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The effectiveness of Families First services: An experimental study

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Abstract

An intensive, short-term, family-based intervention was employed to help families overcome serious problems in child behavior and child management. This service was an adaptation of the Teaching-Family Model of therapeutic group home programming with some elements of child welfare intensive family preservation services. In a controlled, 3-year study, families receiving this service were found to report significant improvement in child behavior, physical care and resources, parental effectiveness, and parent–child relationships, when compared with similar difficulties in families who were referred for the service but not served. Not only were the improvements for treatment families apparent shortly after the conclusion of the service, but these changes were also maintained over a number of months' period, suggesting that the improved skills, behaviors, and relationship changes developed during the intervention may have become solidly implanted in parental and family functioning.

Keywords: Families First; Teaching-Family Model; Child management

1. Introduction

Increasing concern is being expressed among the various helping professions that interventions and practices must meet rigorous tests of effectiveness, for example, the

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the components of the intervention as they relate to specific populations, settings, and types of interventionists (Fraser & Nelson, 1997).

One promising, but as yet untested, intensive, family-based approach for improving child and family functioning has arisen out of the Teaching-Family Model (TFM). The underlying model originated as an intervention program for therapeutic group homes for children and youth, focusing on the group home parents and the manner and content of their interaction with residents. The model is a very tightly specified and systematic approach based principally upon learning theory concepts, including modeling, reinforcement, and generalization of learning (Phillips, Fixsen, Phillips, & Wolf, 1979). The prototype for TFM was a small group home program, *Achievement Place*, established in 1967 in Lawrence, Kansas. With the aid of a group of psychologists from the University of Kansas and a grant from the National Institute of Mental Health, the model was defined and implemented in that facility (Willner, Braukmann, Kirigin, & Wolf, 1977). In the ensuing years, TFM was adapted to other group home settings throughout the country by a number of additional agencies and sponsors. A further development was the establishment of the Teaching-Family Association by these agencies in 1978, to ensure quality and standards in the application of the model. At the current time, as many as 279 group home programs using TFM have been established under auspices of at least 35 agencies across America (McElgunn, 2003; Teaching Family Association, 2002).

Initially, TFM agencies and the Association placed major emphasis on developing effective Teaching-Family parents for service in group home settings. Formalized training methods were developed and progressive certification standards created. In recent years, there has been a trend to apply these approaches across a much broader spectrum of services for children, youth, and families. TFM agencies have experimented with applications of this model in day treatment, adult living, and programs for persons with autism and severe brain damage. The Teaching-Family Association now recognizes treatment foster care and intensive, short-term family or home-based treatment as normal TFM offerings by association agencies, in addition to group home treatment (Teaching Family Association, 2003). A recent survey of Association member agencies demonstrated that 54% provided foster care, 41% had independent living programs, 33% provides school-based services, and 50% offered home-based treatment to families (McElgunn, 2003).

While there has been a good deal of research on TFM model development and processes (Fixsen & Blasé, 2002), especially regarding group home applications, studies of the effectiveness of TFM family-based interventions have been very limited. Two studies are available, both of which limited their investigation to a treatment group. Friman, Soper, Peterson, Ferguson, and Bothern (1993) evaluated the influence of a TFM-based home-based intervention on child behavior problems. Behavior problems were measured by the Achenbach Child Behavior Check List (CBCL). Subjects were 36 children thought to be at imminent risk for out-of-home placement, who with their families were referred for in-home services by the State of Nebraska or Probationary Court. Services lasted 6–8 weeks and involved about 15 h of face-to-face contact a week. The caseload standard was two families. The consultants delivering the service had master's degrees (mostly MSWs) and Boys Town's competency-based training. No control group was used. The CBCL was administered at program entry, 3 months post-treatment and 12 months post-treatment.

Findings were that CBCL scores were significantly decreased on all summative scales at 3 and 12 months post-treatment. The scores also decreased significantly on most subscales.

