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THE EFFECTIVENESS OF FUNCTIONAL FAMILY THERAPY IN SUBSTANCE INVOLVED FAMILY PRESERVATION CLIENTS

by

Andrew D. Butcher

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ABSTRACT

The Effectiveness of Functional Family Therapy in Substance Involved Family Preservation Clients

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Abuse and neglect of children has been a recognized problem in America for many years. Recent developments in the child welfare system have introduced intensive, family-based services, otherwise known as family preservation services. The aim is to preserve the family and provide reasonable efforts to avoid out of home placement. State and private family preservation programs across the country have been faced with the challenge of evaluating program effectiveness and to better meet the needs of client populations by enhancing treatment models and programs.

The Nevada State Division of Child and Family Services (DCFS) has utilized valuable resources to evaluate their Intensive Family Preservation (IFP) service program to

discover its effectiveness. The program has been the subject of a longitudinal study. Research data from the 1999 fiscal year was used to examine the effectiveness of the Functional Family Therapy (FFT) model on substance-involved families. This secondary analysis discovered that the preservation services in Las Vegas are effective but that substance-involved families have significantly lower outcome scores. The data revealed that substance-involved families also have larger households and less income than non-substance users.

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CHAPTER 1

INTRODUCTION

Background and Overview

The abuse and neglect of children has been countered by an expansion of agencies and organizations devised to protect children. Every state has developed their own system of services to meet the needs of abused children. Foster care, group homes, and shelters are filled with abused and neglected children waiting for permanent homes. In March of 1998, U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau (1999) reported that over half of a million children were in foster care. That same report stated that child protective services from 44 states accounted for over 984,000 victims of child maltreatment. These cases were subjects of allegation and investigation that were substantiated. That number does not account for the maltreated children who go undiscovered. Each year, increased numbers of new families are served by child protective services, and many families return again and again.

Recent changes in the American family have added more complications in fighting abuse and neglect and finding safe care for children. Although the family system is valued by many as a necessity for stable growth of the child, many caregivers become unavailable for parenting. Prevention and alternative measures have been organized and are currently being implemented in efforts to lower the overwhelming numbers of children in the system. Since each new program may cost a state millions of dollars, program evaluations must be conducted to provide empirical evidence to support and validate the introduction of additional and expanding services.

In-home, intensive family preservation (IFP) service programs have been one of the major developments in the past couple decades attempting to keep families together. Although preservation services were intended to prevent out-of-home placements, their value has challenged. Preservation programs have been forced to prove that intensive, home-based services are truly in the best interest of family and the child. IFP programs across the country are currently examining their outcomes and making changes to keep the services available and perhaps expand them. The Nevada State Division of Child and Family Services, Intensive Family Service Program has utilized

empirical measures to discover appropriate areas of needed reform through a comprehensive longitudinal study. Significant data from this study were analyzed and described for a closer look at outcomes with substance-involved families.

This study was utilized to build upon the current knowledge base of family preservation practice and policy. Research in this area is necessary and serves to maintain the integrity and progress of IFP programs. The results of this study may be used to enhance the treatment model used by Las Vegas to better meet the needs of substance-involved families.

Organization of Paper

Chapter 1 of this thesis contains a thorough history of child abuse as well as the development of family preservation efforts throughout the United States and particularly in the state of Nevada. The impact of substance abuse on families who are referred to the Division of Child and Family Services is also explained in greater depth. The first chapter also includes a comprehensive review of recent literature on family preservation program components and evaluation. Then a careful discussion of the Nevada's purpose for conducting

the longitudinal study and an explanation for the rationale for a secondary analysis is provided.

In Chapter 2 of this thesis, a critical analysis of Functional Family Therapy (FFT) is presented. Because FFT is the theoretical underpinning of this study, a discussion of its empirical validation as well as limitations are provided. Both cognitive-behavioral and the systems theory have contributed greatly to the FFT model used in Nevada's family preservation services. The use of this theory in other programs has been studied and validated. The core philosophy, treatment techniques, and empirical studies of FFT are also outlined in chapter 2.

In chapter 3, the methodology used for this research is given with its strengths and limitations. Research questions chosen for this secondary analysis are described. This chapter also contains a brief discussion of the setting and circumstances under which the original data were collected and the measurements utilized in Nevada's longitudinal study.

In the fourth chapter, research findings are uncovered. Significant statistics are given attention and clarified for the reader. The statistical data provided in this chapter are discussed in detail. The exploration of each research question is outlined with relevant findings.

Within chapter five, the conclusion of this thesis is provided. The short and long-term implications of the research findings for the social work profession, child welfare, and the future of family preservation services are also given attention. Recommendations have been rendered in hopes that this secondary analysis can build upon the knowledge base of family preservation literature. The significance of this research is clearly identified during the finding implications.

Statement of the Problem

A History of Child Abuse and Neglect

When discussing the history of child abuse and neglect, the changing roles of children in society and in the family, must be considered. According to Crosson-Tower (1998), in earlier times children were considered to be property owned and used as their parents desired. Even in earlier decades, Crosson-Tower continues, children were to be worked as hard as their caregivers. Children of African descent were purchased and sold to work as slaves for their white owners and often worked for their parents as well. Although many families relied on the added income of their minors, early reformers wanted legislative changes that

protected children against harsh and often dangerous working conditions (Stadum, 1996).

Physical abuse and neglect became severe when survival became an issue. Unfortunately, children were often abandoned and even killed when parents could no longer handle the responsibility of another mouth to feed. The Panic of 1837 not only caused unemployment for many, but brought about the homelessness of many of New York City's young children (Nelson, 1995). Cook (1995) described orphan trains that were organized by Charles Brace and the Children's Aid Society (CAS) to place many urban children with rural western families. These children were used to work and help support the family and in turn were provided a place to live.

Sexual Abuse. The definition and recognition of sexual abuse has changed drastically over time and region. The use of children in sexual practices has been tracked as far back as ancient Greece (Crosson-Tower, 1998). Crosson-Tower continues to note that this practice has been common in many other civilizations and can be found in some cultures today. It's its modern definition, sexual abuse was rarely reported and believed in this country 25 years ago (Rycus & Hughes, 1998). Now, in 1999 combined state

reports counted close to 100,000 victims of sexual abuse (DHHS, 2001).

