.
Standard: Single Therapist Operating within a Team	
Each family receives services from a single therapist.	<ul style="list-style-type: none"> • 95% of all client visits are made by a single therapist (not including training or quality assurance activities).
Therapists and supervisors meet HOMEBUILDERS® employment criteria.	<ul style="list-style-type: none"> • 100% of therapists are assigned full-time (1.0 FTE) or half-time (0.50 FTE) to the HOMEBUILDERS® program.
Standard: Supervision and Consultation	
Supervisors are available to therapists 24/7 for clinical supervision.	<ul style="list-style-type: none"> • 100% of therapists are satisfied that the supervisor or designated back-up is available when needed.
Team consultation occurs at least weekly.	<ul style="list-style-type: none"> • In-person team consultation meetings occur at least once per week, at least 48 weeks per year. • When therapists miss regularly scheduled team consultation meetings, 100% of absences are for excused reasons (e.g., vacation, sick, client crises).

<i>Indicators</i>	<i>Performance Measures</i>
Therapists receive at least weekly consultation regarding client families.	<ul style="list-style-type: none"> • 100% of open interventions are staffed weekly; staffings preferably occur during team consultation.
Supervisors routinely accompany therapists on home visits.	<ul style="list-style-type: none"> • Supervisors accompany each therapist at least quarterly for therapists with fewer than 2 years HOMEBUILDERS® experience, and at least semi-annually for therapists with more than 2 years HOMEBUILDERS® experience.
Standard: Ongoing Quality Enhancement	
Supervisors provide on-the-job training to new therapists.	<ul style="list-style-type: none"> • Therapists shadow the supervisor or experienced therapists on at least one complete intervention. • Supervisors accompany 100% of new therapists on at least 80% of client sessions during the first intervention assigned to the therapist.
Supervisors have ongoing client contact.	<ul style="list-style-type: none"> • Supervisors without prior HOMEBUILDERS® experience complete 6 full interventions during their first year.
Program complies with QUEST requirements.	<ul style="list-style-type: none"> • 100% of therapists, supervisors and program managers participate in all required HOMEBUILDERS® training and consultation activities.
HOMEBUILDERS® services reduce the likelihood of out-of-home placement.	<ul style="list-style-type: none"> • At least 70% of children referred for HOMEBUILDERS® successfully avoid out-of-home placement 6 months following closure of intensive services.
Families show improvement in family functioning.	<ul style="list-style-type: none"> • At least 85% of families show progress on goal attainment ratings for at least one goal at service closure.
Provider agency gathers feedback regarding services from family members and referents.	<ul style="list-style-type: none"> • 100% of referents are given a <i>HOMEBUILDERS® Referent Feedback Survey</i> following service closure. • 100% of families are given a <i>HOMEBUILDERS® Client Feedback Survey</i> following service closure.

Intervention Activity Standards (HOMEBUILDERS® Fidelity Measures)

<i>Indicators</i>	<i>Performance Measures</i>
Standard: Promoting Safety	
<p>When safety concerns are identified, family safety is increased during the intervention.</p>	<ul style="list-style-type: none"> • The NCFAS domain(s) identified as the highest priority (when related to safety) have an improved rating at termination in at least 80% of interventions. • On the <i>HOMEBUILDERS® Referent Feedback Survey</i>, therapists receive an average rating of 4.0 or higher (5 point scale) on the question: “How satisfied were you that the therapist adequately addressed safety issues?” • When a serious, immediate safety concern exists (e.g., self-harm, child abuse or neglect, physical violence between family members) an effective safety plan is always developed with family members.
Standard: Individually Tailored Services	
<p>Therapists provide services that are individually tailored to each family’s needs, goals, values, culture, circumstances, learning styles and abilities.</p>	<ul style="list-style-type: none"> • Goals and activities vary from family to family. • On the <i>HOMEBUILDERS® Client Feedback Survey</i>, therapists receive an average rating of 4.0 or higher (5 point scale) on the question: “How satisfied were you that your therapist was respectful of your family’s culture and values.”
<p>Scheduling and length of sessions vary to match the needs of the family and to ensure the therapist is available at times when problems are likely to occur.</p>	<ul style="list-style-type: none"> • Each intervention includes sessions at a variety of days and times, including evenings, weekdays, weekends and holidays. • Session length varies throughout each intervention.

<i>Indicators</i>	<i>Performance Measures</i>
Standard: Engagement and Motivation Enhancement	
Therapists engage with family members.	<ul style="list-style-type: none"> • 85% of families have no more than 2 missed or no-show appointments throughout the intervention (excluding serious illness or other unavoidable emergency situations). • On the <i>HOMEBUILDERS® Client Feedback Survey</i>, therapists receive an average rating of 4.0 or higher (5 point scale) on the question: “How satisfied were you that your therapist listened to you and understood your situation?”
Standard: Comprehensive Assessment	
The therapist completes a comprehensive assessment.	<ul style="list-style-type: none"> • Every family assessment includes information about family strengths, values, skills, problems, needs, and barriers to goal attainment.
Standard: Goal Setting and Service Planning	
Service plans focus on goals related to the danger of placement or barriers to successful reunification, and on goals that can be realistically accomplished during the intervention.	<ul style="list-style-type: none"> • On the <i>HOMEBUILDERS® Referent Feedback Survey</i>, therapists receive an average rating of 4.0 or higher (5 point scale) on the question: “How satisfied were you that the goals were appropriate for this family and addressed the concerns you identified in the referral?” • The <i>HOMEBUILDERS® Service Plan</i> addresses the prioritized problems and barriers identified in the <i>HOMEBUILDERS® Family Assessment</i>. • Indicators of goal achievement are specific, measurable, action-oriented, and reasonable. • Clinical strategies included in the <i>HOMEBUILDERS® Service Plan</i> have been shown to have an impact on the targeted behavior.

<i>Indicators</i>	<i>Performance Measures</i>
Standard: Cognitive and Behavioral Approach	
The therapist applies cognitive and behavioral principles and research-based strategies to facilitate behavior change.	<ul style="list-style-type: none"> • Therapists use research-based behavioral strategies with all families to increase and/or decrease behavior. • Therapists use research-based cognitive strategies with all families to effect change.
Standard: Teaching and Skill Development	
The therapist approaches problems in terms of skill excesses and deficits.	<ul style="list-style-type: none"> • When discussing family problems, the therapist frames them in terms of skill excesses and deficits.
Therapists use a variety of teaching methods.	<ul style="list-style-type: none"> • Therapists utilize direct and indirect teaching methods with all families. • Therapists assign homework and encourage frequent practice of new skills.
Family members acquire needed skills during the HOMEBUILDERS® intervention.	<ul style="list-style-type: none"> • On the <i>HOMEBUILDERS® Client Feedback Survey</i>, at least 85% of families report they utilize new skills as a result of the HOMEBUILDERS® intervention.
Standard: Provision of Concrete Services	
Families receive items, supports and services needed to reduce the likelihood of placement.	<ul style="list-style-type: none"> • Therapists help family members identify and access items, supports and services needed to reduce the likelihood of placement.
Standard: Collaboration and Advocacy	
Therapist maintains frequent communication with the referent.	<ul style="list-style-type: none"> • On the <i>HOMEBUILDERS® Referent Feedback Survey</i>, 85% of referents answer Yes to the question: “Did you have adequate contact with the therapist?”
Therapist collaborates and advocates with others in the family’s social support network.	<ul style="list-style-type: none"> • When appropriate, therapists consult and advocate with other service providers and members of the family’s support network to help family members meet their goals.

