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ABSTRACT

This study implemented objective, self-report measures in family preservation practice in hopes of increasing family involvement in families' goal attainment and growth. The practicum began by administering a survey entitled "Attitudes Regarding Measures" to practitioners, participants, and funders of a small, rural family preservation program. The practicum then educated all of the above parties as to the possible benefits and pitfalls of implementing objective measures. The Family Assessment Device was administered to each of the two families involved once per week. The measures were scored and the findings were discussed and included in the practitioner's reports to participants and funders. The measurement implementation went for 10 weeks and was followed by re-administering the "Attitudes Regarding Measures" survey to the above parties. This study indicated that measures properly administered increased the joining between professional and participant, empowering the participant. It also seemed to create a change in the role of the professional from a problem identifier to one of solution sounding board. Time on task and attendance records were monitored to collaborate the hypothesis that measures would increase the focus and direction of service delivery. Attendance increased but time on task proved too difficult to measure. (Contains 31 references.) (Author/JE)

Title Page

The Implementation of Objective, Self-Report Measures in a Family Preservation Program

by

Darren Thomas Stroh

Cohort 4F

A Practicum Report Presented to the
Master's Program in Life Span Care and Administration
Specializing in Family Support Studies
in Partial Fulfillment of the Requirements
for the Degree of Master of Science

NOVA SOUTHEASTERN UNIVERSITY

1994

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3301 College Avenue
Fort Lauderdale, Florida 33314

VERIFICATION OF PRACTICUM PROJECT STATEMENT

STATEMENT II- To be attached to the Practicum Report.

I verify that the below named student did conduct the practicum project descrived in the submitted Practicum Report and I attest to the fact that this practicum project was carried out by the student in a responsible, professional and competent manner.

Practicum Title: The Implementation of Objective, Self-Report Measures in a Family Preservation Program

Student's Name: Darren Thomas Stroh **Cohort:** 4F

Verifier's Name: Allan Levine, M.D.

Verifier's Position: Consulting Psychiatrist

Verifier's relationship to Student: Work together in RCCF

Name of Verifier's Work Setting: Chicago Creek Roads, Inc.

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Verifier's Signature: Allan J. Levine, M.D.

Date: August 3, 1994

Subscribed and sworn before me this 3rd day of August, 1994 at Idaho Springs, Colorado by Alan J. Levine. My commission expires 1-23-95

Muriel Williams

The Implementation of Objective, Self-Report Measures in a Family Preservation Program

by

Darren Thomas Stroh

Cohort 4F

A Practicum Proposal Presented to the
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VERIFICATION OF PRACTICUM PROJECT STATEMENT

STATEMENT I- To be submitted to Coordinator of Practicum with copy of Verifier's Resume upon completion of Practicum Proposal:

I verify that I am familiar with the Practicum Project being proposed by the below named student. I am willing to review the final copy of the Practicum Report in order to verify that the project took place as described therein, and to attest to the fact that the student carried out the project, as reported, in a responsible, professional and competent manner.

Practicum Title: The Implementation of Objective, Self-Reporting Measurements in Family Preservation Service Delivery and Reporting Procedures

Student's Name: Darren Thomas Stroh **Cohort:** 4F

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Date: 4/1/94

Authorship Statement

I hereby testify that this paper and the work it reports are entirely my own. Where it has been necessary to draw from the work of others, published or unpublished, I have acknowledged such work in accordance with accepted scholarly and editorial practice. I give testimony freely, out of respect for the scholarship of other workers in the field and in the hope that my own work, presented here, will earn similar respect.

4/8/04
Date


Signature of Student

ABSTRACT

This study implemented objective, self-report measures in family preservation practice in hopes of increasing family involvement in families' goal attainment and growth. The practicum began by administering a survey entitled Attitudes Regarding Measures to practitioners, participants and funders of a small, rural family preservation program. The practicum then educated all of the above parties as to the possible benefits and pitfalls of implementing objective measures. The Family Assessment Device was administered to each of the two families involved once per week. The measures were scored and the findings were discussed and included in the practitioner's reports to participants and funders. The measurement implementation went for 10 weeks and was followed by re-administering the Attitudes Regarding Measures survey to the above parties.

This study indicated that measures properly administered increased the joining between professional and participant, empowering the participant. It also seemed to create a change in the role of the professional from a problem identifier to one of a solution sounding board. Time on task and attendance records were monitored to collaborate the hypothesis that measures would increase the focus and direction of service delivery. It was felt that both attendance and time on task would increase. Attendance did increase but time on task proved too difficult to measure.

CHAPTER 1: INTRODUCTION

The Setting of the problem

The proposed problem solving project focused on the family preservation program of a multi-service abuse prevention and rehabilitation agency. The 14-year-old agency currently operates in a small rural county almost 25 miles from the capital of a Rocky Mountain state. Organizationally, the agency is registered as a not-for-profit agency governed by a voluntary Board of Directors and administrated by an Executive Director. The agency employs 26 people that work in four departments. Each of the four departments are headed by a Departmental Director. The residential department operates with 11 direct service workers and three support staff and is responsible for the treatment and care of 18 abused boys and girls ranging in age from 5 to 15. Closely related to the residential department is the educational department. The educational department employs four direct service workers for the on-grounds school and day treatment program. The therapeutic foster care department's two direct service workers are charged with placing children who have no home to return to after treatment has been successful and supporting their foster families. The clinical department oversees the entire agency on a case-by-case basis.

The clinical department's three workers are charged with providing therapy and treatment consultation for each of the 18 residential children and their families if they are involved. They

are also responsible for overseeing the clinical aspects of the educational day treatment program, both child and his/her family, and the therapeutic foster care program. Additionally, the clinical department is responsible for the agency's family preservation program.

For the family preservation program, service delivery remains similar to what it was at its inception in 1983. Each family enrolled in the program receives five hours of in-home support and therapy per week by a family specialist. In addition to this, the family receives one hour of family therapy in the office per week by a master's level licensed therapist. The therapist and family specialist work closely together, coordinating services in a teamwork approach. At its height, the program had 8 families enrolled at one time. Because of county budget cuts, the program now only has room for two families at a time and has a lengthy waiting list. Current legislative funding directions may make some positive changes in this. The agency is also beginning to look at the family preservation program's potential in family reunification and day treatment.

The family specialist's job concentrates on concrete skills and problem solving. The responsibilities of the family specialist include crisis intervention and teaching basic living skills such as budgeting, nutritional needs, hygienic needs and conflict resolution. Often, this person finds it appropriate to accompany program participants to support groups or doctor appointments as a support to the family, helping them feel successful in meeting

their needs and developing support structures. Much of this person's time is spent modeling appropriate behaviors such as cleaning, redirecting children, and home repair. The family specialist quickly becomes the panic button as well as the safety valve for the family.

The therapist works through the office to create a more controlled environment to tackle the job assignment. The therapist's task is to help the family look at issues as a family system problem. Frequently, the therapist delves into the past with genograms and family histories locating the origins of where the family is stuck. Whereas the family specialist concentrates on the here and now problems, the therapist helps the families locate their reasons behind the problems they are facing.

As a team of professional partners, the family, the family's caseworker, family specialist, and therapist collaborate at the beginning of services and form a Goal Attainment Scale. In this process, goals are identified and for each goal three statements are written. The goals begin with what the team decides as optimal. This is "above goal" status. The team then takes a step back and decides what is the least acceptable level of functioning and labels this as "at goal" status. The team continues by labelling the specific problems the family and caseworker now feel as unacceptable as "below goal."

These goal statements are the basis for the monthly reports that are sent to the family's caseworker as justification for continued services. Services concentrate on four major areas:

parenting skills, marital relationship/parent-child boundaries, social supports, and finances. Currently, both the therapist and the family specialist write a monthly report using the Goal Attainment Scale as the framework. They use their professional perception as justification of where the family is with regards to a particular goal. Over the course of the month, the therapist and the family specialist confer regarding the crises the family has faced and discuss how those crises were handled. Together, then, they will decide if the family has progressed or regressed to the stated goals.

The agency has a strong philosophical base that permeates every level of service delivery. First, the agency is dedicated to providing services to underprivileged families that could not receive the quality of services needed through their own means. Consequently, the agency's primary funder is the Department of Social Services, supplemented by charity. Cases involving insurance payments of service are referred to a for-profit organization in an adjacent community. All cases received by this agency are referred by the county Department of Social Services. For many families, this agency is the last hope at staying together or reunifying.