Around the beginning of the twentieth century, greater organization was used in methods of saving children. Groups of people in the community organized homes for orphans and children with disabilities (Downs, Moore, McFadden, & Costin, 2000). Orphanages, almshouses, indenture and other non-profit organizations all advanced the development of child advocacy and eventually furthered government intervention (Rycus & Hughes, 1998).

Legislation and Reporting Laws

One of the earliest child welfare laws is found in the English Poor Laws of 1601. This law introduced parens patriae, which gave overlords the right to intervene in protecting the rights of children. It would also turn over the care of children to the ruler or townspeople when parents were absent (Rycus & Hughes, 1998). Berg and Kelly (2000) assert that by this poor law many children of the unworthy poor were saved by separation from their parents. The law also maintains that the state may only intervene when the parents are unable or unwilling to act in the best interests of the child (Portwood & Reppucci, 1994).

It wasn't until the mid-1800's that the courts in the United States took an official stance on parental rights

and child safety. In the case Fletcher et al. vs. Illinois of 1869, the court set limitations wherein parents should exercise parental rights within humane and reasonable limits (Rycus & Hughes, 1998). This official recognition and restriction of parental rights fueled the upcoming interests in child saving.

Theodore Roosevelt held the first national White House Conference on Dependent Children in 1909 and marked a national shift in philosophy regarding child placement (Downs et al., 2000). The conference gave child welfare workers an opportunity to exchange ideas and proposed that family life was the "highest and finest product of civilization" (Cole & Duva, 1990, p. 12). National recommendations later led professionals to question whether out-of-home placement was always in the best interest of the child. One directive acknowledged that children should not be removed from their home because of poverty alone (Nelson & Landsmand, 1992).

Just three years later, in 1912, the Children's Bureau was organized to assemble data and statistics on children across the country (Karger & Stoesz, 1998). This organization represented official advocacy of children by the federal government. As public concerns for children were emerging, child welfare lobbyists won a victory with

the Maternity and Infancy Protection Act in 1921 (Costin, Karger & Stoesz, 1996). Jane Adams and other well-known child advocates made great legislative progress as they supported the establishment of the National Child Labor Committee (NCLC) in 1904 (Stadum, 1995).

Another very important movement that came from that conference in 1909 was the aid to families in the form of pensions that aimed to prevent the out of home placement of children in poverty (Cole & Duva, 1990). The idea that if out-of-home placement could be prevented when poverty was prevented had some popularity and validity. The provisions offered in title IV and V of the Social Security Act of 1935 later replaced these pensions. Title IV of the Act introduced Aid to Families with Dependent Children (AFDC) while title V not only restored the Maternal and Child Welfare Services but also extended the mission of the U.S. Children's Bureau (Karger & Stoesz, 1998).

In 1962, through amendments to the Social Security Act, title XX mandated protective services and child welfare organizations in every state (Rycus & Hughes, 1998). Every state was now forced to provide protective services and establish a means of investigating reports of abuse. Hacsi (1995) added that title IV-A in 1961 matched state dollars for foster care with federal dollars. This piece of

legislation gave the funding for many needed foster homes. The Child Abuse Prevention and Treatment Act (CAPTA) of 1974 gave even more funding towards child abuse prevention programs and research for more effective services (Crosson-Tower, 1998). Berg and Kelly (2000) explain that the mandatory reporting requirements detailed in this law effect many other disciplines.

From Legislation to Programs

Mary Ellen Wilson.

Public interest in child abuse grew leaps and bounds with the case of one young child. Mary Ellen Wilson was a severely abused and neglected child who lived with her mother (Rycus & Hughes, 1998). Upon discovery of Mary Ellen, a nurse publicly demanded that Mary Ellen receive the same protection of the law that was given to animals at that time (Crosson-Tower, 1998). Within three years, the state of New York passed a law to protect children and punish the abusers (Berg & Kelly, 2000). One of the most important events stemming from Mary Ellen's case was the organization of the New York Society for the Prevention of Cruelty to Children (NYPCC) in 1875 (NYPCC, 2000). The NYPCC was provided authority from the state to remove abused and neglected children (Hacsi, 1995).

Federal Intervention

Although the organization of the U.S. Children's Bureau in 1912 demonstrated the government's responsibility for the nations children (Morton, 1993), decades passed as the country seemed to have lost interest in saving children. It wasn't until the research and influence of a group of medical professionals from Columbia University that protective service programs were set in place (Crosson-Tower, 1998). C. Henry Kempe and his associates made public the effects and signs of child abuse through their work The Battered-Child Syndrome in 1962 (Hacsi, 1995). Hacsi adds that the article educated many child welfare workers and resulted in the flooding of foster care placements. Downs et al. (2000, pg.221) refers to this revival of interest in the 1960's as the "rediscovery" of child abuse. The recognition of abuse and neglect reinforced the presumption that children were better off away from their families. The parent-child bond was not yet recognized as a concern by most. In 1972 the National Center for the Prevention of Child Abuse and Neglect (NCPCAN) was formed to provide training and research to child welfare organizations (Crosson-Tower, 1998). This organization caused even more lobbying, which influenced the passing of the 1974 Child Abuse and Treatment Act

(Karger & Stoesz, 1998). The 1974 act provided the funding and mission for the National Center for Child Abuse and Neglect (NCCAN), which then served to fund many other programs (Crosson-Tower, 1998).

Beginnings of Family Preservation Services

PL 96-272. The rapid increase in foster care placements, due to significant federal funding, attracted wide public attention and concern. McGowan and Walsh (2000) maintain that research demonstrating the negative effects on children floating in the foster care system shifted the political focus to permanency. Finally, after years of lobbying, a bill was passed that proposed much needed changes in the Social Security Act. The Adoption Assistance and Child Welfare Act of 1980 demonstrated the national distress and philosophical focus towards family preservation (Hacsi, 1995). The idea that a child would spend years in foster care with no hope for a permanent home persuaded this law to require "reasonable efforts" to preserve the family (Berry, 1994). Not only did the unnecessary time spent in foster care damage the emotional and psychological well-being of children, Kelly and Blythe (2000) argue, it also created avoidable financial burden at a time that out-of-home placements were at all time highs.

The new legislation intended to enhance parental skills in order to create a safe and nurturing environment for the children (Roditti, 1995). This in turn would prevent many costly placements while improving the lives of families. Danzy and Jackson (1997) reported that the implementation of 96-272 drastically reduced the amount of placements just as the number of available placements went down. Although some have argued about the vagueness of "reasonable efforts," the intent of the law was to offer structure for services provision in which parental rights and permanency for the child would be encouraged (Kopels & Rycraft, 1993). The law does not ignore the fact that many children need protection from their abusers, but maintains that with treatment and sufficient services, many out-of-home placements can be avoided.