<i>Indicators</i>	<i>Performance Measures</i>
Standard: Transition and Service Closure	
Prior to conclusion of services, the therapist and family members assess goal attainment, plan for the maintenance of progress, and collaborate with the referent to address ongoing service needs.	<ul style="list-style-type: none"> • The therapist completes goal attainment ratings for each intervention. • At least 80% of families rate their goal attainment. • The therapist develops a plan with at least 80% of families for maintaining intervention progress.
Families have access to limited post-intervention contact with their therapist.	<ul style="list-style-type: none"> • 100% of families are informed of the availability and process for accessing post-intervention booster sessions.

Source

Institute for Family Development

Request for Proposal for IFPS

Many public agencies contract out some or all IFPS. In order to contract out services, public agencies must first issue a Request for Proposal (RFP). A comprehensive RFP helps assure quality IFPS services by fully informing potential bidders of program and administrative requirements, and by providing the public agency with detailed information about the capacity of the bidder to implement IFPS. The RFP should, at a minimum, address the following:

- Goals and Objectives
- Targeting/Screening and Referral Processes
- 24/7 availability and Caseload
- Family Assessment Process and Tools
- Service Planning and Goal Setting
- Services to be Provided including Clinical and Concrete
- Service Duration and Termination of Services
- Therapist Qualifications
- Supervisor Qualifications and Responsibilities
- Back-Up Services
- Training Requirements
- Data Collection and Reporting Requirements
- Quality Assurance Requirements
- Obligations of the Public Agency
- Payment Structure (See Also: *Payment Structure for IFPS*)

To view a sample RFP for IFPS provided by the State of Missouri, visit:
<http://www.nfpn.org/articles-mainmenu-34/122-missouri-rfp-for-ifps.html>

Payment Structure for IFPS Contracts

There are three basic methods of funding that public agencies typically use for IFPS contracts:

- Capacity or grant funding, which pays the contractor a flat amount per year, based on expectations about the approximate number of families to be served and the estimated cost to maintain the required number of staff. This is the method that has funded almost all clinical trials that have established evidence-based programs. This is also the method originally used in all states attempting to replicate HOMEBUILDERS®. In general, capacity funding insulates the provider from financial concerns related to adequate referrals, leaving them more likely to focus on model adherence.
- Cost funding, which reimburses the contractor for actual expenses. While similar to capacity funding, this method can result in financial problems if providers do not have fairly sophisticated budgeting and accounting procedures or if the public agency definition of allowable costs is too restrictive.
- Fee for service funding, which pays the contractor only when client services are delivered. If referrals are steady and adequate, fee for service payment systems can be used without negatively impacting programs. However, if referrals are not adequate, as is often the case especially during program start up, a fee for service payment structure will lead to site failure. Fee for service funding systems also do not typically cover the initial costs related to the training and consultation requirements of site start up.

Possible Consequences of Fee for Service Funding

Lack of adequate referrals is a common problem in implementation of any new program. Without adequate referrals, two possible consequences of fee for service funding are:

- Contracting agencies will not be able to cover their costs, which will cause them to withdraw from the contract if those losses become unsustainable. Turnover in providers is expensive for the public agency and decreases program quality. It is important to note that small organizations, which cannot sustain even limited losses, will be the least able to continue to deliver the service.
- Contracting agencies may begin to have workers provide revenue producing services through other contracts. They will feel compelled to fill the worker's time, although they know this is contrary to IFPS model standards. Other work commitments may cause the worker to be unavailable when IFPS referrals do occur. Other work commitments are also likely to negatively impact program quality including standards related to flexibility and 24 hour availability.

Funding Recommendations

It is recommended that public agencies implement IFPS using a capacity/grant or cost funding system until there is evidence that adequate referrals are maintained. Once the referral system has demonstrated its ability to consistently generate the appropriate number of referrals, and as

long as this remains the case, fee for service funding can be used. While funding mechanisms and rates vary from state to state, the 2008 payment reimbursement level for high quality IFPS programs is about \$6,000 per family.

As with any funding system, it is important to have procedures in place to ensure that adequate referrals are made, that providers do not turn down referrals inappropriately, and that the expected amount of service is provided. Such procedures include:

- Public agency monitoring of the number and appropriateness of referrals, and intervention when any problems occur
- Public agency monitoring of provider agency client contact hours, caseload size, intensity and duration of services, and other data related to the standards.

Source

Institute for Family Development

Federal Funding Sources for IFPS

For purposes of federal funding eligibility, Intensive Family Preservation Services are defined as specialized services that provide short-term, intensive, in-home, crisis intervention services that teach skills and provide support for families in which a child is at imminent risk of out-of-home placement. These specialized services can include intensive case management as well as an array of child welfare and treatment services which can each be funded by a mix of federal and state funding streams.

Public child welfare agencies that provide Intensive Family Preservation Services report using a mix of six federal funding streams to support the array of services provided by these programs (Title IV-B parts 1 and 2; Child Abuse and Prevention Treatment Act/CAPTA; Temporary Assistance to Needy Families/TANF; Title XIX/Medicaid; and Title XX/Social Services Block Grant). In addition, states can use Title IV-E/Administration and Title IV-E Training funds to support case management and training components of IFPS respectively, and can also use Community-Based Child Abuse Prevention funds.

A description of each funding stream follows.

Child Welfare Services Funding

□ Title IV-E, Administration and Placement Activities

States can be reimbursed for expenses necessary to provide child placement and administration services to children who are in foster care, as well as those who are *candidates for foster care*. These services include case management services for children and families served by IFPS programs, e.g. development of a case plan, case reviews, case management and supervision, preparing court papers, and testifying in court). The federal share of the expenditures reimbursed to states providing these activities is 50 percent, based on the percentage of children who are Title IV-E eligible.

□ Title IV-B, Sub-Part 1 (Child Welfare Services Program)—Federal Grant (Non-entitlement) to States and Some Indian Tribes

Funds can be spent on a wide variety of preventive and placement related child welfare services on the basis of a federally approved Child Welfare Services Plan. These grants require a 25 percent non-federal match. Distribution to states is based primarily on the state's child population under age 21 as it compares to all other states.

□ Title IV-B, Sub-Part 2 (Promoting Safe and Stable Families Program)—Federal Grant to States and Some Indian Tribes

Most of the grant is a capped entitlement (guaranteed federal appropriation), while a portion is discretionary (non-entitlement). Funds must be spent primarily in four categories: (1) community-based family support services, (2) family preservation, (3) time-limited family reunification services, and (4) adoption promotion and support on the basis of the federally approved Child Welfare Services Plan. This grant requires a 25 percent non-federal match. Distribution to states is based on the average monthly number of children receiving food stamp benefits. Distribution to eligible Indian Tribes is based on the Tribe's child population under age 21 as it compares to other Indian Tribes.