Lenerz, Cannon, Johnson-Meester, and Peterson (undated) also studied 79 families who participated in the same Boys Town program. Various measures were administered at admission, at program completion, at 90 day, and 1-year follow-up. No control group was used. Results indicated that family satisfaction, as measured on the Olsen Family Satisfaction Scale, improved significantly from admission to program completion ($p<0.0001$). Parent sense of competence, defined as parents' confidence in their ability to manage their children as measured by the Parent Sense of Competence Scale, also showed significant change from admission to program completion ($p<0.0001$). Child behavior was measured on the CBCL and these scores also showed significant improvement at program completion (internalizing: $p<0.0001$; externalizing: $p<0.0001$). All of the measures above tended to remain steady at 90 day and 1-year follow-ups. Families also reported improved problem-solving, lower family conflict, and increased ability to obtain needed resources.

No studies were identified in the literature utilizing experimental designs or that involved some kind of comparison group.

Given the movement of TFM agencies into home-based interventions and the shortage of programs generally with demonstrated effectiveness in helping families, it is important to answer the question—In families where a child has been identified as having serious behavioral or school-related problems, does a family-based, short-term, therapeutic intervention derived from TFM principles and skills significantly improve child and family functioning?

2. Method

In 1994, Utah Youth Village initiated a new family-focused intervention, Families First, designed to help families overcome serious problems in child rearing and child management. Families First was an adaptation of the Teaching-Family Model of therapeutic group home programming with some elements of child welfare intensive family preservation services similar to the Homebuilders© program. Utah Youth Village is a private, non-profit agency and an experienced TFM provider, having achieved full certification in its group home program in 1992. Utah Youth Village leaders, seeing a broad need in contemporary society to increase the effectiveness of parents, determined to create a service which would help families deal better with problems in their homes. The intervention they designed was home-based, short-term but very time-intensive, with major components involving educational approaches and concrete services. For Families First, the centerpiece of the service was skill building in parents, using the same concepts and methods that had been found to be useful in training Teaching-Family parents for service in TFM group homes.

Two years after initiating Family First services, Utah Youth Village began a formal investigation of the effectiveness of these services. To test the effectiveness of the Families First intervention, a pre-test/post-test/follow-up experimental design was employed. Subject families resided in the Salt Lake City vicinity in Utah, a metropolitan area. They were referred to Utah Youth Village for Families First services because a child had been identified, by a school or the juvenile court, as having serious problems in functioning. Families were

randomly assigned to treatment or control groups at a ratio of 2:1. This ratio balanced the need to obtain an adequate control group at the same time maintaining support from the staff of the referring agencies. A total of 164 families were initially included in the study. These families had been referred for services beginning in July 1997 and concluding in July 2000. Of the 164 families, 14 were dropped from the study. Two families were excluded because of recording problems in the questionnaire, one each from the treatment and control groups. Five treatment families and seven control families were lost to the study because they moved and were no longer able to be contacted. The final study group and the excluded families were not significantly different in regard to age, gender, minority status, and on 59 out of 63 family problem seriousness variables described below as measured at the time of the referral. Ultimately, 105 families were retained in the treatment group and 45 were a part of the control group.

The use of an experimental design with randomly assigned treatment and control groups was made possible by the availability of foundation money for the study. Utah Youth Village offered these services without charge to the referring agencies and their clients during the study period with the understanding that a portion of families referred would be assigned to the control condition and not receive Families First services.

One specific target child was followed in each family in the study. The target children in the sample had an average age of 10.4 years, with a range from 3.9 to 17.3 years. Three-fourths of the target children were males and slightly over a fourth (28%) came from minority families. Families were predominantly from lower income groups. There were no significant differences on these measures between the children in the treatment and the control groups.

Results were drawn from parent responses to a set of questions about the seriousness of a broad range of problems in regard to their child, their family situation, and their current parenting abilities. The 63-item questionnaire was developed specifically for the study. It was administered three times to the subject families. First administration was at the time of referral. Then the initial post-test was administered shortly after the Family First intervention was completed for the treatment group and at a comparable point in time for the control group. The average time for completion of the initial post-test was 5 months after the referral date. The second post-test was administered about 3 months later (average time was 8.5 months after referral). All of the scores were measured on a 5-point scale, with the higher score indicating the more serious respondent concerns. Four composite scales were also developed from the 63 individual questions for comparison across all variables, for concrete services/physical care and resources, for parent effectiveness/parent–child relationships, and for child behavior problems. These scales demonstrated high inter-item reliability (*alpha* scores were: Concrete services/physical care and resources=0.8537, Parent effectiveness/parent–child relationships=0.9556, Child behavior problems=0.8431).