PL 103-66. The next major piece of child welfare legislation to support family preservation efforts was not until 1993 under the provisions of the Omnibus Budget Reconciliation Act also known as public law 103-66. This piece of legislation aimed to set up family-centered programs within each state that met the needs of each community (Roditti, 1995). Prior lobbying for the legislation was done in hopes of reducing the overwhelming number of foster care and other out-of-home placements

(Wells, 1994). States are given the sum of one billion dollars over a five-year period to provide these services (Wells, 1994) and are accountable for their effectiveness. The act does not neglect mentioning funds set aside specifically for "evaluation, research, training and technical assistance" (Omnibus Budget Reconciliation Act, 1993). These funds may be used to develop more effective services and keep family preservation alive.

Adoption and Safe Families Act. While the federal government had made prior legislative attempts to address the permanency needs of children, the Adoption and Safe Families Act (ASFA) of 1997 reinforced that effort with monetary rewards for child welfare programs. The act provides bonuses for states to increase adoption rates. Halpern (1998) argues that adoption should not be the primary goal on the road to permanency, and that the new specifications under ASFA where reasonable efforts are not mandated may be too vague and unfair to some parents. The law expects that petitions for the termination of parental rights be filed within a specific time limit that the child is in foster care (Meier, 2000). The concurrent attempt to reunify or preserve the family while preparing for adoption in the case that reunification fails is the target of

criticism from advocates of both family preservation and adoption.

Family Preservation Programs

Intensive Family Preservation services or IFP services were developed through a change in philosophy within the child welfare system. This philosophy now carries a specific set of core values that are practiced and now taught in some schools of social work across the country (Morton, 1993). Principles of family preservation are based on the positive outlook on the family strengths and ability to adapt and survive (Mac Donald, 1994). The Homebuilders model has demonstrated that families do survive when they are provided adequate services. For this principle, family preservation programs are equipped with both therapeutic and concrete services. Most programs work to teach parenting and communication skills as well as connecting families with valuable resources in the community (Whittaker & Tracy, 1990).

Several key characteristics differentiate IFP programs from other child welfare or other social service programs. IFP programs are short-term and attempt to assist families through the problem solving process during short and crucial time periods (Fraser & Nelson, 1997). Family preservation workers must be available around the clock to

facilitate the change process when the family is most vulnerable and apt to change. Because caseloads are so low, workers are able to meet frequently with the families and implement thorough interventions. Cole and Duva (1990) explain that each family may require from 5 to 20 hours each week in a 4 to 12 week period.

Criticism of Family Preservation

There are several criticisms of family preservation services that stick out in the literature and program evaluations. Many of these criticisms rest in poor program evaluation results as in the Family First program evaluation of Illinois in the early 1990's (Schuerman, Rzepnicki, & Littell, 1994). Other criticisms are based in philosophical beliefs based of tragic life and work experiences like those divulged by Richard Gelles in Gelles (1996), *The Book of David*. Both successful and unfortunate experiences account for diverse attitudes toward family preservation services.

A report was published by the Department of Health and Human Services (DHHS), Office of the Assistant Secretary for Planning and Evaluation in January 2001 on the final results of a family preservation program evaluation of programs in New Jersey, Tennessee and Kentucky. This study examined the effectiveness of the programs in three states

all using the Homebuilders model. Because previous evaluations had uncovered insignificant data results in programs not using the Homebuilders model, some interest of this study existed to target programs currently using the Homebuilders model. An experimental research design was used for this study to test program effectiveness in meeting three service goals. The study uncovered no significant difference between the control group and the experimental group with respect to the prevention of foster care placement, increased family functioning and child safety. Although this report uncovers serious limitations in the efforts of some family preservation programs, the simple fact that some programs do show significant success cannot be avoided. Kirk (2000) reported success with preventing out-of-home placements with high-risk families with the North Carolina family preservation program. Kirk stated that because practice experience was not consistent with many current research findings, it was viewed essential to employ a retrospective, matched-group research design to evaluate the North Carolina IFP program. Many children from high-risk families were prevented from going to out of home placements.

Critics of family preservation services argue that the reasonable efforts mandate of the 1980 law places children

at unnecessary risk. This argument is strengthened when children are reunified with their parents and the abuse or neglect continues. Gelles (1996) argues that the impossible task of protecting children cannot be done while simultaneously reunifying the children with the abuser or neglectful caregivers. Seader (1994) maintains that family preservation services are not only inadequate at meeting the complete needs of the family, but work toward preserving the family when the primary goal should be what is in the best interest of the child. This position assumes that family preservation services are ineffective and that workers of family preservation cannot recognize those families who cannot be preserved. Although there is some agreement on the limitations of family preservation research, Rzepnicki (1994) argues that controlled studies have failed to demonstrate service effectiveness and that program goals are not ideal for success. In their 1996 evaluation of IFP programs, Heneghan and Horwitz asserted that more attention should be placed on the progress and safety of the child and that the political application of family preservation to all families places children at risk.

Although it is agreed upon that many evaluations uncover low improvement on child well being, many program

treatments are modified to better meet the safety and general needs of the children. Epstein, Jayanthi et al (1998) report that children in family preservation and reunification programs were doing poorly in school with too many absences. Other studies report poor or no improvement in overall child well-being (Wells, 1994). Heneghan and Horwitz (1996) maintain that child well-being must be considered when searching for an alternative to family preservation. Many critics with this same argument have influenced the changes to the reasonable efforts mandate that appeared in ASFA in 1997. These changes focus on the child safety in unusual or extreme cases in which the family cannot be preserved. Family preservation workers understand this principle and support it in practice.