Secondly, the agency has a strong commitment to the family systems approach to helping families and children. Reframing family conflicts and problems from a blaming and scapegoating viewpoint to a breakdown in a system is a major focus. This concept is carried over to the administration of the agency. The

agency has a long standing commitment to parallel processing, or treating workers as workers should treat participants.

The agency as a whole has begun to examine family support concepts of parental-professional partnership. Traditionally, the agency has worked from a deficit model of treatment. This entails finding where the family and child is weak and using professional know-how to shore up the vulnerable places in the family. This has largely been encouraged by the Department of Social Services. When deficits are the emphasis, services appear more justifiable but families may be disempowered because of the constant focus on where they are weak. When strengths are emphasized families feel more empowered but service justification becomes more difficult. Consequently, the agency and specifically the family preservation program has begun to seek a balance between justifying services for the funder's sake and seeking methods of empowering families through family support orientation at the same time.

The Goal Attainment Scale holds a valued position both inside and outside the agency. Various Departments of Social Services have commented that reporting on family progress using the Goal Attainment Scale is a thorough and professional method of reporting. Both the Board of Directors and administration have asserted that the Goal Attainment Scale will remain an important piece of this agency's tools in helping families despite it's tendency to focus on deficits.

At the same time, the administration has allowed some experimentation regarding pre-Goal Attainment Scale family work to

empower families through the goal setting process. Some pilot work has been done helping families develop family statements of identity before setting goals. These statements include the family's core beliefs, values, strengths, and identity. Goals are then set by looking at the family statement and seeing where the family feels stuck or incongruent with what their ideal is rather than merely focusing on what professionals assess as being the family's weak areas. This pre-Goal Attainment Scale work has gained the Clinical Director's approval and will probably be incorporated as standard procedure in the future.

Student's role in setting

This practicum project was undertaken by an agency therapist who also served as the family specialist for the family preservation program. Since the family specialist held a low organizational position in the agency, much work was done to set the stage for the practicum with intra- and extra-agency policy makers. The Executive Director, Clinical Director, and family preservation therapist were all briefed on the proposed problem solution and were interested in participating in the practicum and reviewing the findings. The Board of Directors determined that the practicum lies well within the philosophy of the agency. The local Department of Social Services was also prepared for the changes proposed and agreed to the 10 week trial period.

CHAPTER 2: THE PROBLEM

Problem statement

On the outset of this practicum, assessment of goal attainment is not a family matter in this family preservation program. The family was involved in the process of developing the goals and, as mentioned in Chapter One, have received more and more power in that process. Determining what the direction the services take in individual families or whether stabilization has occurred was largely a matter that is left to the professional family specialist and therapist. Additionally, assessment by the professional was subjective, based on the professional's experience and judgement. No standardized methods of measurement were implemented in determining the family's status on their goals. Furthermore, no systematic method of family input was operationalized in the reporting procedures. If what the family states was congruent with the professional's assessment, it was included in the reports and seen as insightful. If it is not, the professional's vantage point was taken as more plausible. Therefore, the problem is a lack of objective methods of goal assessment that enhance family input into the family's program direction and add the family's perspective to reporting procedures.

Description of the Problem

According to Maluccio (1991), family preservation is traditionally steeped in the philosophy that participating families should be considered colleagues or partners. Mannes (1993) states,

> "Treatment ideologies under family preservation help families meet their essential needs in more natural settings, such as the home, by way of imparting life skills and linking them with environmental supports as opposed to employing 'personalistic psychologies' designed to assess and resolve the pathologies of individual members." (p.12)

In short, family preservation holds to the concept that families in crisis need help in finding methods of helping themselves. Often, the family specialist of this family preservation program entered a family attempting to set up the professional partnership by stating that he/she is an expert in how families operate in general. The family members are experts in their own family operation.

Theoretically, this fulfilled the philosophical requisites of family preservation and support. In practice, however, an implicit hierarchy existed that placed the professional above the family. This was largely because of the reporting procedures. The family knew that the last say was left to the professional. It was doubtful for a family to fight for equality when it had been in the system and feels beaten down by it.

One would have thought that objective measures would have been a welcomed addition to service delivery. This was not necessarily the case. The overall barrier to measurement implementation can be broken down into two main issues. First, objective measures clearly redefine roles in the service delivery process. This means change and change of any magnitude is often met with some amount of resistance. Specifically, those who have control now in crisis identification and growth awareness (i.e., the providers and

funders) lose control with measurements because their subjective professional assessments may be challenged with objective measures. Those who may not want control or want others to take control (i.e., certain types of participants) will find themselves having to take on the responsibility of identifying where they are stuck as well as how effective they are in overcoming their problems.

The Practitioner

For the practitioner, the root problem seemed to stem from an incongruence between research and practice. Several barriers exist both within the agency and outside that keep client-centered research out of practice. Outside the agency, Floyd et al. (1989) identified the following,

> "One likely reason for the neglect of structured, empirically-based assessments by family clinicians is the resistance to research-like activities by family therapists [service providers] who perceive a clash between the goals of research and treatment. That is, many clinicians view structured data collection as a futile attempt to reduce constantly fluctuating family processes into static statistics." (p. 271)

Similarly, within the agency, one perceived complication was lack of time. Each therapist has an enormous amount of work to fit into 40 hours a week. To take the time to find appropriate measurement tools, incorporate them into the service delivery as well as integrate the findings into the reporting procedure would take some adapting and pioneering, all of which will take time and energy.

The agency met this study proposal with several hints of apprehension while showing interest in implementing self-report measures. These apprehensions suggested other barriers. In

discussing the practicum proposal with the clinical staff, a concern was voiced that such objective measures would pigeon-hole families. From an interpretation of family systems, such standardized measures could scapegoat family members, neglecting to point out the dynamic causes of the static roles within the family. This agrees with Floyd's statement mentioned above.

Families also span a wide spectrum of normality. To use standardized objective measures may miss the family's actual problem areas. For these families, finding a more suitable measure may be necessary, thus increasing the workload of the professional even more.

Another point of anxiety was the perceived threat to professionalism that the objective measures carried. Objective measures could conflict with the subjective findings of the professional, putting the professional on the defensive. Dunst et al. (1988, p. 67) call this phenomenon "oppositional encounters" caused by a newly created balance of power in the therapeutic relationship. The measures may switch a system from professional assessment to one where the family rates their problems and their progress. This may move treatment in a different direction than the professional may see as most beneficial. Furthermore, Dunst and Trivette point out that the application of objective measures in practice "implies that theory and research should govern or even dictate intervention practices, whereas we believe it should suggest and guide practice." (Dunst & Trivette, 1988, p. 132) The

fear remains that the professional will be replaced or overruled by the measure.

The meaning behind using these measures emphasizes that participant and professional are on equal footing. Professionals who enter the field "to save families" may now find themselves helping families save themselves--a much less glamorous occupation. One concern stated specifically was that the need for the professional may become obsolete if the Department of Social Services decided to use the same objective measures in goal assessment and forego purchasing services from the agency.

These barriers are not exclusive to this particular agency. Floyd reported that,

> "Many family clinicians have not kept pace with empirical developments in their own field. Instead, they have continued to rely on impressionistic data collected in an unstandardized fashion as the primary method of evaluating the families they see." (p. 271)

The Participant

Regarding barriers that relate to the participants, Grinnell and Williams (1990) state,

> "The first practical consideration we have to examine is whether our clients or subjects will complete the instrument. There are three factors which influence this: how long the instrument is; whether the subjects understand it; and whether the subjects like the look of it." (p. 94)

Taking into consideration the crisis mentality that permeates families in family preservation (Kagan, 1982), the simple task of getting families to fill out the form was thought to prove most difficult. In addition, scheduled appointments are often canceled or missed because of the numerous crises that arise. It was highly

probable that getting the measures to the participant, having them fill it out, and scoring it within a week's time may be unfeasible.

From the participants' perspective, the potential problems for these measurements were several fold. First, a large concern was that time or memory were not available to do the measures on a consistent basis. This was seen as resistance to both change and empowerment. As mentioned in Chapter One, most of the families in the program have been through and failed at many programs. The families have learned from their dealings with a large, powerful system that to follow directions is much more profitable than creating their own and justifying it. One participant responded to the idea of objective measures by saying, "You mean this piece of paper will tell me where I'm stuck and if I'm getting un-stuck? I'm not sure I want to find that out in plain English."