❑ **Child Abuse Prevention & Treatment Act (CAPTA)—State Grants**

CAPTA was reauthorized by the “Keeping Children and Families Safe Act of 2003”. The primary purpose of the CAPTA State grants is to assist States in improving the child protection services system. This includes, but is not limited to: assessment and investigation of reports of abuse and neglect, case management and delivery of services to children and families, strengthening and supporting child abuse and neglect prevention, and treatment and research programs in the public and private sectors. The amount of the state grants is based on the proportional number of children under the age of 18 residing in each State. As a part of the reauthorization of CAPTA, the Community-Based Family Resource and Support program (CBFRS) was renamed and is now referred to as the Community-Based Child Abuse Prevention (CBCAP) program. CAPTA was again due for reauthorization in 2008 but congressional action was deferred to 2009.

❑ **Community-Based Child Abuse Prevention (CBCAP)**

The primary purpose of the CBCAP program is to support community-based efforts to develop, operate, expand, and enhance programs and activities designed to strengthen and support families in order to prevent child abuse and neglect. This includes, but is not limited to: family resource and support programs, voluntary home visiting, respite care, parent education, community referral, and comprehensive support for parents that are accessible, effective and culturally appropriate. The grants require a 20% non-federal match.

❑ **Title IV-A Temporary Assistance for Needy Families (TANF)**

TANF, a block grant that replaced Aid to Families with Dependent Children (AFDC), is a capped *state* entitlement (not an individual entitlement). To be eligible, families with a child must meet one of the four purposes of the program, which are:

1. To provide assistance to needy families (means test);
2. To end the dependence of needy parents by promoting job preparation, work and marriage (means test);
3. To prevent and reduce out-of-wedlock pregnancies (no means test); or
4. To encourage the formation and maintenance of two-parent families (no means test).

There is great latitude in determining eligibility, benefit levels, and services provided to families. In addition, states that administered a Title IV-A Emergency Assistance program prior to TANF are able to continue to administer the program using TANF funds, with the same program requirements that were in place prior to TANF. The grant to each state is based on the amount of Title IV-A funds the state was claiming prior to TANF. There is not a federal match requirement, but there is a Maintenance of Effort (MOE) requirement.

❑ **Title XIX Medicaid**

Medicaid is an open-ended entitlement through which states provide a wide range of mandated and optional medical services based on each state’s unique plan including: Physical Health, Behavioral Health, Rehabilitation Services and Targeted Case Management (TCM). All IV-E eligible children (foster, adopted and children living with a relative guardian) have categorical eligibility with a state option for coverage of non IV-E eligible children. States are reimbursed

based on the Federal Medical Assistance Program (FMAP), ranging between 50 percent and 83 percent, based primarily on a state's per capita income. This percentage is adjusted at the beginning of each federal fiscal year.

□ **Title XX Social Services Block Grant**

Title XX is a federal block grant that can be used for a broad array of social services including those for children and their families, with one of its stated goals being to prevent neglect, abuse, or exploitation of children and adults. Title XX is not an entitlement and no federal match is required.

Training Funds

□ **Title IV-E Enhanced Reimbursement for Court, Legal & Private Agency Training**

States may use Title IV-E training dollars for training of public and private child welfare agency staff who deliver IFPS. Those authorized to receive short term training include staff of state licensed or approved child welfare agencies providing services to IV-E eligible foster or adopted children or children living with a relative guardian; staff of child abuse and neglect courts; attorneys representing the agency, children or parents; guardians ad litem; and court appointed special advocates. Effective October 7, 2008, the federal share is 55 percent and increases by 5 percent every year until October 1, 2012 when it will be and remain at 75 percent. The reimbursement is further adjusted based on the appropriate IV-E eligible population.

Source

Annie E. Casey Foundation/Casey Family Services. Creative Funding Strategies to Achieve & Sustain Family Permanence (Draft – Spring, 2009).

Assessment Tool for IFPS

The North Carolina Family Assessment Scale (NCFAS) is a comprehensive family assessment practice tools for practitioners working in agencies serving at-risk families with intensive, home-based service models. The NCFAS was designed to help IFPS therapists conduct assessments by providing an organizing framework for gathering information during home visits and from collateral contacts. The NCFAS organizes the information along five domains of family functioning: environment, parental capabilities, family interactions, family safety and child well-being.

The NCFAS scale utilizes a 6-point scaling strategy that ranges from clear strength to serious problem. There are three strength ratings and three problem ratings along the scale, but no midpoint is available. Therapists must conclude that the families are either in the strength range or the problem range, and then the degree of the problem (mild, moderate, serious) or strength (baseline/adequate, mild, clear). Although there is no midpoint, per se, the definition of a “baseline/adequate” level of functioning is that level above which there is no legal, moral or ethical reason for exercising an intervention mandate. Such a level of functioning does not imply that the family is functioning optimally; it simply means that the family has the right to be left alone or to refuse voluntary services. While areas rated as “baseline/adequate” are therefore not usually a focus of IFPS, families often can and do improve functioning on these domains as a result of services, or vicariously as a result of improvements on other (but sometimes inter-related) domains.

All of the domains and the subscales that comprise each domain utilize the same scaling strategy. Domain ratings are assigned after all of the subscales have been rated, and the domain ratings represent the therapist’s best judgment of the overall level of family functioning on the domain. During training, therapists are instructed to focus and prioritize services on domains of family functioning where a family has moderate to serious problems, working on mild problem areas only as time, resources and opportunity permit. Although service resources are rarely focused on domains where strengths are identified, strengths are noted as family resources and therapists strive to mobilize those strengths when they offset problems or risk factors.

Once ratings have been assigned, the domains (and relevant subscales) can be used for case planning purposes, service prioritizing, resource allocation, and as a focus for reviews and reassessments of family progress. At service closure families are reassessed by the therapist using the same scales, thereby noting changes in family functioning (or lack of change) relating to the services provided. The closure ratings also serve to inform decisions that need to be made with respect to placement recommendations, continuation of services or treatment in areas where insufficient progress was made or where the family may need continuing support to sustain progress and ensure child and family safety. Thus, the NCFAS domain intake ratings provide valuable information for service planning and goal setting, and closure ratings can provide the measures needed to calculate change scores that reflect case progress. Domain ratings at closure can also be conceptualized as outcome measures reflecting the status of the family on the respective areas of family functioning.

The reliability and validity of the NCFAS has been demonstrated through a number of studies (Reed-Ashcraft, Kirk & Fraser, 2001; Kirk, Kim & Griffith, 2005).

A 2006 study that compared assessment instruments found the NCFAS to be the most relevant for use in the child welfare system (Johnson et al, 2006).