Crisis Intervention

In the same year that the Child Abuse Prevention and Treatment Act was passed, Jill Kinney and David Haapala of Tacoma Washington were working on The Homebuilders Model with funds from Catholic Community Services and Behavioral Sciences Institute (Wells, 1994). The model presents a short-term treatment in which the workers would carry small caseloads and work intensively during the family's crisis or immediate time of need (Kinney, Haapala & Booth, 1991). Alstein and McRoy (2000) maintain that although the

Homebuilders model was designed primarily for families with defiant adolescents, the model has proven to be very effective with minorities and urban families with a variety of problems. The model was not expected to work at first, but surprisingly, many foster care placements were prevented, and in consequence, the program flourished (Schwartz & AuClaire, 1995). Homebuilders model is also based on the family systems model and assumes that families do the best they can when given an opportunity to problem solve (Staundt, 1999). Since then, many versions of the famous Homebuilders model have been developed, implemented, and evaluated throughout the country and in some parts of the world. Campbell (1998, p.80) reported on a pilot program in Australia where a private organization attempted to imitate the Homebuilders model. Campbell reported that the program had difficulties with "industrial issues" and the specific program constraints. Perhaps with more time the model can be developed further to meet international needs and demands.

Kinney et al. (1991) state that the model proved to be very successful and comfortable for the family since the intervention occurred in their own environment. Being home-based, the services were able to be where the crises occurred most frequently, in the home. Family therapists

are able to utilize the crisis as an opportunity for the family to learn from the events, when the experience is fresh in their mind.

Though the makers of the Homebuilders parented the use of crisis intervention in family-centered, home-based services (Nelson & Landsman, 1992), crisis intervention as a theory is not new to the social service field. A crisis has been described as an external event that causes great internal emotional and/or psychological distress to an individual (Jerry, 1998). Crisis intervention theorists claim that families and individuals are not only more willing to accept intervention at critical moments, but if they are not helped they will continue to function poorly (Simington & Cargill, 1996). Thorman (1997, p.69) gives 5 tasks of crisis intervention: 1) purge the symptoms of the crisis; 2) restore the family to their optimal level of functioning; 3) understand the events that triggered the crisis; 4) assist the family in coping with the crisis at hand; and 5) equip the family with the ability to cope with future crises. The crisis intervention model brought the Homebuilders project success as well as other programs that utilized crisis intervention later on (Nelson & Landsman, 1990).

Home-Based Models

A second major model used in family preservation services is home-based approach. Nelson, et al. (1990) explains that this model was introduced in the FAMILIES program in Iowa in 1977. The Iowa program began as a state funded project that aimed for longer treatment spans, assessments that are more comprehensive and greater empowerment of the family. This model has been driven by the theoretical underpinnings of the family systems theory. Home-based services have been known to vary greatly in the amount of time that families are serviced in the home. Some programs have served families for years while others keep brief treatment as an objective. Although these services differ somewhat, Minuchin, Colapinto and Minuchin (1998) describe several primary characteristics that home-based services share. They report that services generally aim to delivery services to the entire family with the parents heavily involved, and that the workers treat the family in their natural habitat where they can utilize local services in the community.

Family Treatment Models

Success from the Homebuilders model challenged others to apply their preferred model to the family preservation

paradigm and make it work. There are several variations of family treatment models in family preservation. They are used in diverse settings from small private agencies to large state-run programs (Morton, 1993). Generally, models used for family preservation are short-term, intensive, multi-service, and deal with the family in times of crisis, much like the Homebuilders model. However, some treatment models are longer in duration, less intensive and make more referrals out to other service providers in the community for specific services.

The Family Treatment Model is another distinguished theory used in the implementation and creation of family preservation programs. This theory has promoted the advancement of several other family therapy models (Whittaker, Kinney, Tracy, & Booth, 1990), including Functional Family Therapy. The Family Systems Theory, also used in family preservation, maintains that poor family functioning is revealed in the behaviors and health of the individuals (Bott, 1994). Bott also explains that understanding the family life cycle is of key importance in the therapeutic process. Nelson and Landsman (1990) explain that the Family Treatment Model consists of a three-phase intervention that may utilize diverse behavioral techniques.

Nevada's IFP Program

The state of Nevada IFP program is housed under the Division of Child and Family Services (DCFS). The child welfare system in Nevada is unique in that the county runs Child Protective Services (CPS) and DCFS is run by the state. This is important to note because of the distance placed between the IFP program and CPS that many states may not have. The IFP program is broken up into six main offices that document their segment of the program evaluation individually. The six sites are: 1) Las Vegas, 2) Reno, 3) Carson City, 4) Elko, 5) Ely, and 6) Fallon. The later three sites mentioned share rural characteristics and correspond frequently. Carson city and Reno are able to share an office with a state-contracted, private organization that performs IFP services. This site also encompasses some rural locations. The Las Vegas site has very distinct urban obstacles that differ from any other site in Nevada.

The growing and transit characteristics of Las Vegas offer unique challenges to the IFP program. For instance, the longitudinal study has determined that a 3, 6, and a 12-month follow up would be effective in evaluating the program. Unfortunately, these later follow-up visits are

often not possible because families have relocated to other states or have not provided updated addresses. These same characteristics of Las Vegas that affect the evaluation also determine the staffing pattern within the program. While most therapists tend to remain in the program for several years at a time, once gone, the vacancies are difficult to fill.

Las Vegas currently has 5 full-time therapists, 1 part-time therapist, 1 clinical supervisor, 1 secretary, and 2 full-time homemakers. Each therapist is qualified with at least a master's degree in social work, psychology, or another counseling field. The family homemakers are bachelor level workers providing concrete and referral services to families as needed. Each full-time therapist carries an average of 6 cases and 3 for each part-time therapist.

Like other IFP programs, Nevada's program attempts to deliver family-centered services within a short period of time. Home visits are generally made 2 times at the convenience of the family. A therapist becomes available for the family 24 hours a day and 7 days a week to assist in times of crisis when the family is most vulnerable to change. Therapists deliver family-centered treatment for approximately 90 days for each case.

The assessment process implemented at the beginning of each case involves several family-centered assessment tools that look at the entire family and the relationships between each member. The assessments make use of the genogram, ecomap, timeline, North Carolina Family Assessment Scale (NCFAS), the Family-Centered Behavior Scale or Beach and a behavioral sequence. The genogram and ecomap are both widely used family assessment tools that capture the family history and well as support systems, conflictual relationships and family strengths. Altshuler (1999) explains that genograms used with children can not only facilitate the engagement process as well as provide valuable insight to the quality of care a child receives. Zastrow (1999) shares the view that ecomaps proved holistic perspectives on a client family as they coexist with outside organizations, groups and individuals. A timeline may display patterns across time in the important events recounted by each family member. Behavior sequencing is a tool more specific to Functional Family Therapy that is later discussed in greater detail. Raymond Kirk and associates developed the NCFAS through rigorous testing, research and further modification, for optimal reliability. The BEACH is a very useful instrument designed to measure the degree to which clients and families view the

therapists as "family-centered." Allen, Petr, and Brown (1995) developed this instrument while working at the University of Kansas, Beach Center on Families and Disability.