Surprisingly, families felt more uncomfortable at the prospect of measuring their own progress. This phenomenon was similar to initiating the family statement portion of the program. The probable cause of this seems to lie in that many of these families have grown comfortable in denying that a problem exists in their family. For some families, if someone outside the family system perceives a problem, the outsider is bounced out of a position to help the family (Walsh, 1982, p.65). For others, such problem finders are solution-makers on whom the family grows dependent (Walsh, 1982). In both extremes, the prospect of the family identifying their own crisis areas can be a scary step of responsibility.

Along the same line of thought, most families have learned to guard their words carefully because all information gathered could be used against them. If the professional subjectively stated that a problem existed and it was not going away, the family could dismiss it as either the professional's incompetence or uninformed status. The situation could change completely when the participant's own pen brings to light a crisis or the continuation of one.

Another family support program offers additional insight into possible barriers that may have lay ahead with participants. Rodriguez and Cortez (1988) evaluated the ADVANCE parent-child education program. During the study, involving questionnaires and interviews, the Rodriguez and Cortez noted a pattern of behavior from the participants. Stated Rodriguez and Cortez,

> "...although genuinely interested in helping ADVANCE and willing to cooperate and assist in whatever they could, the participants were unimpressed with the research aspects and more eager to proceed with the services and other activities." (p. 295)

The possibility existed that the participants may see implementing research tools as simply an academic project that inhibited service delivery.

The Funder

The primary funder of the program, the county department of social services, had one major concern for the implementation of objective participant-oriented measures. This concern surrounded the concept that the participants could score and learn from the measures without professional help. The door would be open for

families to lie and "cheat" to get out of services earlier than the social worker would feel comfortable with closing the case. Furthermore, according to the director of the county department of social services, legal officials tend to prefer objective measures over subjective judgements of professionals. If a measure inaccurately showed a family was ready to rely on their informal support structure prematurely either through lack of validity or reliability, it would be doubly difficult for the case worker and service provider to justify continued services based merely on instinct or isolated incidence. In such cases, the case worker and/or service provider would have to prove the invalidity or the ease of "deception" in the measure used; thus, in effect, raising questions of their own competence.

The Potential of Applying Measures

Many barriers to using objective measures exist as seen above. The underlying cause of these barriers seems to stem from a misunderstanding of how measures are optimally implemented into practice. Dunst and Trivette (1988) call this optimal procedure "assessment and intervention." (p. 11) If measurements are used correctly in practice, the benefits far outweigh the barriers listed above.

Several important concepts exist in correctly implementing measures in practice. The first concept is to emphasize that measures are tools used by practitioners and participants to gain insights where the practitioner-participant relationship clouds objectivity. Measures influence; they should not dictate program

directions, nor should they replace the people factor (Grinnell and Williams, 1990, p. 21). Secondly, assessment and intervention needs to be seen as a "dynamic, fluid process." (Dunst and Trivette, 1988, p.11) It is an avenue for practitioner and participant to interact in a focused and productive manner. Measurement tools start and focus discussion. They are not program dictators. Thirdly, using measures in practice must be done in non-invasive methods to be most effective. If families feel that the goal of the practitioner or funder is to incriminate them, they will resist any treatment offered (Beavers, 1977). If, however, the practitioner uses the measures to help determine that the family and practitioner are operating from the same mindset and priorities, measures could potentially be a powerful joining tool that will enhance the professional partnership (Dunst & Trivette, 1988). If these standards are met, measurement implementation in practice stands to improve practice for all involved.

Participants stand to gain a more empowered stance in the program process. Whitehead et al. (1990) found such tools helped clarify the direction of individual family progress and goal formation in a concise manner. When the participant has the ability to take responsibility for assessing goal attainment, the family stands to gain a sense of personal empowerment over the problems they face. According to Cole and Duva (1990), this is one of the primary goals of family preservation.

Floyd et al. claim that "a more purposeful approach to therapy is created, where the clinician is testing, refining or refuting

hypotheses rather than drifting unproductively." They continue by stating that such measurement tools are "less subject to some of the biases that can distort clinicians' judgements." (p. 273) In practice, practitioners often find themselves drifting unproductively because the alliance they have with the participants tends to blind them to what is actually going on in the family system. In order to be effective, joining the family on some levels is necessary. Joining the family too much or too little can create "blind-spots" to potential problem areas. Measures can provide practitioners and participants with a view of those blind spots and create a more focused and clear strategy for program directions. Floyd et al. state,

> "They [structured assessments] provide an empirical basis for prioritizing the mound of information a family presents to the therapist, helping to sort salient issues from 'noise' in the system." (p. 273)

Measures can also be helpful in the practitioner-funder relationship. According to Littell (1986), "...evaluation can help you describe your program to people outside the organization (p.3)." Using a reliable, valid measurement tool in practice can be an effective selling tool for the program. Implementing objective measures in family preservation practice has a secondary effect of showing a program's overall effectiveness. In a time when funding will continue to grow scarce, funders will appreciate spending their money in programs that can be objectively and subjectively proven effective (Littell, 1986, p. 3).

CHAPTER 3: GOAL AND OBJECTIVES

Goal

Through Chapters One and Two, two concepts have been established. First, research and practice have suggested that using objective measures enhance the participant's growth and ownership of goal attainment in family support and preservation. Secondly, such measures are not widely used in practice because of various reasons. Therefore, from the standpoint of this practicum, the problem rested in a lack of objective measures used in practice and reporting procedures that resulted in disempowered participants. The goal of this practicum was to introduce and implement objective measures in family preservation work.

To reach the goals of this practicum the objectives address both attitudes and knowledge regarding measures from participants, providers, and funders. The objectives also address accurate and consistent implementation of the measures chosen.

Objectives

Based on the goal stated above, the objectives were identified as follows:

(1) The participants would increase their involvement in their own growth and goal attainment as a result of feeling more empowered by the end of the 10 week trial period. This will be measured by attendance records and time spent on task during sessions.

(2) The participants', practitioners', and funders' attitudes would change, feeling more acceptance toward the stance that objective measures benefit service delivery. This will be measured by the Attitudes Regarding Measures survey (see Appendix B) in a pre-test/post-test format.

CHAPTER 4: SOLUTION STRATEGY

Objective Measures in Practice

Regarding the problems that surround lack of measurements in practice, most of the research point to simply implementing it. The type of measure used, however, has varied across a vast spectrum. According to Walker and Crocker (1988), four types of family assessment measures exist: "(1) direct interviews including structured tasks, (2) observation/rating scales, (3) self-report scales, and (4) projective techniques." (p. 158) Each type of measure has been used in practice, showing strengths and weaknesses alike.

Direct Interviews

Using direct interviews and supplementing them with task assignments is a common attempt at objective measurement in family work. (Floyd, 1989; Dunst & Trivette, 1988; Holman, 1983; Leader et al., 1981). Although this is not a clearly objective method, the advantage to this method of measurement is that many people find it more comfortable for the participant. States Grinnell and Williams,

> "Most people are more comfortable talking than they are writing, possibly because they learned to talk quite painlessly while learning to write involved strained finger muscles and injudicious chewing of erasures." (p. 211)

Two disadvantages exist with direct interviews that create service delivery barriers in family goal attainment assessment. First, direct interviews are time consuming (Grinnell & Williams,

1990). To do a complete interview on the family's progress on a regular basis would take a considerable amount of time from service delivery. Secondly, direct interviews are open to higher levels of interviewer bias and the interviewee's desire to give what is thought to be the correct answer than the other forms of measurement. They are, therefore, valued more as tools of description rather than tools of standardized and quantified measurement of goal attainment (Walker & Crocker, 1988). Because of this quality, direct interviews are often used with other methods of objective measurement (Floyd, 1989; Dunst & Trivette, 1988).

Observation/Rating Scales

These types of scales involve watching a family for a given period of time and then filling out a scale afterwards. Such scales include the Caldwell-Bradley HOME scale (Caldwell & Bradley, 1984) and the Beavers-Timberlawn Family Evaluation Scale (Lewis et al., 1976). The advantage to this method of measurement is that, unlike the direct interview, it lends itself well for progress assessment. The standardized scales filled out after a session do not allow the researcher or participant to stray off topic during the assessment.

Numerous barriers to observation/rating scales' effectiveness in service delivery exist. First, as Grinnell and Williams note,

> "The thing about participating and observing is that it is difficult to do both at the same time. If we participate fully, we will not have time to observe; if we observe fully, we will not have time to participate." (p. 223)

The HOME scale has not been shown to be effective unless 6 uninterrupted hours are spent observing before filling out the scale. This increases the number of hours necessary for service delivery dramatically.