Sources

Raymond S. Kirk, Ph.D, NCFAS developer

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Research on IFPS

Recent Advances in Research on Intensive Family Preservation Services and Reunification Services

Family preservation can be traced back to the 1900s with the “friendly home visitors” and through various stages of development such as the “multi-problem” or intensive family therapy efforts in the 1950s (e.g., Geismar & Ayers, 1958; Reed & Kirk, 1998). However, its emergence as a formal program was most notably marked by the HOMEBUILDERS® program in the mid 1970s. The HOMEBUILDERS® model was fully operationalized in 1991 with the publication of *Keeping Families Together: The HOMEBUILDERS® Model* (Kinney, Haapala & Booth, 1991). However, between the mid 1970s and the 1991 publication of *Keeping Families Together* the concept of Intensive Family Preservation Services (IFPS), including the formal HOMEBUILDERS® model, were widely disseminated based upon the belief that IFPS could prevent a large number of the out-of-home placements that were thought to be responsible for the burgeoning foster care population in the United States.

The implementation of IFPS programs nationally coincided with the availability of federal funds under the newly implemented Child Welfare and Adoptions Assistance Act of 1980 (PL96-272). The increasing expenditures for IFPS and the fervent claims of program success led policy analysts and researchers to become interested in testing the efficacy of the model. Because the HOMEBUILDERS® model was (and remains) the most well-defined intensive family preservation services (IFPS) model, it was the subject of most of the research studies. Indeed, during the mid-1980s and onward through the mid 1990s, several large studies were conducted (Feldman, 1991; Yuan, Y.Y., McDonald, W.R., Wheeler, C.E., Struckman-Johnson, D., & Rivest, M., 1990; Shuerman, Rzipnicki, Littell & Chak, 1993). These studies employed experimental research models and gathered data from large samples in an effort to “prove” whether family preservation worked or did not work. Experimental models employ random assignment of potential service recipients into experimental groups (that receive treatment) and control groups (that do not receive treatment). The statistical methods used in experimental designs are based upon “difference testing” (e.g. t-tests, analysis of variance, etc).

However, much of the research on IFPS from this period was flawed with respect to both research design and implementation. Other researchers who examined the cited studies found that the studies suffered methodological and implementation problems. Most notably, Heneghan (et al, 1996) and her colleagues at Yale analyzed several of these experimental studies to see if they adhered to rigorous methodological criteria. These criteria included: eligibility for services; standardized assessment of imminent risk; exclusionary criteria; method of assignment to experimental/control groups; purity of experimental/control cohorts (i.e., no crossover), adherence to family preservation services treatment model, measurement of “customary” social services (for the control group), and treatment outcomes, including outcomes other than placement. None of the cited studies fared very well, when held to these criteria. For example, Heneghan (et al, 1966) found that the Shuerman study (perhaps the most widely referenced of the experimental studies of family preservation), met only three (3) of the 15 criteria.

Other researchers (Pecora, Fraser, Nelson, McCroskey & Meezan, 1995; Rossi, 1992; Fraser, Nelson and Rivard, 1997) criticized these studies with respect to design and implementation. They concluded that the existing “experimental” literature does not conclusively demonstrate that IFPS works or doesn’t work as much as it demonstrates the enormous difficulty of conducting experimental studies in practice settings.

These studies have also been criticized for testing programs of dubious treatment model fidelity (Kirk, Reed-Ashcraft & Pecora, 2002). An emerging body of research contradicts earlier findings and suggests that IFPS is effective when model fidelity is high. Blythe & Jayaratne (2002) used an experimental design employing random assignment, and two other studies (NC DSS, 2002; Kirk & Griffith, 2004) employed different approaches to the research and evaluation of IFPS that do not rely on random assignment or experimental models. Rather, they relied on broadening the scope of measurement to include multiple measures of family functioning, and on different statistical/analytic techniques that do not require random assignment or the use of control groups.

The Blythe & Jayaratne study (2002) was conducted in Michigan and assured a high degree of model fidelity with respect to the IFPS program. High-risk families (as determined by a court agreement to remove the child[ren]) were randomly assigned to either IFPS or traditional child welfare services, including foster care. At 6 months after IFPS, 94% of children were living at home or with relatives (88% were at home) compared to only 34% of non-IFPS children living at home or with relatives (17% were at home). The 12-month follow-up data are similarly disparate, with 93% of IFPS children living at home, compared to 43% of non-IFPS children.

The North Carolina study (NC DSS, 2002) measured family functioning in five areas (environment, parental capabilities, family interactions, family safety and child well-being), and demonstrated the ability of IFPS interventions to improve family functioning in those areas. In turn, those improvements were statistically associated with the policy goals of placement prevention. Kirk & Griffith (2004) demonstrated statistically significant superiority of IFPS services over traditional child welfare services in preventing out-of-home placement in high-risk families when risk factors are controlled and accounted for in the analyses. These findings are based on the use of survival curves to plot the different placement trajectories of the cohorts of children in the study, and event-history analysis to test the differences.

The importance of model fidelity cannot be overstated. The Washington State Institute for Public Policy (WSIPP, 2006) conducted a meta-analysis of five experimental studies that used the HOMEBUILDERS® model across 14 program sites, assuring that both model fidelity and methodological rigor were sufficient for the studies included. They compared the findings to a similar meta-analysis of eight studies purporting to have used rigorous experimental methods, but without establishing model fidelity. In the words of the study’s authors: “Intensive Family Preservation Services that are implemented with fidelity to the HOMEBUILDERS® model significantly reduce out-of-home placements and subsequent abuse and neglect. We estimate that such programs produce \$2.54 of benefits for each dollar of cost. However, non- HOMEBUILDERS® programs (even those claiming to be based on HOMEBUILDERS®) produce no significant effect on either outcome” (WSIPP, 2006, p3.).

A recent non-experimental study of high-fidelity IFPS programs used case-level data from state or private contract agencies in seven states (Kirk, Griffith, & Martens, 2007). The programs responded to a survey designed to estimate program model fidelity, and provided case data stripped of identifying information using a data template intended to standardize the data collection procedures. When appropriate, data were collapsed across contributing sites, after accounting for between-site differences on some variables of interest.

With regard to fidelity, all participating sites had well-developed IFPS models, with the typical features associated with intensive services largely in evidence: small caseloads, rapid response, 24/7 availability, time limited services, large amounts of face-to-face contact with the families in their homes or communities, provision of both clinical and concrete (e.g. financial) services, etc. There were some variations, including, for example, the length of time that services were available, and the permissible caseload. There were also differences in the types of families served by programs, with some serving a broad mix of family types and others focusing primarily on one type of child maltreatment.

These minor differences notwithstanding, across all types of families and types of maltreatment, the IFPS programs achieved a 93% placement prevention rate (i.e., the children were living with their biological parent, adoptive parent, relative; with 85% living with the bio-parent), a rate that is in line with previous research on IFPS. Family assessments revealed substantial progress on several domains of family functioning, including the families' environment, parental capabilities, family interactions, family safety and child well-being. Progress in these areas was associated with successful placement prevention. There were no significant differences in the placement prevention rates as a function of type of maltreatment. This finding suggests that although some service providers may choose to specialize or focus on particular types of maltreatment, the service model itself appears to be similarly effective across maltreatment types. Therefore, there is no apparent reason to restrict access to the service on the basis of maltreatment type.