There are two primary theoretical approaches used in Nevada's IFP program. Solution-focused therapy is utilized in the northern region of Nevada while the southern region employs Functional Family Therapy. Both treatment approaches are brief and operated through a family-centered framework.

Family Preservation Program Evaluation

The funding provided by the Omnibus Reconciliation Act in 1993 required that families be provided these services in order to prevent out-of-home placements. Millions of federal dollars were allocated not only for the provision of adequate services, but proper program evaluations. In order to validate the objectives of the act, it is crucial that preservation outcomes be measured and met. An argument asserted throughout both the child welfare field and the juvenile justice arena, maintains that family preservation services are too often ineffective in preventing out-of-home placement or the delinquency of minors (Fraser & Nelson, 1997). Program evaluations of complex IFP service programs have presented mixed results that stir debate

about whether the services are really effective (Pecora, Fraser, Nelson, McCroskey, and Meezan, 1995). Berrick and Lawrence-Karski (1995) suggest that although family preservation was now federally funded, weak evidence supporting the prevention of out-of-home placement made preservation programs an easy target for criticism. Heneghan and Horwitz (1996) assert that most evaluations have looked at the effects on out-of-home placements and have mixed results. The evaluation of FPS Programs is essential to maintaining program support throughout the country. Ford and Okojie (1999) state that answering the question of program success has been difficult because of the diverse characteristics of programs regarded as family preservation.

Several FPS program evaluations have been done to answer the effectiveness question. Ciliberti (1997) analyzed the 6 and 12-month follow-up data of a program in an African American community. This researcher experienced difficulties establishing validity in the study because the cases used were not randomly selected. This is a common problem found with program evaluations. Chang (1994) found distinct challenges in dealing with disproportionate sampling.

Lujan (1999) faced difficulties in the study of a program serving Native American populations due to the small number of cases available for research. This limitation can be applied to other programs across the country. Particularly in rural communities, small caseloads may limit the research substantially. Wright (1992) also discussed this limitation in the study of preservation services in the state of Texas. Inadequate or missing paperwork was also a limitation of the data collection and analysis (Lujan, 1999). Many similar limitations were confronted in the primary data collection and analysis of this study and is addressed later on in this report of the secondary analysis.

Serving Substance Involved Families

Child welfare professionals are increasingly attentive to substance abuse problems experienced by their clients. Slowly, substance abuse counselors and child welfare workers are realizing that they share much of the same population (Tracy & Farkas, 1994). Historically, the two disciplines have developed with separate goals and knowledge base. Tracy and Farkas continue to note that substance abuse counselors still have not received the training to identify child maltreatment or parenting issues.

The two fields took a giant leap when the Child Welfare League of America organized the first North American Commission on Chemical Dependency and Child Welfare in 1990 (Curtis & McCullough, 1993). The commission met and discussed political movements and current issues involving both subjects. One such issue is the concern for prenatal exposure to alcohol and other drugs (AOD). The problem has received national attention in child welfare as well as the media (Fisher & Harrison, 2000). Severe consequences of maternal use of alcohol and other drugs have been discovered and caused great political concern. Foster care workers and families report an increasing numbers of children who are prenatal exposed to AOD entering the system (Curtis & McCullough, 1993). When examining the factors of risk for child abuse and neglect, child protection workers are now quick to look for AOD involvement. Studies have indicated that substance use among parent's places children at a significantly higher risk for abuse and neglect (Pagliaro & Pagliaro, 2000). Sexual abuse is a particular danger when alcohol is involved. Paagliaro and Pagliaro assert that alcohol has been involved in the sexual abuse cycle of both male and female perpetrators.

The question of adequate parenting capabilities while under the influence of AOD is easily answered. Fields (1995) explains that AOD prevent structure, support, and caring guidance that children require for healthy growth and development. Poor parenting often causes other behavior and development issues in children of AOD users. Thompson (1990) claims that there exists a trend in the human service arena to overlook the use and abuse of AOD and instead treat the symptoms.

The State of Nevada, Division of Child and Family Services shares clients with not only juvenile corrections and probations, but adult substance-abuse organizations. The State of Nevada, Commission on Substance Abuse, Education, Prevention, Enforcement and Treatment (CSAEPET) stated in the 2000-2001 Master Plan that 35% of our youth are trying alcohol and 16% are trying marijuana before the age 13. Although juvenile substance use percentages remain comparable to national numbers, Nevada is not content with national averages. The CSAEPET plan continue to note that Nevada's problem is so serious that it costs the state nearly one billion dollars every year. This yearly estimate does not include the suffering of many children who are born with defects from prenatal exposure to substances.

Purpose of the Study

Rationale for the Study

Nevada, like other states, is interested in evaluating its Intensive Family Preservation services program to ensure that services are meeting the needs of families. This research was used to determine the 1999 fiscal year results of the DCFS longitudinal study in order to explore the effectiveness of FFT with substance-involved families. FFT has been implemented for years with the understanding that it would be evaluated and refined. This study contributes greatly to this objective.

Pecora et al. (1995) explain that evaluations must aim at answering pertinent research questions about current challenges faced by the program. This research presents a secondary analysis that has provided the opportunity to examine specific areas of Nevada's program that may build upon the current study's findings. Program reform is a consistent aspect of IFP services. While overall program effectiveness is important, distinct characteristics of families who received IFP services must be examined (Ford & Okojie 1999).

Significance of the Study

Within this research, provide valuable information about a rather large proportion of the clients of the Nevada state IFP program. Because substance abuse is prevalent among families in the Las Vegas, the results of this study have direct implication on services provided within Nevada's child welfare system. The outcomes of this study may be used to refine similar IFP programs across the country. The indirect influence of this study may reach the political realm to reform child welfare policy.

Scope of the Study

This study involves the data collected during the second year of the longitudinal research project of Nevada's IFP program. The cases of the study that were analyzed are from the Las Vegas area were primarily referrals made to the IFP program by Child Protection Services (CPS) and other DCFS workers. This study has not included cases outside the Las Vegas area because of the unique therapeutic model used by the Las Vegas site. The research questions are;

1) what is the social demographic profile of each family?
2) What are the families' overall pre-test and post-test NCFAS scores?