Semi-structured in-depth interviews were also conducted with a small sample of treatment families to validate experimental findings. Ten families were interviewed shortly after the Follow-up Post-test questionnaire was completed, in the period 8 to 10 months after Families First services were initiated. These interviews were initiated shortly after the midpoint of data collection. Once the interviews were started, families were contacted in the order that they returned their last questionnaire, until enough interviews were conducted to obtain a consistent pattern of responses.

3. Families First service: The experimental condition

In the Families First intervention, a Family Specialist worked intensively with families in their own home and community settings for a period of about 6 weeks. Family Specialists spent as much as 15 h/week with the family during this time period. The intervention used a strengths-based approach that focused upon the parents' agenda for change. It involved skill-based teaching, with an emphasis on modeling and the supervised practicing of effective parenting and parent–child relations, for such skills as communication, rule-setting, and providing praise and consequences for child behaviors. The intervention also involved the provision of concrete services, such as helping with finances and improving community support in the schools and elsewhere. Much of the work was performed when the entire family was together on evenings and weekends. During the period of the service and for a time after completion, the Family Specialist was available to respond to crises, 24 h/day, 7 days/week. Caseloads were no more than three cases at a time.

Ten different Family Specialists were involved in the provision of the Families First service to families in the treatment group. These workers all had college degrees. Three of the Specialists had master's degrees in social work or counseling. Specialized training had been provided by Utah Youth Village, including an intensive 35-h Teaching-Family Model (TFM) pre-service course. Immediately after this foundation, the new Family Specialist shadowed a supervisor through an entire 6-week service episode to a family, participating in all family contacts and assisting in details of the intervention. During this period, additional classroom instruction hours were also provided, focused on family dynamics and intervention techniques. In the next stage, the Family Specialists were assigned single cases of their own, with a supervisor in a mentoring role and present in at least 50% of family contacts. When the intervention with the family was successfully concluded, the supervisor and Specialist developed a detailed plan to help the Specialist further refine and develop intervention skills as work with other cases proceeded. These plans included direct in-home observations, consultation meetings, treatment planning meetings, and file reviews. Initially, the in-home supervisory observation of Specialist interaction with the family occurred weekly, then was gradually reduced to once a month over the next 12 months. At this point, the Family Specialists were considered fully trained. For all Family Specialists, supervisors were available 7 days/week, 24 h/day. All of these workers were certified with the Teaching Family Association as Family Specialists in the home-based Teaching Family Model intervention.

4. The control condition

Families in the treatment and control groups were referred to Families First by either a school or the juvenile court, and assigned at random. School referrals were generally instigated by staff of multi-disciplinary programs, serving children with special needs and their families. Children referred by the court also were already involved in a system of services. Therefore, the comparison for Families First Services was not with a total absence of services but with other interventions normally available to the schools and courts and in the community.

5. Results

To answer the study question, change scores were calculated comparing pre-test scores to both the initial post-test and the follow-up post-test scores, and the significance of these changes determined. Comparisons were made for the four composite scales described above. Table 1 shows the results, which demonstrate a strong positive effect of the intervention when compared to the control group. Combining all 63 problem-related variables, significant t scores were found for both the pre-test to initial post-test changes (p=0.001) and pre-test to follow-up changes (p=0.008), demonstrating highly significant improvement. There was very little fall-off in the level of significance of change from the initial post-test to the follow-up post-test indicating a good level of maintenance of the overall gains that families reported in connection with the intervention.

When changes within the three sub-groupings of these variables were tested, all but one of these groups of measures also demonstrated significant change. All of the pre-test to initial post-test change scores were significant. For pre-test to follow-up post-test change, two of the three were significant, concrete services/physical care and resources and child behavior problems. The comparison of parent effectiveness/parent–child relationships was not statistically significant but approached statistical significance (p=0.066).