The most recent study available that examined the impact of IFPS (Kirk & Griffith, 2008) demonstrates that IFPS may be useful in remediating racial disproportionality among high-risk children, and possibly even among children placed out of home. The large sample study compared the treatment outcomes based upon race, controlling for other variables. In the study population at large, Black children were significantly more likely to be placed than White children, but among those children who received IFPS, the disproportionality was completely reversed, appearing to benefit, differentially, the Black children. This study represents an initial foray into the realm of differential effectiveness of IFPS on racial disproportionality, but the findings were robust and promising, suggesting that additional research is needed in this area.

Thus, although early research on the effectiveness of IFPS is equivocal, more recent research indicates that IFPS is capable of preventing high rates of out-of-home placement among high risk families, when the comparisons between families served and not served by IFPS are based on equivalency of groups, and when model fidelity is high.

The use of IFPS interventions with *reunification* cases commands an interesting assortment of research questions, and some have been studied. The earliest study was conducted in Utah (Lewis, Walton, and Fraser, 1995) and employed an experimental design and an IFPS

program model to see if IFPS was more effective than routine foster care services for reuniting families. The intervention lasted 90 days and focused on family strengthening and intensive preservation services methods. Children were returned to the families within 15 days of the beginning of service, providing a minimum of 75 days of service to the intact family. At the end of the 90-day intervention, 92% of the treatment groups had returned home, versus only 28.3% of the control group.

Walton (1998) conducted a six-year follow-up on the same treatment population and determined that children who had received the reunification based IFPS services required less case supervision time, lived at home longer, and, if placed, were in less structured placements. This series of Utah studies offers strong support for the use of IFPS interventions with reunification cases, but was tied to a single model of intervention. Other researchers explored differing models.

A study by Pierce and Geremia (1999) in Missouri utilized a 60-day treatment model during which workers were available “24/ 7”, similar to IFPS interventions. Case loads averaged 3 families, and families targeted for the service were those who were determined to be unlikely to be reunited in less than six months without intensive services. At the end of service, 63 percent of the children were successfully reunited, as defined by not reentering care.

Another Missouri program model recently studied and reported by Lewendowski & Pierce (2000) used a less intensive model known as The Family Centered Out Of Home Care Pilot. The results of this intervention model were not impressive, there being no statistically reliable differences between the groups’ reunification or recidivism rates, although the pilot appeared to be more successful with children who had been in out of home care for long periods of time.

There is research that suggests that reunification cases possess unique features that differentiate them from placement prevention cases. Among the most informative of these are studies by Hess, Folaron and Jefferson (1992) and Hess and Folaron (1991). The setting of these two studies was Illinois, and the study methods included intensive case record reviews and interviews. From the results of the study Hess, et al proposed that a major impediment to successful reunification is parental ambivalence. The strongest predictors of parental ambivalence were identified as:

- biological parents requesting child placement before the initial placement
- biological parents requesting child placement after reunification
- biological parents refusing treatment or services
- biological parents missing court appearances
- **biological parents missing scheduled visitations**

Taken as a whole, this modest body of research on IFPS interventions with reunification cases indicates that IFPS may be quite effective in assisting with the reunification process; and, taken as a whole there are indications that IFPS interventions may be tailored specifically for reunification cases. For example, the studies reviewed suggest that a treatment interval of 60 to 90 days makes the most sense. The treatment models that employed the more intensive services achieved higher success rates than the less intensive, longer-term services They also suggest that the factors that make reunification cases unique when compared to placement prevention cases

(e.g., ambivalence and resolution of pre-existing risks and service needs prior to reunification) can be identified and addressed.

These findings led the National Family Preservation Network (NFPN) to develop a family assessment instrument to help reunification workers design more focused reunification service plans and to provide measures of family functioning. Although not an experimental design, the reliability and validity study conducted during the instrument development process (Kirk, 2001, 2002) revealed promising reunification rates, with results from three test sites showing approximately a 75% success rate in reuniting families who receive the IFPS-based interventions.

The previously cited 2007 study conducted by the national Family Preservation Network (Kirk, Griffith & Martens, 2007) also examined reunification cases across the 7 contributing sites. Findings from the examination of reunification data were more mixed than those for placement prevention, but were largely positive. Although between-site differences exist with regard to local definitions of reunification, 69% of families were reunited as a result of these services. Of that number 54% were reunited with biological parents and the balance were living with adoptive parents, relatives, or guardians. As with placement prevention cases, families that were successfully reunited made progress on a variety of areas of family functioning including environment, parental capabilities, family interactions, family safety, child well-being, ambivalence and readiness for reunification. The last two domains were particularly predictive of successful reunification. With respect to maltreatment type, families in which physical abuse was the referring problem experienced higher reunification rates than did other maltreatment types, particularly neglect.

This study suggests that IFPS continues to hold promise as a service to help families overcome a variety of problems that might lead to child removal, IFPS and variations of the model for reunification cases appear to be successful but more research is needed on model variations to help understand the differences observed in the success rates. Future research on the use of IFPS interventions with reunification cases will need to confirm these initial positive findings, continue to examine variations of the basic IFPS-reunification models, and compare IFPS-reunification results to results obtained using other intervention strategies.

Source

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IFPS for Reunification

Most agencies that have strong IFPS programs for placement prevention also offer IFPS for families that are reunifying. Some agencies use the exact same model for Intensive Family Reunification Services (IFRS) as for IFPS. Other agencies adjust the IFPS model for reunification to reflect that families who are reunifying may not need the crisis response or service intensity of IFPS, or may benefit from longer service duration. Model changes may include extending the time frame for initial response, length of intervention, and adding step-down services. While IFPS models have generally not included step-down services, this may be a critical area for reunification. Nationwide, half of the states fail to meet federal standards for preventing re-entry of children into foster care following reunification.

Although there are little specific data available on the reasons why states struggle with preventing re-entry, some insights are available through research on reunification conducted by the National Family Preservation Network in 2007. IFPS programs were effective across all types of families and all types of mistreatment. The findings encourage broader use of IFPS to address the critical issues of substance abuse and disproportionality within the child welfare system and other systems. The findings for IFRS were more mixed than for IFPS. For IFPS, programs involved in the study achieved a 93% placement prevention rate. For IFRS, 69% of the families were reunified. There was a 22% dropout rate in IFRS families compared with only a 9% dropout rate for IFPS families. The high dropout rate for IFRS may indicate some inappropriate targeting, perhaps using the service to justify filing for termination of parental rights (TPR). This issue needs further exploration. The study found that IFRS programs were most successful in reunifying families involved in physical abuse and were also successful with substance abusing families but less so with families of color and families involved in neglect.

Source

An Examination of Intensive Family Preservation Services. Available online at: <http://www.nfpn.org/articles-mainmenu-34/105-ifps-research-report.html>

Intensive Family Reunification Services (IFRS) Model

Based on the available research, NFPN has developed a model for IFRS. Note that the model deliberately provides for a range of standards, whenever possible, in order to allow flexibility among programs. The program component is listed first, followed by a rationale based on research, or on strong models of IFRS, or on strong models of IFPS. Many of the proposed model components have been used successfully in IFPS programs.