3) What are the differences of overall NCFAS scores between those substance-involved families and their non-involved counterparts?
4) What are the differences, if any, in social demographic characteristics between substance-involved families and non-involved families.

When individual IFP workers collected the primary data, the level of substance use was not recorded, rather whether or not the family problems included AOD use. Additional data limitations are influencing the scope of this study.

Limitations of the Study

Many similar limitations exist in this research as the ones previously discovered in the literature involving other evaluations. Some of these involve low case numbers, missing data, worker error, and the lack of a control group. Some of these significant limitations are discussed below.

A unique limitation of this study is due to the secondary nature of the analysis. As with any secondary analysis, the data have has already been collected and therefore research questions, data variables or method of data collection cannot be altered. Rubin and Babbie (1997) point out that an obvious disadvantage of a secondary analysis is the question of validity. In other words, it

is difficult to know whether the research questions asked in this study can be adequately answered by the data gathered for the original study.

Another limitation that must be discussed is use of a single-subject or single-system design. Smith (1991) states that this method is recommended when it is not practical or possible to provide a control group. The lack of a control group presents the risk that the difference in scores is due to other factors such as time or unrecognized influences.

Another limitation of this study is that the workers themselves recorded the case information. The risk of worker bias shows up with this limitation. For example, if a worker believes that change in substance users is not likely, that worker might record lower scores for all substance abusing cases, even without being aware of the bias involved. Although this risk is present, it may not be the case in this research.

CHAPTER 2

CONCEPTUAL FRAMEWORK

Functional Family Therapy

The Functional Family Therapy (FFT) model has been the primary treatment modality used in the Las Vegas or the southern region of Nevada's family preservation program. FFT effectively lends itself to the family-centered nature of the IFP program because of its analysis of family relationships, perspective on functions of behavior and short-term characteristics. Included in Chapter 2 is a discussion of the development and background of FFT and how the model is used for family preservation.

Background

The 1960s provoked a great deal of curiosity and uncertainty in the minds of most human service workers. The sixties introduced new ideas as well as challenged the faultlessness of traditional explanations of human behavior. The philosophical shift from individual therapy to family and group therapy had already gained national recognition and success, but was still in the works as far

as the full development of effective theoretical concepts. Nichols and Schwartz (2001, p.14) recount that in the 1950's, therapists began to recognize that family members would take turns portraying symptoms of the problem as if the family needed a "symptomatic member." It became popular to include other family members in the treatment to further understand the facets of family behavior.

Nichols and Schwartz also report that the 1950's and 1960's introduced Gregory Bateson and the Palo Alto group of California, who made popular their ideas on the family in relation to schizophrenia. The Palo Alto group focused on the immediate symptoms and behaviors attempting to provide brief therapy, rather than taking years to uncover the pathological causes of behavior (Schlanger & Anger-Diaz, 1999). Don Jackson and Jay Haley also popularized family therapy with their ideas of family homeostasis and communication.

During the early development of in-home, intensive family services, the provision of therapeutic interventions as well as concrete services became standard. Therapy in family preservation has been provided primarily through three types of models (Nelson & Landsman, 1990). In 1974, the Homebuilders model provided short-term, crisis intervention therapy while ensuring that concrete family

needs were met. Two other types of models are family treatment and home-based models. Family treatment models, like FFT, focus on overall family functioning by assisting the family with "practical problem-solving" in meeting immediate concrete needs while addressing the "intrafamily conflicts" and maladaptive behaviors (Nelson, 1990, p.25). The introduction of family therapy in child welfare was unavoidable because of the critical need for interventions in preventing abuse and neglect during family interactions. Henggeler et al. (1998) add an important note by reporting the success of Multisystemic Treatment interventions that are provided in the home in order to prevent the out-of-home placement of troubled youth. These interventions utilized several types of service provision to meet all immediate family needs.

Since these earlier movements in family therapy, several professionals have been key in the development of Functional Family Therapy. The development process began in the early 1970's, when James F. Alexander was working with troubled adolescents. Like many therapists, Barton and Alexander (1981) state, Alexander was attempting to find a clinical framework that could explain the reoccurring patterns he observed while working with troubled children and their families. Barton and Alexander

continue to note that the systems and communication theories demonstrated by the Palo Alto group implore for greater analysis of interpersonal relationships for the meaning of behavior. The more traditional theories focused on the individual while Alexander's explanations of behavior are derived from the family system. Cole and Alexander explain that older clinical approaches originate from traditional Judeo-Christian values that have tendencies to view maladaptive behavior as individual choice. A break from the traditional views of behavior was one of the theoretical targets of FFT. Another major empirical phenomenon was the evident patterns of family communication. Fallon (1991) relates that the behavioral principles of family therapy give strong emphasis on direct and clear communication within the family. Fallon also adds that the skill-training model lends itself to the development of more effective communication patterns.

Assumptions and Concepts of Behavior

How a theory views behavior will guide the way therapists view both positive and negative behavior. The development of a theory is a multifaceted process of inductive and deductive analysis aimed at answering the question of "why" behavior occurs (Robbins, Chatterjee & Canda, 1998). In the explanation of behavior, Functional

Family Theory was guided by two major theoretical approaches. The systems and cognitive-behavior theories gave Alexander all the answers he needed to equip FFT with empirically validated, explanatory principles as well as effective treatment techniques. The theoretical assumptions underlining FFT are ones compatible with the two theories just mentioned.

The primary assumption proposed by FFT is that human behavior stems from within the context of family relationships (Barton & Alexander, 1981). The meaning of behavior can be uncovered in the analysis and assessment of relational perspectives (Cole & Alexander, 1981). In fact, according to Barton and Alexander (1981, p.407), behaviors by individuals are "meaningless" by themselves. The systems perspective has shaped this concept in the field of family therapy. Family interaction patterns are guided by the prescription of each relationship in the family (Becvar & Becvar, 1982). This concept rests on the assumption that behavior, as Barton and Alexander state, is reciprocal. Both the individual and the environment generate behavior.

Alexander, Pugh, Parsons and Sexton (2000) state that behavior modification is a result of proper technique and timing. Treatment techniques work at changing the way family members view themselves and other members. This

concept of behavior change carries several assumptions with it. The primary assumption is that behavior change will occur because the therapist has utilized the right technique at the right moment in the life of the family. The concept might also assume that behavior change will occur in a short amount of time with the therapist working as a motivator. If the family will develop a working relationship with the therapist, Alexander et al. assume that circumstances will be optimal to employ these behavior-changing techniques. Though this idea appears to be simple, to explain why change in behavior takes place is not simple.