Halpern (cited in Upsher,1984) recommends that such measures not be administered by practitioners who may be too close to the participants to be objective. So, along with the amount of time necessary to participate and observe, it is also recommended that additional practitioners be involved costing more money and intrusion into family life.

Projective Techniques

Projective techniques of assessment place the family or individuals under a pre-specified set of stimuli and observe the responses of the participants. Such measurement tools as the Family APGAR Index (Smilkstein, 1978) and the Thematic Apperception Test are included in this type. Even though the validity and reliability of such measurements tools are debated vigorously, the main problem with projective techniques is that they conflict with family preservation philosophy. The format of the tests assume that the family will give biased information and thus needs to be kept in the dark as to what is actually being tested. This is why projective techniques require trained clinicians to administer the tests and interpret the data collected. A genuine partnership between family and practitioner cannot exist when the practitioner has an unspoken agenda. On a more practical level, projective techniques are unrealistic in family preservation work because

families and direct service providers are not qualified to complete the assessment process (Walker & Crocker, 1988).

Self-Report Scales

Self-report scales are completed by participants and often require no special training to interpret. The disadvantages to such tools are that they require time to fill out and that the participants may feel inhibited or drawn to deceive practitioners by putting things down in black and white.

Regarding the need for self-reporting, or client centered, measurement tools, Brickman et al. (1983) states that it is the "recipient's own belief in [him or herself] as a causal agent that determines whether gains will last or disappear." (p. 32) Both Dunst et al. (1988) and Bandura (1977) agree that help is much more readily received if the participant is able to take ownership of the awareness of both the crisis and the growth in their life. Furthermore, Dunst et al. state, "Help is more effective when the help giver allows the locus of decision-making to rest clearly with the help seeker." (p.94)

The statements above confirm the theory that family help is most effective when the family has the control. Self-report scales give more control to the family than any other method listed above. This research also confirms that objective measures maintain high potential for enhancing the therapeutic process of family preservation. If the barriers can be overcome through implementation and education, all involved in the program will see

an increase in family empowerment and program efficiency and effectiveness.

Whitehead et al.(1990) noted a lack of objective measures in goal assessment in Delaware's FIRST program, a special education program. Their study involved simply implementing the measures and recording changes in goal attainment as a result. Others have followed this simple research strategy. (Wells et al., 1993; Szapocznik et al., 1991) Most of the research regarding such strategies, however, are primarily intended to prove reliability and validity of a certain measure and secondarily concerned with the effects measures have on program effectiveness.

According to Littell (1986),

> "In general, it is better to gather information from several different sources (eg., program participants, direct service personnel and program administrators." (p. 42)

This broader based research approach allows the researcher to take a more systems orientation to identifying problems. It allows researchers to move away from identifying only single causes for existing problems. In objective measure impact research, the participant's reaction to objective measurement implementation is only a piece of the full impact. Floyd (1989) took such a larger perspective on the problem of lack of measures. He and his colleagues hypothesized that measures were not being used because of a lack of understanding and an abundance of biases regarding measures. His study took a two-pronged approach to the problem solution. First, much time was spent in orienting participants to using measurements. Then, once oriented, the measures were

implemented. Both the participation and the goal attainment were closely monitored by a team of service providers. Floyd and his team found that this approach benefitted both practitioner and participant in further developing the partnership as well as increasing goal attainment.

Practicum Study Strategy

For this particular study, much of what was stated above was useful. Logically, the best way to solve the lack of measures is to implement them as Whitehead did. Certainly, Floyd has a point that biases and lack of understanding are barriers to their usefulness in treatment. However, the structure of this study added to Floyd's approach. In Floyd's study, the providers and the funders were in agreement that measures would be helpful because of their understanding about measures. The study was to find methods of helping participants grow towards the same feeling. In this study, one practitioner understood this potential. The other practitioners and funders as well as the participants felt less inclined to believe that measures will be effective. The additional step of educating all of the above parties regarding how measures would be advantageous was incorporated to enhance the measure's effectiveness.

The solution strategy was to systematically measure the attitudes and knowledge of all involved regarding implementing measurement tools in practice. This was done by administering the Attitudes Regarding Measures survey (See Appendix B) in a pre-practicum/post-practicum format.

Following the pre-test survey, a workshop was offered to the providers and funders to explain the particular measurements to be used and how measurements have proven effective in similar programs. The same information given in the workshop was provided to the two currently enrolled families during service delivery. The week following was the first implementation of the measurement tools.

The measures were self-report scales because of the amount of control they transfer to the participant from the provider in assessment. The measure used was the Family Assessment Device (Epstein et al., 1983). The Family Assessment Device is a 60 question self-report measure that yields insight into such areas as problem solving, communication, affective responsiveness and involvement, behavior control and general functioning. These areas closely coincide with goals that the Goal Attainment Scales currently center around.

The reasons behind the selection of the Family Assessment Device were numerous. First, the philosophy of the self-report measure fit the goal of empowering families by giving them equal and objective input in the reporting procedure. Secondly, the Family Assessment Device complemented the current parameters of goal assessment scaling (see Chapter One). Thirdly, the measures could be completed by all members of a family able to write, thus using a family system approach. The Family Assessment Device could be completed within 20 minutes and scored immediately. The Family Assessment Device has shown itself to be valid and reliable as well

by at least two separate sources (Kabacoff et al., 1990, Miller et al., 1985). A computer program complemented the Family Assessment Device making it easier for the family specialist and therapist to collate and incorporate the findings into the Monthly Reports in a professional and graphic manner.

The strategy called for the measures to be administered every week and scored immediately as a joint venture between the practitioner and participant. The families indicated during the implementation that scoring was not to their liking. They were satisfied in knowing how to score the measure and trusting the family specialist to do it for them. At the end of the month, the practitioners and participants were to summarize the measures' findings and discuss what beliefs or behaviors caused changes in the measures' findings. Because of the funder's unavailability, this happened only once formally during the two and a half months this practicum was implemented. The rest of the meetings to summarize were done informally between the family specialist and the family. The practitioners then incorporated the information received from the measures and the discussion mentioned above into the Monthly Reports sent to the participants and the funders.

At the end of the 10 week trial period, a summative presentation was offered to providers and funders. This presentation illustrated the changes that could be directly tied to the objective measures in participant participation and progress in goal attainment. Specifically, the families' goal attainment, attendance records, and time on task, during the 10 week trial

period were contrasted with previous records. This showed that measures add a definite clarity to goal attainment and program direction for individual families. At that time, the Attitudes Regarding Measures (see Appendix B) was re-administered to each provider and funder. During the last week, the instrument was administered to each family individually as well to document any changes in opinions of the use of measures.

Calendar of Implementation

Below is the planned calendar from the onset of the practicum's implementation. Every attempt was made to remain within the plan put forth in the calendar. A few deviations from the planned strategy were made, however. First, it was discovered that the families saw the scoring of the measures as an unwise use of time. They were comfortable with learning how to score the measure and then allowing the family specialist to do it for them, sharing the results soon after scoring. The measures were then implemented and then the scores were shared during the next session. Secondly, the monthly conferences to discuss the finding of the measures were greatly hindered by the funders' availability and the coordination of many conflicting schedules. Only one of the three scheduled meetings took place formally. The formal conferences were replaced with informal conferences between participants and the family specialist. The rest of the calendar was followed closely.

Before Week 1: 1. Give the participants a short introduction to the study proposal and

give them opportunity to think about voluntarily participating.

2. Administer the Attitudes Regarding Measures survey to practitioners, funders, and volunteering participants.

WEEK 1:

1. Do the Introductory Workshop with providers and funders.
2. Do introductory workshops with individual participants.
3. Administer the Family Assessment Device and score with participants.

WEEK 2:

1. Administer the Family Assessment Device and score with participants.

WEEK 3:

1. Administer the Family Assessment Device and score with participants.
2. Hold staffing with family and all providers involved to interpret data from the Family Assessment Devices.

WEEK 4:

1. Administer the Family Assessment Device and score with participants.
2. Incorporate findings and interpretations into Monthly Report.

WEEK 5:
1. Administer the Family Assessment Device and score with participants.

WEEK 6:
1. Administer the Family Assessment Device and score with participants.

WEEK 7:
1. Administer the Family Assessment Device and score with participants.