□ Target Population

Eligibility: Families in which the child(ren) has been in out-of-home placement for 3–8 months. Families need the intensive IFRS services in order to reunify. At least one parent is willing to reunify and the case plan is to reunify the child with the parent.

Rationale: Nationwide, about one-third of children in out-of-home care return home within 5 months. IFRS should be targeted to families in which reunification is doubtful without intensive services. For example, a case in which a child has been in placement for up to 3 months may be referred for IFRS, if the child cannot be returned home without intensive services. On the other end of the continuum, IFRS should not be used to justify termination of parental rights. Thus, the cut-off point for a case referred for IFRS should not exceed 8 months of out-of-home placement in order to allow families time to complete the intensive phase of services and any step-down services. These combined services could take up to 5 months and adding in nearly 9 months in placement (for cases referred late in the 8th month) totals 14 months. The 15-month time frame is the point at which the family should either have been reunited or a TPR must be filed, according to federal law. Willingness of a parent to reunify ensures commitment to work on a reunification plan. A case plan to reunify, especially if court-ordered, ensures that IFRS services are not used to justify termination of parental rights.

❑ **Time Frame to Meet with Family**

The reunification worker meets with the family within 72 hours of the referral.

Rationale: The family is generally not in a crisis at the beginning of IFRS so there is no immediate urgency to meet. Extending the time frame to 72 hours, instead of the usual 24 for IFPS cases, is the standard for several strong IFRS programs. The additional 48 hours also allows for more agency flexibility in managing caseloads and eliminates the need for on-call referrals. However, it's important to note that if a child will be returned home at the same time the referral is made to an IFRS program, the worker should meet with the family within 24 hours.

❑ **Worker Availability**

The reunification worker is available 24/7 including evenings and weekends.

Rationale: The availability of a worker 24/7 is included in successful models referred to in research studies (Lewis, Walton, etc.; Pierce, Geremia). Full-time availability ensures family access to the worker when most needed and contributes to family safety.

❑ **Parent–Child Visitation and Time Frame to Return Child Home**

The public agency plans to return the child home within 15–30 days of the referral, with court approval. Regular visits have taken place prior to the child's return home.

Rationale: Returning the child home within 15 days is included in successful models in research studies (Lewis, Walton, etc.; Pierce, Geremia). In addition, most strong IFRS programs require the child to be returned home within 30 days. These time frames assume that the referring agency and court agree that the child can be returned home within 15–30 days.

Research supports the significance of parent–child visitation as a predictor of family reunification (National Clearinghouse on Child Abuse and Neglect, 2006). A study of reunification in a sample of 922 children aged 12 and younger found that children who were visited by their mothers were 10 times more likely to be reunited (Davis, Landsverk, Newton, & Ganger, 1996).

□ Family Assessments

There are many different types of assessments. The public agency would generally complete a safety assessment before referring for reunification services. Therapists should also complete a safety or risk assessment prior to returning the child to the family. Specialized assessments may also be used in connection with substance abuse, mental health, developmental delay, and other issues. An overall assessment of the family measures the level of family functioning. It's critical for the therapist to link all assessments to case planning, goal setting, determination of needed services, monitoring the family's progress, and evaluation.

Rationale: Research has demonstrated that adequate assessment often does not occur in child welfare, and this failing may be linked to the instability of reunification (National Clearinghouse on Child Abuse and Neglect, 2006). In a review of 62 failed reunifications, Peg McCartt Hess and her colleagues found that “poor assessment or decision-making by the caseworker or service provider” was a factor in 42 cases (Hess, Folaron, & Jefferson, 1992).

The use of standardized tools to aid assessment is an emerging area of child welfare research that offers some promise of improving practice in this area (Corcoran, 1997; McMurtry & Rose, 1998). The North Carolina Family Assessment Scale for Reunification (NCFAS-R) is the only validated instrument designed specifically for use in reunification (National Clearinghouse).

□ Caseload

The reunification therapist has a maximum caseload of 5–6 families in the process of reunifying and a maximum of 3 if the therapist is also providing step-down services. Other staff may also assist with step-down services and follow-up contacts with the family.

Rationale: Mathematical calculations by a researcher show that a therapist can provide intensive services, defined as 48–60 hours over a 90-day period of time for 11 months of the year, to 5–6 families at a time. However, many factors affect caseload and agencies should always err on the side of lower caseloads. Cases need to be assigned consecutively, not all at one time. A caseload of 3 full-time families receiving intensive reunification services is supported by a successful model from research (Pierce, Geremia).

The matrix shown here provides a guide for determining reasonable caseloads and is based on a therapist providing 24 hours of direct service (phone, face-to-face) per week over 11 months of the year:

	IFRS Service Hours (90 days)	Step-Down Service Hours (60 days)	Maximum Caseload Per Year	Maximum Caseload at One Time
Reunification Only	48–60	0	20–25	5–6
Reunification Plus Full Step-Down (for all families)	48–60	16–20	15–19	4–5

	IFRS Service Hours (90 days)	Step-Down Service Hours (60 days)	Maximum Caseload Per Year	Maximum Caseload at One Time
Reunification Plus Full Step-Down (for 25% of families)	48–60	16–20	19–23	5–6
Reunification Plus Partial Step-Down (for all families)	48–60	8–10	17–22	4–5
Reunification Plus Partial Step-Down (for 25% of families)	48–60	8–10	19–24	5–6
Full Step-Down (Only)	0	16–20	60–75	9–10*
Partial Step-Down (Only)	0	8–10	120–150	16–20*

* Straight mathematical extension of the Maximum Caseload/Year to Maximum Caseload at One Time actually results in caseloads of 10–12 for the Full Step-Down model, and 20–25 for the Partial Step-Down model. However, caseloads that high are impractical for this type of work, and the recommended caseloads have been adjusted downward to increase the likelihood of success of the step-down service and to achieve manageability of the caseloads. Therefore, additional workers (at a ratio of 10:9, that is, one additional worker for every 9 workers in Full Step-Down and 5:4, that is, one additional worker for every 4 workers in Partial Step-Down) will be needed to cover caseloads in the Full Step-Down (only) and Partial Step-Down (Only) models.

□ Clinical Model

The research shows that a cognitive behavioral, family-focused clinical model of service is most effective and all staff must receive training, supervision, and evaluation on its use with families.

Rationale: About 40% of strong IFRS programs indicate that they have a specific clinical model (NFPN, 2007). Without a clinical model, it is impossible to know what interventions work with families. The National Clearinghouse on Child Abuse and Neglect (2006) cites a number of studies that looked at programs with a behavioral, skill-building focus and that address family functioning in multiple domains, including home, school, and community (Corcoran, 2000; Macdonald, 2001). Cognitive-behavioral models have been demonstrated to reduce physical punishment and parental aggression in less time than alternative approaches (Kolko, 1996, cited in Corcoran, 2000). The most effective treatment involves all members of the family and addresses not only parenting skills, but also parent-child interaction and a range of parental life competencies such as communication, problem solving, and anger control (Corcoran, 2000; Dore & Lee, 1999).