A major concept of FFT is that all behaviors, problematic or not, serve functions of family needs. Simultaneously, a single behavior may serve a function of several members of the family. An assumption of this concept is that no adaptive or maladaptive pattern carries on without serving at least one function within the family. These functions cannot or should not be changed in the short period or duration of the treatment. FFT aims at changing behavior within family relations while maintaining ingrained functions of those behaviors. A value of FFT holds that functions in themselves are not problematic, nor good or bad.

Functions are defined by FFT in terms of distancing and intimacy needs of family members. Each family member can regulate and maintain the closeness of their relationship by their behaviors and interactions with other members. For example, when a mother is constantly sending her son to his room for misbehaving, her distancing needs could be met by the interactions in their relationship. From the example just mentioned, interactions within the family must be viewed from the context of the relationship and from what function they serve. Although the mother may claim to want her son around her, Alexander and Parsons (1982) state, the actions will provide an accurate picture of the functions present. Functions are vehicles for all people to adjust their relationships according to their individual needs (Alexander & Parsons, 1982). The mother is perfectly able to adjust her son's distance or closeness as she truly desires. In this same example, it is important to remember that the son is also meeting some needs of his own by acting out. How can the mother and the son meet both of their needs by behaving differently?

The Clinical Model

The developers of FFT have encouraged and supported the continued use and study of FFT in a variety of settings. For this purpose, it is essential that FFT experts develop

measurable objectives to facilitate the replication and testing of the theory. According to Alexander et al. (2000), there are four objectives of Functional Family Therapy as it was designed and implemented. These four objectives are: 1) engagement; 2) motivation; 3) behavior change; 4) and generalization. Through these four objectives, the model can be repeated, evaluated and tested for empirically significant results.

The first and second steps in this treatment go hand in hand. The process of engagement involves initiating an assessment while simultaneously committing the family to become involved in behavior change. This beginning phase also involves removing the obstacles of inadequate housing, food, clothing and other necessities. An accurate assessment of the family needs and behaviors to be changed can occur right in the home. Alexander and Parsons (1982) maintain that direct home observation is a useful diagnostic technique used by many family therapists. The therapist will assist the family in viewing the possibility of positive change. Once the family is engaged, the therapist is free to elicit motivating experiences from family members. Here several techniques can be utilized to develop a strong relationship with the family. The most influential technique in motivating the family is

relabeling (Barton & Alexander, 1981). Questions about what Alexander refers to as "interrelating feelings, thoughts and behaviors" (Alexander & Parsons, 1982, p. 52), will not only aid in the assessment process, but give the therapist ammunition to use when relabeling family behaviors. Barton and Alexander (1981) state several methods to confront resistant behavior and communication from family members. Once resistance is defeated, motivating the family will require less time and resources. This is consistent with the brief nature of FFT.

Behavior change begins to occur in the assessment phase. For clarity, Alexander and Parsons (1982) detail assessment and therapy as two separate phases. Contextual relationships are taken into consideration when finding less problematic behaviors for each family member to adopt. Several cognitive-behavioral and communication techniques have been explained by Alexander and his associates to facilitate this process. In order to ensure long-term effects, the therapist works hard at educating family members to access outside resources or, as Alexander et al. (2000) states, "mobilize community support systems."

Finally, generalization work is performed with the family. Alexander et al. (2000) state that many problems cannot be changed directly. Changing these problems call

for the generalization phase, which occurs after the family has begun to change internally. Generalization techniques are individualized to each member of the family and address problems such as school performance, peer relationships and community involvement.

Techniques of Treatment

Although the distinct treatment techniques are therapeutic in nature, they facilitate the on-going assessment process. Once an appropriate assessment of functions and behavior is made, the therapists can then begin to educate the family. According to Denby and Mears (In Press), FFT involves education of the family in the therapeutic process. If the family members' ability to understand abstract processes has been assessed, the therapists can then explicate the functions of family behaviors in understandable terms to each family member. This explication can be facilitated through several techniques. Alexander and Parsons (1982) list a few of these techniques as: 1) asking questions; 2) making comments; 3) offering interpretations; 4) identifying behavior sequences; 5) nonblaming or relabeling; 6) and shifting the focus to other family members.

Behavior sequencing is a valuable tool frequently practiced in FFT. This technique is used highly for

assessment purposes yet has valuable educational and therapeutic characteristics. Generally the therapist will record a circular pattern of behavior as the family reports it. The therapist may ask, "o.k., tell me what happens next," in order to verify that the sequence is accurate to family member perspectives. The sequence can then be analyzed for relational patterns and individual functions that drive behavior and interactions. Alexander and Parsons (1982) share that a therapist may then at this point emphasize specific aspects of the sequence or de-emphasize others to the family. This process may add substantially to the family's understanding of their own behavior and the functions of those behaviors. When family members are able to look somewhat objectively at their behavior, they can see possible alternatives to conflicting patterns. This technique functions well at all stages of the treatment process: engagement, motivation, behavior change and generalization. The family is easily engaged when discussing what goes on in the home. When nonblaming perspectives are taught to the family, members are motivated to change those maladaptive behaviors with more appropriate ones. Once behavior change has begun, the family can then use their newly discovered sequence to

generalize their knowledge of functions in broader areas for more long-term effects.

Reframing is another important technique used during the treatment phase. It is valuable in it's educational characteristic. When the therapist views the family interactions, he or she may want to provide insight to a more non-judgmental perspective on the behavior than the one that has been presented by the family. For example, the therapist may point out that a disobedient child may be getting his or her closeness needs met by acting out. The parent could then see how meeting the child's closeness needs can be met while distinguishing the acting out behavior. Barton and Alexander (1981, p. 406) refer to this technique as the "manipulation of the meaning of behavior within the interpersonal context of the family."

These and other techniques used by FFT therapists are simple and effective tools of treatment. Using these techniques therapists then endeavor to examine the distancing and intimacy needs of each family member and find optimal behaviors that will better meet those needs. It is the firm assumption of FFT that function cannot and should not be changed since the functions themselves do not create problems for the family members. It is the behavior that causes problems for the family and should be replaced

with a more functional behavior that will work to meet the same needs of the family. With this in mind, it is easy to understand how treatment can occur within a short period of time.