For all variables, the comparison of scores across the three points of measurement showed that the slight narrowing of differences over time between the treatment and control groups was largely due to some improvement in the scores representing the situations in the control families, who received traditional services in the community. The treatment group means were essentially stable from the initial post-test to the follow-up post-test. This finding also

Table 1
Comparison of scores across time

Scales[a]	Change from pre-test to initial post-test		Change from pre-test to follow-up post-test		Mean scores[b] at study measurement points			
	t	p	t	p	Group	Pre-test	Initial post-test	Follow-up post-test
All variables (63)	3.422	0.001**	2.701	0.008**	Treatment	2.79	2.09	2.07
					Control	2.68	2.39	2.24
Concrete services/ physical care and resources (18)	3.055	0.003**	3.125	0.002**	Treatment	2.40	2.09	1.98
					Control	2.26	2.28	2.22
Parent effectiveness/ parent–child relationships (27)	2.329	0.021*	1.860	0.066	Treatment	3.37	2.35	2.30
					Control	3.19	2.72	2.54
Child behavior problems (16)	2.461	0.015*	2.043	0.043*	Treatment	2.37	1.86	1.79
					Control	2.17	1.99	1.98

[a] The numbers in parentheses report how many specific questions from the basic questionnaire were aggregated to create the above scales. The numbers for the three sub-scales do not total to 63, because two items that reduced the reliability levels of the sub-scales were not included.

[b] Higher scores indicate more serious respondent concerns.

* $p<0.05$.

** $p<0.01$.

supports a conclusion that the overall treatment effect on families did not erode appreciably over the time.

Examining the mean scores for the three sub-groupings over time, in every case there was major improvement in the treatment group scores from pretest to initial post-test. From initial post-test to follow-up post-test, small improvements also occurred across all three sub-grouping measures. Therefore, there was no area of response in which gains demonstrated at the initial post-test were lost by the time of the follow-up post-test measurement.

The lack of a significant difference between the treatment and control groups in pretest to follow-up post-test in the area of parent effectiveness/parent–child relationships appeared to be mostly due to a moderate improvement in the control group scores after the time of the initial post-test measurement, not negative change or regression in treatment group scores.

The in-depth follow-up qualitative interviews with treatment families also supported the results described above. Two conclusions were evident. First, the respondents reported substantial improvements in family and child problems and consistently attributed remediation of these problems to the Families First intervention. Families were able to describe significant positive changes that they attributed to the intervention of the Families First Family Specialist. They were universally enthusiastic about the way that the Specialist related to family members and the differences the service made to family and child functioning. Second, the respondents were able to describe important parenting techniques and practices, taught in the Families First intervention some 8 to 10 months earlier, which they were still using effectively at the time of the qualitative interview. They believed that they were continuing to implement the principles and techniques that were provided to them by the intervention and could cite specific capabilities that they had learned and were currently using.

In Table 2, a sampling of statements by respondents to the interviewer is listed giving their impressions of the impact of the Families First service on their family situation.

Table 2
The impact of the Families First service on families

"[Without the Families first service] I would have lost my kids to the street. . .My kids were headed downhill and they would have crashed and lost everything. . .It has been way helpful with my kids. It has helped them get in different programs and my sons have had a really good turnaround in their attitudes."
"He [the target child] had a pretty bad attitude. Now he is actually decent to live with."
"We're not breaking furniture anymore. So that's good. They would wrestle and break furniture. . .My husband, he finally realized, you know, you can't just be the big buddy all the time."
"We are a lot closer. [Without the Families First service] I think I would have given one of my children back to my ex-husband or put him in foster care. . .I was at my end! I didn't know what to do. My children. . .wouldn't mind [me]."
"The good thing that came out of it was my stress level has gone down tremendously. And [my son] has become more manageable. Now there are some boundaries for him."
"[Before starting the Families First services] I felt like I wanted to kill [my son]. I couldn't deal with it. I kept thinking I should just call the state and tell them to take him."
"[The Families First service] was very useful. It taught me a whole bunch. . .to understand, to be patient, to learn how to deal with my kids in a different way. I was just getting my kids back. I didn't know what to do with them. [Without the Families First service] I probably would have been screaming my head off still, not knowing how to deal with my kids."