WEEK 8:
1. Administer the Family Assessment Device and score with participants.
2. Hold staffing with family and all providers involved to interpret data from the Family Assessment Devices.
3. Schedule Summative presentation and the re-administration of the Attitudes Regarding Measures.

WEEK 9:
1. Administer the Family Assessment Device and score with participants.
2. Incorporate findings and interpretations into Monthly Report.

WEEK 10:
1. Administer the Family Assessment Device and score with participants.

2. Hold summative presentation on the effects of measurements on participant progress and participation.
3. Re-administer the Attitudes Regarding Measures survey and note changes from pre-testing.

CHAPTER 5: IMPLEMENTATION

Strategy

The implementation period began in late February of 1994. Few deviations from the planned schedule were made, however, two significant ones did occur. First, practitioners were unable to hold monthly evaluative conferences because of the unavailability of the caseworker. Second, families were unwilling to score their own measures, resulting in the family specialist taking this responsibility. The rest of the plan was carried out as outlined in chapter four.

The Practitioner/Funder Initial Workshop

The practicum began with the scheduled initial workshop for practitioners and funders. The practitioners and program administrator were able to attend. Included in the practitioners was a social worker intern from a local university, who worked side-by-side with the family specialist with one family for the duration of this practicum. The funder was unable to attend at the last minute because of a crisis. The initial workshop began by looking at what was currently being done in goal assessment. It took a look at how assessment was done primarily by the professionals prior to the practicum. A look at family preservation philosophy, especially family empowerment, followed this discussion. After this, the proposed solution strategy was explored. A general sense of either frustration or anxiety was felt during the workshop. This general feeling was later

identified through individual discussion as an uncomfortableness with measures and the potential of needing to use statistics in practice.

The workshop was rescheduled for the funder for the following week. As it turned out, the funder was finally available in the eighth week of the practicum. She had the opportunity of not only hearing the theory behind the practicum proposal but seeing some of the raw data that seemed to support the theory.

The Families' Orientation

Both families that participated in the practicum were oriented to the use and theory of measures in family preservation practice. Both families completed the Attitudes Regarding Measures survey. After a general introduction to measures in practice, specific instruction was given regarding the Family Assessment Device. Both families were shown how to score the Family Assessment Device as well as how to interpret the device. Once the families felt knowledgeable about what was being proposed, they were given the opportunity to participate. Both families accepted.

Findings: Participants' Involvement

Family Assessment Device Completion

The Family Assessment Device was administered on a weekly basis by various practitioners. The measures were administered primarily during service delivery. Occasionally, the measure was left as a "homework assignment." Each of these times, the measures were not completed.

Both families expressed a large disdain to scoring the measures. Since family preservation is dedicated to building on strengths and both families expressed that math was not a strength, the family specialist scored the measures outside service delivery time. The results were then graphed and shared with the family for discussion and interpretation.

Each family completed five out of the 10 weeks' devices. Failure to complete the measures can be divided into three categories: lack of contact with service providers, habit of filling out the measure not established, and fear of change that may result.

For Family A, one of measures was not completed because they were unavailable to see the family specialist and the therapist for the week. Two of the administrations were given as assignments and were "forgotten." One administration was refused because both parents were not available at the time of administration. One week, the therapist agreed to administer the measure and neglected to do so.

For family B, one administration was missed because of an unwillingness to see the therapist and an inability to see the family specialist. One administrations was given as homework assignments and were not completed and two were not given by the therapist because the therapist forgot to administer the measure. One measure was declined by a teen child because it was causing too much change. He attempted to burn his measure in the fireplace,

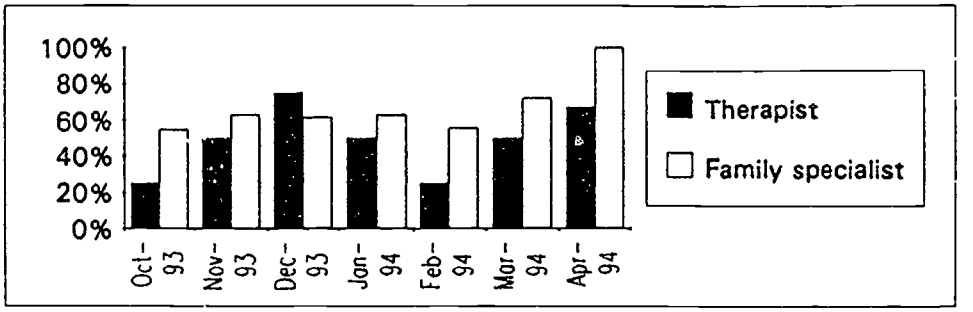
causing his family to react by declining to take the measure as a whole.

Attendance Response to Measurement Implementation

The attendance records for the two families showed an interesting pattern that may have occurred because of the measures. The family specialist's attendance records showed an increase in attendance following the implementation of the measures. Powell (1983) noted a 38% same day cancellation rate in his 21-month parent-child support program study. This showed the prominence of crisis mentality in the population served. This prominence is evident in this program's population as well. Before this study's implementation, this family preservation program ran an average of 43% cancellation rate for the family specialist and a 68.6% cancellation rate for the therapist. As seen in the following chart, the family specialist's attendance records shows either a gradual increase or a maintenance of attendance up until April, 1994. April was the second complete month of implementation. In April, the attendance records increased significantly for both families. One family increased their attendance from 72% to 100%. The other family went up from 50% to 87.5%. For the therapist, the numbers continued to fluctuate in both families regardless of implementation. The family specialist's cancellation rate decreased considerably to 22% while the therapist's cancellation rate decreased minimally to 64.5%.

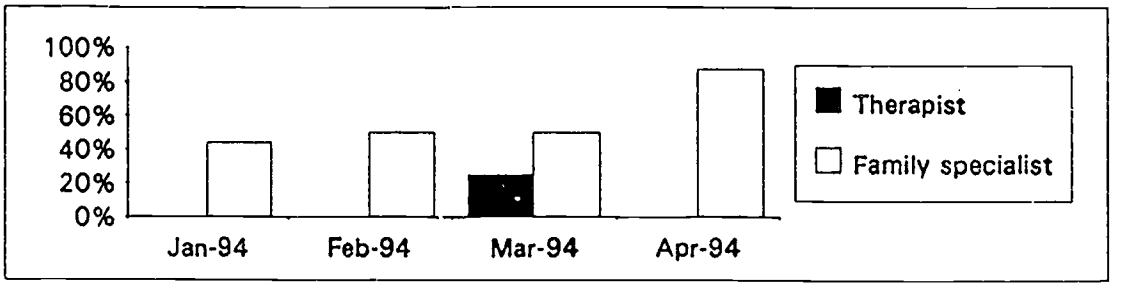
When this fact became apparent, the family preservation team attempted to find the cause of the difference. During a

Family A attendance tracking



	Therapist	Family specialist
Oct-93	25%	55%
Nov-93	50%	63%
Dec-93	75%	61.50%
Jan-94	50%	63%
Feb-94	25%	56%
Mar-94	50%	72%
Apr-94	67%	100%

Family B attendance tracking



	Therapist	Family specialist
Jan-94	0%	44%
Feb-94	0%	50%
Mar-94	25%	50%
Apr-94	0%	87.50%

brainstorming session, it was discovered that the therapist was administering the Family Assessment Device but leaving the sharing of information received to the family specialist. On further

investigation, the families shared that they became uneasy with the therapist's administration practice, wondering if he was gathering information to use against them. It is important to note, however, that having families come into the office for clinical counseling has been a consistent problem in the past. Both families, typical of those families that qualify for the family preservation program, had stopped attending clinical therapy numerous times previous. It appears that the families involved in this study took their weariness of the "therapist" into the therapy session and presupposed that the therapist was being intrusive by giving the measure without the sharing the results.

Olds (1986) found in researching a prenatal/early infancy project that administering measures and "tests" to an experimental group can cause a reactivity towards services. Formal assessment can either inspire families to work hard as a in order to please the assessor, or the families may give up because they feel the statistics will show them to be a failure. It appeared that during the first month of implementation, both families were reacting negatively to the test. One family's attendance went down by 6% during the first month of implementation. The other family's measure results were showing little crisis in the home, but the discussions were uncovering multiple overwhelming crises. Old's advice of minimizing the testing was taken to heart. The families were assured by the family specialist that the measures were an attempt to improve services to families and that their attitudes about measures were more important to the study than the measures.

This took the pressure off the families to show on paper that they were without crisis. It also focused them in determining whether the measures would be helpful for the future participants.