□ Direct Service Hours

The total direct service hours for face-to-face and telephone contact with the family ranges from 48–60 hours.

Rationale: Service intensity is one of the key characteristics of successful IFPS and IFRS programs. The definition of “service hours” includes face-to-face and telephone contact with the family with face-to-face contact primarily in the family’s home and community. In one study involving intensive services, families in the treatment group received intensive casework services, parenting and life skills education, family-focused treatment, and help in accessing community resources. The treatment group had a reunification rate three times that of the control group and remained intact at a far higher rate 7 years later (Lewis, Walton, & Fraser). The recommended model allows the therapist 24 direct service hours per week based on an 11-month year in order to also allow for travel, paperwork, training, annual and sick leave. Therapists who must travel long distances to meet with families should have a reduced caseload in order not to sacrifice direct service hours. The 48–60 hours of service is the mid-range of strong IFRS programs.

❑ Length of Intervention

The range of service length is 60–90 days with a maximum of 90 days.

Rationale: The 60–90 days of intervention is included in successful models in research studies (Lewis, Walton, etc; Pierce, Geremia) and is the range provided for by strong IFRS programs.

❑ Concrete Services

Funds are available to provide the family with basic needs (i.e. rent, utilities, food, car repair). The recommended amount is \$300–\$500 per family.

Rationale: The National Clearinghouse on Child Abuse and Neglect reports that the provision of concrete services such as food, transportation, and assistance with housing and utilities has been demonstrated to be an important aspect of family reunification services. A study reviewing effective family-centered service models (Wells & Fuller, 2000) identified concrete services as critical elements of practice. The most effective programs studied not only provided services to meet concrete needs, but offered families instruction in accessing community resources so that they could do so independently in the future. In a study of 1,014 families participating in a family reunification program in Illinois, the 50 percent of families who experienced reunification demonstrated high utilization of concrete services such as financial assistance and transportation (Rzepnicki, Schuerman, & Johnson, 1997).

The amount of \$300–\$500 per family is the range for most strong IFPS programs.

❑ Step-Down Services

All families with moderate or serious problems or negative change at case closure, as measured by the NCFAS-R assessment tool, receive step-down services. Total direct service hours for step-down are 16–20 hours for a maximum of 60 days. A paraprofessional may complete the service hours when the family is stabilized, i.e. no longer exhibits serious problems or negative change.

Rationale: The National Clearinghouse on Child Abuse and Neglect (2006) finds research support for follow-up services that enhance parenting skills, provide social support, connect families to basic resources, and address children’s behavioral and emotional needs in order

to prevent re-entry into foster care. Post-reunification services are especially important when parental drug or alcohol use is a concern (Festinger, 1996; Terling, 1999).

Targeting is based on current research using the NCFAS-R assessment scale data on families that are still experiencing moderate or serious problems or negative change at case closure following intensive reunification services (up to 25% of families). The 16–20 hours of recommended service is based on one-third the time of the IFRS intervention, and the maximum of 60 days allows for sufficient time to improve family functioning and monitor the stability of the family. There is no available research on optimal hours or optimal length of step-down services.

Some agencies may prefer to have the same IFRS therapist provide step-down services to the family while other agencies may assign paraprofessional staff to do step-down. It is recommended that the original therapist provides the initial step-down services until the family is stabilized, that is, no longer exhibiting serious problems or negative change.

❑ Follow-Up Services

All families receive a monthly home visit for a period of 90 days following case closure of the IFRS intervention and any step-down services. A staff-support worker may make the contact with referral to a paraprofessional or professional for services if indicated.

Rationale: Nationwide, the first federal CFSR audit of all states showed an average rate for re-entry into foster care at just over 11%, with a range of 1% to 25%. Initial research on the NCFAS-R showed a re-entry rate of 6% with IFRS services. Because re-entry can be anticipated for a certain percentage of families who may not be targeted for step-down services, follow-up services may help identify vulnerable families and prevent re-entry. Follow-up visits can also address any safety issues and allow the agency to track the families for at least three months following the intervention and step-down services. Agencies may provide families with small gifts for their cooperation in follow-up visits. A monthly home visit for 90 days post IFRS intervention (and any step-down services) is recommended. A trained staff support worker may make the visits and, if indicated, refer the family to a paraprofessional or professional for additional services.

❑ Staff Qualifications

The reunification therapist has a master's degree in social work or a bachelor's degree in a related field with two years of experience in family-centered practice. The paraprofessional has an associate degree with specific training on reunification. Staff-support workers receive training in assessing for problems and referral. All staff receive initial and ongoing training.

Rationale: The qualifications for IFRS professional staff are based on qualifications for staff in strong IFPS programs. Paraprofessional and staff support workers need training specific to reunification. All staff should have initial and ongoing training.

❑ Agency Support

The agency has policies for staffing including qualifications, training, and supervision. All staff have supervisors with the ratio of supervisors to staff of 1:4 to 1:6. Data are collected electronically and a program evaluation is conducted annually. The agency provides initial and

ongoing training for all staff who have any contact with families. Quality control measures are in place and used to measure and improve performance.

Rationale: All staff need supervision. The supervisor to worker ratio of 1:4 to 1:6 is the standard used by most strong IFRS programs. Electronic data collection is critical for data analysis and interpretation and program improvement. All agencies should implement quality control measures.

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Data Collection and Evaluation

Every IFPS program needs to collect data and conduct an annual evaluation in order to determine its effectiveness and areas for improvement. NFPN recommends use of the North Carolina Family Assessment Scale (NCFAS) because it provides the worker with an assessment tool and the agency with a data collection and evaluation tool. A database that accompanies the tool provides for electronic entry and access to all data by an evaluator. The following items should be viewed as the minimum data that needs to be collected:

Data Collection Items

- Number of families, number of children accepted for services
- Number of families, number of children not accepted—reason
- Referral source (if more than one source)
- Age/gender/race/employment/income of primary parent(s)
- Age/gender/race of child(ren)
- Reason for referral
- Number of prior contacts with CPS (provided by public agency)
- Response time for first face-to-face meeting with family
- Length of intervention
- Number of in home sessions
- Total service hours of intervention by category
- Service length
- Reunification status at case closure and 3, 6, 9, 12 months post-services (provided by public agency)
- NCFAS domain ratings at case opening, closure, closure to end of step-down, 3 and 6 months post-closure.

NCFAS ratings should be aggregated for “baseline and above” on all domains to compare to other research findings on IFPS. Negative movement on the scale and ratings in the moderate or serious problem range should be used to identify the need for step-down services.

An evaluator or researcher should analyze the data annually and prepare a report, including recommendations.

In addition to the data collection items, the IFPS contracted provider and the public agency also need to have a list of goals for the family, a summary of intervention techniques and the family’s response, an itemized list of concrete services provided to the family, the plan for post-intervention services, and the termination summary.