Table 3
Families First skills maintained by parents and families 8 to 10 months after the intervention

Showing respect (by not screaming or getting angry, staying calm, listening)
Giving each other space, especially the use of a time out procedure
Improving communication with children
Setting up rules and expectations and applying consequences
Giving specific praise to reinforce desired behavior
Skills for handling child tantrums, swearing, yelling
Not yelling or screaming at children
Disciplining with a loving tone
Communication between parents to reach agreement on how to discipline
Developing structure for children (assigning chores for bad behavior)
Spending time together/family recreation, to improve relationships
Improved parent self-esteem

Evidence for maintenance of the gains developed at the time of the Families First intervention was also present in responses of parents to the qualitative interviews. At the time of these interviews, respondents described and reported their continuing effective use of a number important parenting techniques and practices, presented to them by the Families First Specialist some eight to ten months earlier. Some of the improved skills that respondents identified that they were continuing to implement are listed in Table 3.

6. Discussion

Based upon parental reports in the context of an experimental study with random assignment of study families to treatment or control conditions, the Families First intervention demonstrated a significant positive impact on overall family functioning and factors of child behavior, physical care and resources, and parental effectiveness. Not only was this finding true shortly after completion of the intervention, but there was also evidence that families were able to maintain the gains and skills for a longer period of time.

Adding some weight to the positive findings was the fact that the standard of comparison, the control group, showed evidence of some improvement perhaps as a result of accessing other community services. In spite of this, scores for the experimental group demonstrated statistically superior positive change. Only for the construct parent effectiveness/parent–child relationships was the difference nonsignificant at the last follow-up and that because there was sizeable parallel improvement in the control group scores. Perhaps this was the one area in which the community had alternative resources that were more closely comparable in effectiveness to the power of the Families First service, or that this area of family difficulty was the most transitory and/or susceptible to regression to the norm.

That families were maintaining these positive changes over a number of months is a hopeful finding. In a field where many interventions have lacked staying power, this finding suggests that the Families First service may have promise for helping families make significant permanent changes for the better. It tends to validate the usefulness of an intensive, skill-building, home-based approach for overcoming child behavior problems.

Another aspect of Families First that may merit more consideration is the fact that the interventions were being conducted, by and large, by workers who did not have standard clinical credentials. Quality appears to be derived from the structured TFM approach to services and the intensity of the training and supervision provided by the agency. If a high quality for the Families First intervention can be maintained in this manner, then the possibility exists that such services can be delivered for less cost and with more flexibility in hiring of less clinically trained persons as interventionists. This finding should be viewed cautiously and subjected to additional study.

Other cautions should also be exercised in the weight given the results of this study. While qualitative and quantitative measures were consistent, these findings were based entirely on parent perceptions. Future studies might effectively include a broader range of outcome measures including standardized measures of child and parental functioning and the utilization of success indicators from sources such as school, court, and child welfare databases.

The methods followed in this study would seem to meet the Fraser and Nelson (1997) recommendations, in most respects, for an initial study of a particular family-based program. The focus of this study was a single program and setting, Utah Youth Village's Families First intervention. A consistent model of service was used throughout the study, standardized by consistent training and supervision and by having 2 years experience with the intervention before the evaluation was initiated. Children and families studied appeared generally to be uniformly "at risk." One area in which the study deviated from the Fraser and Nelson proposal was that the children were not homogeneous in terms of age, but ranged over the entire spectrum of school age. The sample size approximated the Fraser and Nelson recommendation of 65–75 families in each experimental condition, but was somewhat smaller for the control group.

As the initial study of the Families First service, the focus was on effectiveness. This study could serve as a starting point for other research that would replicate or improve upon the original design and later to extend the focus of study to applications of the intervention to other problems, conditions and settings, and to look in more depth at the efficacy of specific components of the intervention as applied to various situations.

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