Time on Task Measurement

Another objective stated as a possible measure to this practicum was time on task. Specifically, time on task was defined as how much time was spent directly dealing with the issues that warranted family preservation services for the family. This proved to be too difficult to measure. Before the practicum, the general practice of service delivery was for the family specialist to enter the family sessions with an agenda that was decided on in the last session with the family. The latter four weeks of the practicum, it was noted that sessions were not being pre-planned. A new pattern emerged as a result of the Family Assessment Device. The family would complete the Family Assessment Device and the family specialist would score it for the next session. The family specialist would then take the scores and graph them showing the family's progress or continued crisis in the different areas. The families were then given an opportunity to explain the changes in scores using their own words. This accomplished two things. First, it proved to be a valuable joining tool with the families. The family specialist would use the family's terminology instead of the human service terminology. This created a genuineness to service delivery. The family specialist was not seen as part of "the system" as much as a support to help the family out of the "system." Second, it helped the family take ownership for the

problems they perceived, spurring them on to create their own solutions to the problems they stated as having. The family specialist's role shifted from being a problem identifier to being a solution sounding board for families. Families then increased their progression on their Goal Attainment Scales as a result of the joining and empowerment.

General Observations of Participants' Involvement

At the onset of this practicum, it was hypothesized that both attendance and time on task would increase because of the additional focus and family empowerment the measures would provide. What was discovered was that the families valued the potential for joining and empowerment more than the potential for focus offered by the measures.

Several steps were taken by the family specialist that may have resulted in the higher levels of attendance with the family specialist. These steps were neglected to be accomplished by the therapist which may have negatively affected their attendance with him. First, the family specialist used the measure to join with the family by sharing the findings as soon as possible. When the families identified the cause of their unwillingness to be "tested" by the therapist, it was discovered that they struggled with the therapist's delegation of sharing the findings with the family specialist. The sharing of the findings strengthen the bond between the family and practitioner through active listening and using more family-friendly terminology. When the sharing did not

take place, skepticism and doubt of intentions created a chasm in the relationship between family and practitioner.

Secondly, the family specialist took every opportunity to point out that the only significance the measure offered was for the family to help itself. This helped the family see the intentions of the family specialist clearly. The therapist did not verbalize this concept and the families responded by being concerned as to why the therapist wanted to "test" them.

Although a clear, objective determination was not possible in measuring time on task, both the therapist and the family specialist assessed a subjective decrease therein. In retrospect, this was not a failure of the families nor of the practitioners. It was a part of a faulty hypothesis. When families feel more empowered, they "need" less help. Time on task decreased but the families felt more in control and perceived greater goal attainment as a result. They no longer needed to discuss everything with the practitioner. They were able to take advantage of the measures' ability to help them focus and act on their own to problem solve. The families also felt that they were able to maintain goal attainment for longer periods of time because they were the driving force behind the changes, not the professional.

Findings: Attitudes Regarding Measures

During the final week of the practicum, the summative evaluation was held. Once again, the funder was unable to attend and was briefed individually before completing the post-test survey. The practicum proposal was briefly reviewed and graphs

showing attendance records and the families' weekly scores were distributed. These scores were discussed at length as the family specialist and the family specialist intern reviewed the families' reasons for the changes in scores. What was discovered during this discussion was that although the practitioners did not agree with the families regarding the severity of the perceived problems, they did agree on the growth the measures indicated. For example, the practitioners felt that Family A was in a higher level of crisis than Family B. Family B's scores, however, showed consistently that they felt more in crisis than Family A. After discussion, it was felt that Family A was either willing to live under greater levels of stress or more guarded in their answers than Family B. After the practitioners were willing to accept the family's perception of their functioning on an individual family basis, the growth patterns and struggles were assessed as accurate. This showed that the scores were not as important therapeutically as the families' perceptions of change. After the summative evaluation, the post-test survey was distributed and each practitioner completed one.

The Practitioners

The following chart illustrates the initial survey results as compared to the post-test results. Several patterns can be extrapolated from the survey's results. First, the measures did not change much of the practitioner's basic philosophy of service delivery, although the positions varied across the board. Positions that remained similar included: the practitioner's

PRACTITIONER'S RESPONSE TO SURVEY

Question No.	Practitioner 1		Practitioner 2		Practitioner 3	
	Pre-	Post-	Pre-	Post-	Pre-	Post-
1	2	2	4	4	2	2
2	3	2	3	2	1	2
3	2	2	3	2	2	3
4	2	2	2	1	3	3
5	3	4	2	3	3	5
6	3	2	4	3	2	1
7	4	4	3	4	2	4
8	4	4	4	4	5	4
9	2	1	1	1	1	2
10	4	4	4	4	5	4
11	2	2	2	2	3	3
12	2	3	4	3	4	4
13	3	1	1	2	1	1
14	2	2	5	5	5	4
15	2	2	2	2	3	3
16	2	2	3	4	1	2
17	2	2	2	1	2	2
18	2	1	2	1	5	2

Please note that the findings listed above are based on the administration of Appendix A: Attitudes Regarding Measures survey. This was a likert-scale questionnaire. Readers are encouraged to compare this raw data with the questions listed in APPENDIX A.

perceived family need of professional help (question 1), whose goals take priority (question 4), and the belief that professional,

subjective assessment is more valuable than objective measures (question 12). The practitioner's belief that participants want help and are generally honest remained unchanged as well (questions 11 and 15).

For the practitioners, the general movement in attitudes regarding measures were with the use of measures in service delivery itself. The practitioners moved from a place of uncertainty to believing that families will find measures intimidating (question 7). This was largely because of the "burning" incident mentioned above. The number of missed administrations also contributed to the leaning towards believing that families would find measure intimidating. This also led the practitioners to solidifying the beliefs that families will not find time nor want to fill out the measures on a weekly basis (questions 5 and 6).

Another pattern was noticed resulting from this practicum. The practitioners showed a stronger awareness of the congruency between practitioner and participant in goal setting and attainment (questions 2 and 3). In the initial survey, two of the three practitioners were not sure if the practitioners' goals and the families goals were congruent. Two of the three were not sure if the participants had substantial input in the reporting procedures as well. After the practicum, all three practitioners showed a higher level of agreement of congruency of goal setting and reporting.

Another move that the practitioners made as a whole was a growing belief that using measures in service delivery would be an improvement. Throughout the study, the practitioners surveyed continued the belief that objective measures would not take up valuable service delivery time (question 10). Two out of the three practitioners surveyed post-tested strongly agreeing that objective measures will be helpful in directing services (question 9). All practitioners ended up agreeing with this belief. All three continued the belief that adding objective measures to service delivery would be worth the effort to make permanent change (question 17). All three moved towards a stronger agreement in their willingness to use measures in service delivery (question 18). Said one practitioner, "I'm surprised to say that I actually enjoyed something statistical."

Beliefs about measures that remained the same included: objective measures do not attempt to standardize families (question 8) and judges will applaud the inclusion of measures. One practitioner noted that the measures added a level of accountability that was a relief to her. The responses given concerning whether measures take away power from practitioners and participants remained varied with each practitioner holding to their original stance.

The Participants

Each parent of the families were asked to fill out the Attitudes Regarding Measures survey in a pre-test/post-test format. Out of the two families involved, one was a single parent family

PARTICIPANTS RESPONSE TO SURVEY

Question No.	Parent A			Parent B		Parent C	
	Pre-	Post-		Pre-	Post-	Pre-	Post-
1	1	2		1	2	2	2
2	2	2		1	1	2	1
3	3	2		1	1	4	1
4	3	2		2	2	3	2
5	1	2		3	1	1	1
6	5	4		2	5	3	4
7	4	4		2	5	2	2
8	5	4		4	4	5	5
9	1	2		2	1	2	2
10	5	4		2	5	4	4
11	2	2		1	1	2	3
12	4	4		2	4	2	2
13	2	2		3	3	1	4
14	4	4		4	5	4	3
15	2	2		1	1	3	2
16	1	1		4	1	3	4
17	2	2		2	1	2	1
18	3	2		1	2	1	1

Please note that the findings listed above are based on the administration of APPENDIX A: Attitudes Regarding Measures survey. This was a likert-scale questionnaire. Readers are encouraged to compare this raw data with the questions listed in APPENDIX A.

and the other was a dual parent family. Consequently, three scores are shown for the two families. In the above chart, the raw data

can be seen by family. As mentioned above, the participants had a more clear and dramatic movement in beliefs than practitioners and funders as a result of this practicum.