Step-Down Services

The research on IFPS consistently shows that high-fidelity models of IFPS are very effective with placement prevention rates of 80% and above. IFPS is a short-term service targeted to specific families with the immediate goal of helping these families remain safely together. As such, IFPS services are not designed to address all of the problems a family is experiencing. Nor does receiving IFPS mean that a family will never again need help or support.

There is some research that shows the positive treatment effects of IFPS may diminish at about four to five months following the IFPS intervention. NFPN's research study in 2007, using the NCFAS assessment tool for data collection, found between 10% and 18% of families continue to have moderate or serious problems at case closure of IFPS services. The highest percentage of families struggle in the area of Parental Capabilities.

Thus, there are some indicators for a need for a “booster shot”, step-down services, or at least the offer of services at four to six months following IFPS. About 60% of IFPS programs nationwide offer step-down services. But there are almost no data available on the type and duration of these services. They range from offering two booster shots within six months of the original referral to providing services to families for up to one year following the IFPS intervention.

NFPN recommends that step-down services be targeted to families that have moderate or serious problems, or negative change, at case closure as measured by the NCFAS assessment tool. Especially note that any negative change in the domain of Child Well-Being is associated with a very high probability of out-of-home placement.

Source

IFPS Paper, available online at: <http://www.nfpn.org/articles-mainmenu-34/116-ifps-paper.html>

Success Story: The Walker Family

Christie Walker was born premature. She spent the first three months of her life in the hospital and was ready to come home. But a public health nurse assigned to the case was worried about what Christie would face at home. Christie's brother Billy, three years old, was diagnosed as hyperactive with some brain damage. Both the public health nurse and the Child Protective Services (CPS) caseworker were concerned about three concussions that Billy had suffered over the past year. Another infant in the family had died from Sudden Infant Death Syndrome. CPS was suspicious of the injuries sustained by the 3 year old, and about the former infant death. The family had had an open CPS case in another state, but left that state when the mother became pregnant with the current infant. CPS decided that Christie and Billy would both be placed in foster care unless the family agreed to intensive services.

The public health nurse and the CPS caseworker discussed their concerns with the parents and the CPS caseworker referred the parents to Intensive Family Preservation Services (IFPS). The parents, William and Judy, agreed to IFPS services. For the first visit, the IFPS therapist went to the home unannounced because the family had no phone. The first thing the worker noticed was the smell of gas from a furnace. Judy said she too had noticed the smell but had not done anything since they had no phone. The therapist suggested that Judy dress herself and the children warmly, open the window, and turn down the furnace while the worker phoned the landlord. After, Judy began to talk about herself and her family. By age 22, she had been married for five years, suffered four miscarriages, and given birth to three children. Judy was very thin and pale and had decayed front teeth due to poor health. She said she was lonely with her husband gone for long hours trying unsuccessfully to sell insurance. Every previous counselor had told her that William was rotten and encouraged her to leave him. But Judy said she loved him and he was not mean to her. Judy explained that she had been very depressed since Christie's birth and often felt the baby did not belong to her. She was extremely upset about Billy's wild behavior and believed it came through a "bad seed" from an uncle who was in prison. During this visit, the therapist focused on Judy's interactions with the baby, and determined that Judy was bonding well with the infant. They discussed the infant care and SIDS prevention techniques taught to Judy by public health.

On the second visit the next day, the therapist worker took Judy to a local charity where they received a donation to get the family a cell phone. They also got bed sheets for curtains. Judy was fearful because she had been raped as a teen, so a phone and curtains helped her feel more secure. The therapist scheduled an appointment with a dentist to begin work on Judy's teeth. On this day, Judy and the worker spent a lot of time talking about Billy. Judy said she did not love Billy and described his behaviors: Billy would throw himself backward off furniture, touch a hot stove and laugh, bang his head against the wall, and bite, scratch, and hit other people. His parents locked Billy into his room at night because he only slept a few hours at a time and would go into the kitchen and eat until he vomited. Billy would not kiss or show any affection towards his parents. Judy felt she could not cope with Billy and wanted to have him placed elsewhere.

The IFPS therapist talked to Judy about options for coping with Billy's behavior including timeouts. The worker gave Judy her phone number and told Judy to call any time day or night if

Billy's behavior was unbearable. The worker scheduled an appointment for Billy with a special pre-school program. The therapist also volunteered to babysit later in the week. During the five hours she spent with the children alone, the worker watched Billy engage in some of the behaviors Judy had described. By the end of the day, however, Billy was responding to positive reinforcement and timeouts. The therapist worker taught Billy to play a kissing game and Judy cried the first time that she and Billy played the game together. The therapist's time spent teaching Billy new behaviors proved to his parents that Billy could change.

As the intervention continued, Judy talked about her discontent with her marriage. She said she knew that William wasn't working during all the time he spent away from home. She resented the fact that he had good clothes while she had only one nice outfit; that he was out playing while she sat in the apartment with the children; that he wouldn't let her get a driver's license but refused to take her places. The therapist saw a "teachable moment" and began talking about how Judy could assert herself in a positive way to get her needs met. William became curious about what was happening with his family and decided to stay home one day. While Judy was at the dentist, William and the worker talked. William shared his frustrations about not being able to support his family and agreed to participate in the intervention.

During the final weeks, the therapist counseled both Judy and William on behavior management skills. Billy had begun attending the pre-school program. Judy reported more positive feelings toward Billy and no longer wanted to send him away. Christie was doing well, and the public health nurse was pleased with her progress. Judy now had caps on her teeth and smiled more often. She was beginning to gain weight.

As the intervention ended, the therapist helped Judy obtain a counseling appointment at a local mental health center. The family moved to a better apartment in a safer neighborhood. After they moved out, they found out that the school bus wouldn't pick up Billy. At first Judy was very upset but then she began to problem solve and found another school program for him. A follow-up phone call several months after the intervention revealed that the family was still together. Judy was seeing a counselor regularly and she and William had started marital counseling. William quit his job selling insurance and enrolled in a job training program. Billy was beginning to talk and his behavior had improved. Christie, the infant daughter, continued to thrive.

Source

Kinney, J., Haapala, D., & Booth, C. (1991) *Keeping families together. The HOMEBUILDERS® Model*. New York: Walter de Gruyter.

Resources

For information on an assessment tool (NCFAS) designed for use with IFPS, visit:

<http://www.nfpn.org/tools-and-training/>

For the most recent research on the effectiveness of IFPS with various types of families and presenting problems, visit:

<http://www.nfpn.org/tools-and-training/articles/105-ifps-research-report.html>

For a summary of recent research on IFPS with implications for practice, visit:

<http://www.nfpn.org/articles-mainmenu-34/116-ifps-paper.html>

To see how IFPS has been used effectively for post-adoptive services, visit:

<http://www.nfpn.org/tools-and-training/articles/20-research-shows-ifps-with-post-adoptive-families-is-effective.html>

To order books with an overview and critical features of the HOMEBUILDERS® program, visit:

http://www.institutefamily.org/products_books.asp

For technical assistance or training related to IFPS programs, contact:

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