All three parents ended the study generally agreeing that professional help is needed in determining how a family is progressing (question 1). Two of the three, however, did not agree as strongly, showing a movement towards family empowerment. All parents surveyed ended in the "mostly agree" category of believing that family goals take priority (question 4). For two of the three parents, this was a move from being unsure to believing that their family held a large part of the control of the direction of service delivery.

The parents showed a variety of responses towards their predictions of how families will view measures in the future. One parent moved from being unsure to strongly agreeing that families will be willing to fill out the measures weekly (question 5). This brought about a unity in the family's opinion in responses for that question. The other family's parent moved from strongly agreeing to mostly agreeing, showing more hesitancy towards weekly administrations. Conversely, both families ended the study stating that they did not believe that families will find the time to fill them out weekly (question 6). This suggests that the families are willing but because of crises or other obligations will have a difficult time completing their commitments to filling out the measures. The 50% completion rate supports this theory. One parent maintained that families will find the measures intimidating

(question 7). This parent's spouse moved from mostly agreeing to strongly disagreeing that families will find the measures intimidating. The single parent maintained that families will most likely not find them intimidating.

Although all three parents agreed that they had substantial input before the practicum, one parent felt more involved (question 2). The other two felt the same. The parent that felt the increase stated that the measure gave this parent a equal footing in the problem identification process and solution strategies not only with the professionals but with this person's spouse. All three parents ended the study feeling that their goals and the professional's goals were in agreement (question 3). One parent moved from mostly disagreeing with that statement to strongly agreeing.

Two of the three parents moved away from the belief that measures are more accurate than professional observation (question 12). The parents either maintained a disagreement or moved towards that in response to the statement that measures may take power away from the people involved (question 14). All parents concluded that measures will not take up service delivery time (question 10). For one parent, this was a move from mostly disagreeing with that statement on the onset of the study. All three parents agreed that measures will be useful in directing services (question 9), two of the three feeling strongly that measures should be made permanently

a part of service delivery (question 17). All three parents concluded as well that they were excited about continuing using measures in service delivery.

The Funder

The following chart shows how the practicum affected the Social Service caseworker's beliefs assigned to both of the participant families' cases. It is important to reiterate that the caseworker was largely unavailable for this study. The only information she received regarding this study was the Family Assessment Device charts, the monthly reports sent by the family specialist and therapist, and the two individualized workshops presented by the family specialist. She had little to no contact with the families during the study.

The funder maintained her belief that families need professional help in progress assessment. However, she showed

FUNDER'S RESPONSE TO SURVEY

Question Number	Funder A: Pre-test	Funder A: Post-test
1	1	1
2	3	1
3	3	1
4	4	2
5	3	3
6	3	3
7	3	4
8	5	5
9	2	1
10	4	5
11	3	4
12	4	3
13	1	1
14	5	5
15	4	3
16	3	4
17	1	1
18	1	1

a dramatic shift from mostly disagreeing to mostly agreeing with the idea that family's goals should take precedence. To this response shift, she stated that this study proved to her that families in crisis can still make "appropriate and healthy goals for themselves with professional prompting some of the times." Seeing the Family Assessment Device charts and comparing her assessment of the families strengths and crises shifted her position of being uncertain in believing that families are honest on questionnaires to believing that they generally are. She moved to a position of uncertainty from mostly disagreeing regarding the statement that objective measures give a more accurate perception than professional observation.

The funder's beliefs regarding the participants' response to the addition of measures in service delivery remained largely unchanged. She remained undecided regarding whether the families would be willing or find time to fill out the measures on a weekly basis. She shifted in belief to generally believing that families will not find the measures intimidating. This shift moved from a position of being uncertain.

The largest movement in belief for the funder surrounded the congruency of practitioner and participant goal assessment and reporting. From an undecided opinion of whether the practitioner's goals were harmonious with the participants, the funder moved to believing strongly that they were. Similarly, the funder ended the study believing strongly that the participants had substantial input in the reports she received. This was a move from being

uncertain at the beginning of the study. The funder saw evidence that led her to believe that a new and more powerful joining was taking place as a result of objective measure implementation.

This new joining led the funder to hold more firmly that adding measures would be helpful in future service delivery. She felt more strongly that these measures will not take up valuable service time and will not slow down the therapeutic process. She also felt more strongly that these measures will be helpful in directing services for families of the future. She continued to hold to believing that these measures will not attempt to fit each family into a standardized mold and continued to assert that adding measures on a permanent basis will be worth the effort.

General Observations of Responses to Survey

Looking at the pre-test and post-test results a few observations can be made when all three parties' scores are compared. While the practitioners maintained their varied stances on the importance of professional help in goal assessment, the families generally moved away from strong agreement and the funder moved towards strong agreement that families need professional help. The funder explained this as recognizing that the practitioner introduced the measures as an intervention that the family would not have recognized as an option. The practitioner also "refereed" the discussion of the results which the funder was not certain the family could do on their own. Thus, the need for professional help in administering and helping the family interpret the findings increased.

Regarding whether the family's goals take precedent, the practitioners did not move as a group significantly. However, it can be observed that the families' and the funder's moved more towards agreeing that families goals take precedence. It is theorized that when the families believed that the practitioners encouraged their own goal setting without a hidden agenda, they worked at the areas that concerned them that, in turn, remedied the concerns of the practitioners as well as the funder.

All three parties showed more congruency in believing that the measures increased the families' input in the reporting procedures. Although the practitioners did not move much in their stance that the families' and professionals' goals are similar, the funder and the participants did move towards agreeing more with this statement. It is interesting to note that the literature surveyed suggested that practitioners were the ones that would have to move the most in giving up the "professional unilateral approach to treatment." Here, the practitioners did not move much at all. The change in adding measures seems to have helped the families feel more empowered to come to similar conclusions thus showing a congruency in goals and goal assessment.

The practitioners moved away from agreeing that families will want to fill out the measures on a weekly basis whereas the families moved towards this belief. The funder remained uncertain. The practitioners' move resulted from the numbers of missed administrations. The families move resulted from the additional input the measures gave the families in solving their own problems.

The families attributed the missed administration to lack of time not lack of willingness whereas the practitioners attributed the missed administration to a lack of willingness and not a lack of time. The funder remained uncertain. All three parties moved generally towards agreeing that the measures used were not going to intimidate future families.

All parties remained certain that measures will not pigeon-hole families nor will they take power away from practitioners or participants. A higher level of uncertainty arose around whether measures are more accurate than professional observation with the practitioners' and funder's responses. It is believed that the introduction of measures challenged the predominant assessment tool of observation and the practitioners and funder were attempting to seek a new balance as a result.

The practitioners continued their general belief that participants will be honest in completing the measures. The participants remained similar with one participant moving to a more uncertain position. The funder moved to disagreeing that participants will be honest. When asked, the funder explained that there were differences in opinion regarding the severity of the crises she perceived. In the beginning of the study, the funder expected that the measure would place families on a standardized continuum of crisis, indicating how much crisis a family is experiencing. By the end of the study, the funder recognized that the measures were based on the families' perceptions and not upon a standardized diagnostic criteria. She noted that the measures

were not capable of "standardizing" families into levels of crisis. Instead, the measures indicated the level of comfortableness the individual families felt in the eight categories. Despite this lack of black-and-white diagnostic ability, the funder continued to believe strongly that judges will applaud the addition of measures in service delivery. The practitioners remained similar in agreement. The participants remained the same as well, except one participant moved from strongly agreeing to mostly disagreeing. This parent felt that judges would initially look to these measures as concrete levels of functioning rather than the family's own level of comfortableness of present functioning. This parent felt that judges would be frustrated with the individualized reasons for the measures' scores and patterns and would be confusing because it does not fit each family into a mold. This was corroborated with all parties' general belief that measures do not provide a complete picture of the family.

Regarding the future usefulness of these measures, all three groups remained relatively unchanged in their position. All three groups generally saw that objective measures would be helpful in service delivery direction. All three groups disagreed that objective measures would take up valuable service delivery time and detract from the therapeutic process. The three groups agreed that making measures a permanent addition to service delivery was worth the additional effort and all three expressed an excitement about including measures in the future. As mentioned above, one

practitioner moved from strongly disagreeing to mostly agreeing about feeling positive about adding measures to service delivery.

CHAPTER 6: CONCLUSIONS

Obviously, due to the size of the population studies, it would be inappropriate to generalize this study's findings even on a limited basis. This study does provide informed indications and plausible theories that a larger-scaled study could find extremely useful.

Briefly stated, this study suggested that implementing objective measures as discussed in chapter four resulted in a favorable response by practitioners, participants and the funder. Specifically, the participants felt more empowered and felt an increase in taking ownership for their problems as well as their solution strategies. All three groups recognized that implementing the measures created a stronger bond between the practitioners and the participants.

Although at the beginning of this study, it was believed that implementing objective measures would improve the relationship between the participant and the practitioner, it was not fully understood how. The discovery of the "lingo" factor, or the joining around how to conceptualize the families' problems or crises was not expected. When the practitioners left their academic understanding of family problems at the door and allowed the participants struggle through figuring out how to explain the problems they faced, the families felt less pigeon-holed and more in charge. This helped change the role of the practitioner from a problem identifier and solution consultant to a solution sounding

board and general family support. Thus, time on task seemed to decrease but time on task was discovered to be linked to goal attainment in a much different way than originally thought. Families spent less time discussing their problems because the measures provided them with a tool they could use in solving their own problems rather than relying on the practitioner.

Another unexpected finding of this study involved the therapist's administration procedure. When the practitioner was not the one to share the information received by the measure, the family became leery of the practitioner's intentions, resulting in a higher absentee rate. It seems important that the relationship between practitioner and participant be nurtured by discussing the information received before disseminating it to other practitioners or funders. The attendance records collaborated this. When the participants were included in the administration and discussions of the findings, their attendance seemed to increase. Conversely, when the practitioner did not share the findings or not participate consistently in administration, the families seemed to not show or cancel more often.

All three groups continued to feel that including measures in future service delivery was an improvement in service delivery. During this study, the program's administration decided primarily because of funding opportunities to expand the family preservation program.

This study had direct influences on this restructuring of the program. First, objective measures will be implemented on a more

permanent basis. It was decided that the administrations of the measures will be decreased to twice a month instead of once a week. This was because of the family's statements that time was a roadblock to weekly administrations.

Initially, it was believed that families would want to score the measures themselves because of the empowerment potential and the general mistrust of social service oriented people. In actuality, the relationship already built with the families and the discussions before administering the measures proved to be adequate for the family. After scoring the measures once, the families delegated the scoring and charting of the responses to the family specialist stating that they had not the time nor the inclination to be involved with the mathematics of the process. The computer scoring program proved to be immensely helpful for the practitioners. It did the mathematics for them with a minimal time expenditure, thus relieving the "statistic" anxiety.

Because of the balance that the objective measures produced between subjective and objective assessment, it was decided that the family specialists will work independently from the therapists. No longer will the therapist and the family specialist work as a team for a family. Group consultations and supervisions will continue to take place, but the measures proved to give the clinical team a balanced assessment of a family by one practitioner, showing little need for the direct team approach. The benefits to this separate approach include: it will be possible to serve more families at one time, the families will not have to

form two attachments to practitioners and will be able to incorporate to the style and personality of a primary service delivery practitioner.

The measures used will also be incorporated in the initial assessment process as well as the program assessment after families end with services. These will provide an objective component to the program evaluation as well. These will take minimal amounts of additional time over all for the program.

Further work needs to be done in basic family preservation and family support philosophy. All three groups involved continued to hold to the belief that families in crisis need professional help and much ambivalence continued around whose goals take precedence, professionals' or participants'. It is possible that this study helped begin the shift in belief but it is important to realize that one study will not change decades of paradigms. Further education and studies are recommended in helping professionals understand the importance of family sovereignty in service delivery and how recognizing this concept will help the joining process between professionals and participants.

Since judges and the legal system were not included in the study, further studies should explore the ramifications of measures in the legal arena. Will measures that delineate a family's self-perception be useful or too confusing? Will opposing lawyers tend to misconstrue the information, making the family's honesty work against them? Will the legal system expect such measures to fit

families on a standardized continuum of crisis or functioning? If so, will they be disappointed or encouraged by the family's input?

Recommendations

As a result of this study, it is highly encouraged that other family preservation and support programs implement measures in a similar fashion as described in chapter four. A test period was helpful in seeing exactly how the measures were beneficial within the program's philosophy and policies. Then, after their usefulness was ascertained, policies and implementation procedures were formalized.

Finding the proper measurement tool is also highly important. As a side note to this study, it was extremely difficult to find valid and reliable objective measures regarding family functioning. Such measures were not well publicized and difficult to locate. In addition, many of the measures located and seen as possibilities were unavailable because the publishing companies were no longer in existence. Time and perseverance should be allowed for in finding the appropriate measure for the program. It would be helpful for family preservation and support programs if publishing companies would turn over their measures to established institutions such as hospitals, organizations, or universities to ensure their continued use. It would also be helpful if organizations would dedicate sections of newsletters or publications to describing and advertising measures.

Summary

For this program, at least, measures proved to be a valuable untapped resource of goal assessment. Families ended up feeling more empowered and joined with the practitioner. The funder saw an increase in goal attainment as well. All three interactions sped up the service delivery process through feelings and expressions of success. All three groups ended up on a higher level of family preservation and support with minimal amounts of additional effort. It is hoped that other agencies will find this study useful and inspiring to attempt the same.

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APPENDIX A:

ATTITUDES REGARDING MEASURES

Name:_____ **Date:**_____

This form is a part of a study to discover people's stance on the use of measures in family preservation work. Those who have been asked to fill out one of these forms are family preservation participants, practitioners, and funders. Below are several statements regarding the use of measures in family preservation practice. Please read the statements and circle the number that best represents your feelings. For scoring purposes, please do not circle more than one number or only between numbers. Keep in mind that your answers will in no way affect your status in the program. Your individual names and your status in the program will remain confidential. Your participation is highly valued but strictly voluntary. If you would like to see a copy of the final report, please contact Darren Stroh at (303) 567-4600 after July 1, 1994.

Are your a ___participant? ___practitioner? ___funder?

---

1 you strongly agree
2 you mostly agree
3 you are not sure
4 you mostly disagree
5 you strongly disagree

TERMS THAT MAY BE UNFAMILIAR

SERVICE DELIVERY:	The help one receives through the family preservation program
PROFESSIONALS:	Therapists, family specialists, caseworkers
OBJECTIVE MEASURES:	The checklists or worksheets that families will be filling out on a weekly basis and scoring with the family specialist and/or therapist.

1 Professional help is needed in determining how a family in the program is progressing.....1 2 3 4 5

2 The family has substantial input now because the reports reflect accurately what is going on in the home.....1 2 3 4 5

3 The family's goals and the professionals' goals are in agreement at the present time.....1 2 3 4 5

4 When the family's goals and the professionals' goals do not agree, the family's take priority.....1 2 3 4 5

5 Families are willing to fill out the measures on a weekly basis.....1 2 3 4 5

6 Families will not find the time to complete the measures on a weekly basis.....1 2 3 4 5

7 Families will find the measures intimidating.....1 2 3 4 5

8 Objective measures attempt to fit everyone in the same mold.....1 2 3 4 5

9 Objective measures will be helpful in directing services.....1 2 3 4 5

10 Objective measures will take up valuable service time, slowing down the therapeutic process.....1 2 3 4 5

11 People are generally honest when filling out objective measures.....1 2 3 4 5

12 Objective measures give a more accurate perception than professional observation.....1 2 3 4 5

13 Judges will appreciate the addition of objective measures.....1 2 3 4 5

14 Objective measures take away power from participants and professionals.....1 2 3 4 5

15 People are generally honest when filling out measures.....1 2 3 4 5

16 Objective measures do not give the whole picture on crises families have.....1 2 3 4 5

17 Adding objective measures will be worth the effort to make permanent changes in future service delivery.....1 2 3 4 5

18 I am excited about adding objective measures to service delivery.....1 2 3 4 5

ADDITIONAL COMMENTS ABOUT THIS STUDY:_____

_____

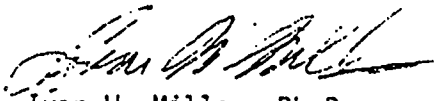
APPENDIX B:

PERMISSION TO USE THE MCMASTER FAMILY ASSESSMENT DEVICE

Enclosed please find the FAD packet that you ordered. You have permission to duplicate the copyrighted Family Assessment Device, the manual scoring sheet and instructions, and the Family Information Form. We may contact you in the future to receive your feedback on the instrument.

Thank you for your interest and good luck in your future project.

Sincerely,



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IWM/
Enclosure