Evaluation of FFT

Because Functional Family Therapy is such a new theory and therapeutic model, it must be evaluated and further developed. Chafetz (1978) stated that theories are to be evaluated by several critical questions. When evaluating any theory, Chafetz adds, one must ask: 1) what use is the theory at explaining known phenomenon? 2) Can the theory be empirically tested? 3) Are the assumptions implicit and logical? 4) Are concepts clear, cohesive and consistent with their meanings? 5) Is it possible to create operationalizations and are there internal conflicts?

FFT is particularly successful at explaining human behavior as it occurs in the context of the family. Barton and Alexander (1982) share the success of four studies that support the conceptual framework of FFT. All four studies have direct associations with family systems and treatment of human behavior. One validated truth is that behavior does not always work to the best interests of the family. Problematic behavior, although serving a function for certain individuals, is not effective in meeting the whole

family's needs. For successful explanatory power, a theory must be able to explain why people continue problematic behavior.

FFT has some limitations addressing cultural and racial issues in the family. Because FFT was developed in the United States, it has struggled to explain behavior as it occurs in the traditional American family. Although it can be argued that FFT developers have worked with some minorities and diverse families at-risk, it does not attempt to distinguish American family behavior from that of culturally and ethnically diverse families, but assumes that all families behave to meet similar distancing and intimacy functions. When facing the challenge of crossing international boundaries, FFT might have difficulties validating its explanatory power in foreign families.

Because FFT is highly clinical, its terms are more complex and difficult to operationalize than many traditional approaches. This can be problematic when expecting professionals who are untrained in FFT to use its concepts and explanatory ability. When helping professionals are investigating the theory, many questions may arise while attempting to understand theoretical concepts. What is a function of behavior? How can functions be identified? Why do distancing or intimacy

functions exist? Whose function is being met with any specific behavior? The answers to these questions may only create more questions.

Some criticisms of FFT have been concerned with sustaining the sexist or oppressive roles in this society. Avis (1985) maintains that traditional sex roles and functions of those roles are only reinforced by FFT principles. Since the approach only attempts to exchange ineffective behaviors for more effective ones, the functions of traditional roles in the family are preserved. Alexander states in relation to Myers' critique that functions themselves do not carry sex biases and that changing functions cannot be a goal of a short-term therapy model such as FFT (Alexander, Warburton, Waldron & Mas, 1995). Although women and other contributors have validated the FFT approach when working with diverse families, the model has need to address the concerns of gender roles in families with oppressed women. The feminist criticism of FFT relies on the assumption that the oppressed situation of women is directly an effect of the functions as defined by FFT. Since Alexander et al. (1985) consider it unlikely to change the functions of family members, Avis considers FFT to be supportive of traditional and sexist gender roles. Alexander et al. continue to

argue that therapists often misunderstand the relationship and definition of functions and roles in the family.

Another limitation of FFT is that the educational characteristic of the model limits its effectiveness when working with small children or adults with intellectual or cognitive challenges. Because the theory has somewhat abstract principles, the possibility for misinterpretation of theoretical principles by a therapist is greater. Just as Avis (1985) misunderstood the meaning of function, others may lack the guidance to appropriately administer treatment within the FFT paradigm.

As mentioned previously, theories are vehicles for effective research. Each study uncovers valuable information about whether that theory works in each particular situation. Chafetz (1978) explains that each theoretical proposition can be used to various hypotheses. When hypotheses are tested in diverse settings, the theory can then be modified and validated. Testing the theory in various situations may become a problem when distant sites are not well trained in the theory and do not use the theory accurately. The ability to be tested is dampened by the need for adequate training and a conceptual understanding of abstract concepts.

Pelton (1990) strongly criticizes the attempts of family preservation services at using clinical models to beat the real causes of abuse and neglect, which Pelton attributes to poverty and unsafe environmental conditions. Although FFT meets specific philosophical requirements of family preservation (i.e., short-term, family-centered and behavior-changing), it cannot account for significant past attempts to improve the physical needs of the family. Can a highly clinical model such as FFT meet the needs of the family who suffers from poverty, a lack of resources and discrimination in everyday life?

Alexander and his associates as well as other child welfare professionals have addressed this question. Both sides of the issue have some sense that concrete needs of the family must be fulfilled. In recent studies for the Center for the Study of the Prevention of Violence (CSPV), modifications of FFT have targeted risk factors to ensure child safety as well as overall family functioning. In a recent report, Alexander et al. (2000) explain that behavior changing involves alleviating intrafamiliar and extrafamiliar risk factors. This might include the provision of concrete services as well as clinical services. Assertion training, Alexander et al. add, can be

offered to empower minorities and the poor to recruit outside resources to meet physical needs.

Finally, FFT must be evaluated for its utility in family preservation services. Obvious strengths of FFT make it ideal for its use family preservation services. Lantz (1985) details the attempts of a Utah child welfare agency in preventing out-of-home placements of youth. The report gives a working definition of how the program used Functional Family Therapy to meet the requirements of the Child Welfare Act of 1980. In the end, Lantz reported an 82% success rate with preserving the family unit by increasing the family functioning.

FFT is a short-term approach designed to be intensive. It has been proven effective to work with families of adolescents and delinquents. Alexander and other therapists using FFT have used FFT behavioral techniques while working with adolescents with severe behavior problems. The non-blaming perspective of FFT has proven to facilitate change in adolescents and their families. Gordon and Graves (1995) state that FFT has also shown promising results with serious multiple offenders.

Despite the strengths of FFT in working with behavior modification, there are noteworthy concerns to be raised when examining its utility with substance abusers.

Alexander et al (2000) address the factors that place juveniles and their families at risk for violence. Although the factor of substance abuse is not ignored, adequate research on this population is not apparent. Additional, and more focused, research is required for an accurate assessment of FFT strengths in this area.

CHAPTER 3

METHODOLOGY

This research report details an examination of the effectiveness of FFT in the Las Vegas, Nevada Intensive Family Service program. The research goals are in discovering the model's effectiveness with substance-involved families, who make up a large portion of families who receive preservation services in Nevada. The research questions and design for this secondary analysis have been detailed below.

Research Questions

Four research questions are addressed in this study. Each question is described with its utility towards understanding the objectives of the study. In order to examine the overall effectiveness of FFT with substance-involved families, it must first be asked: What is the social demographic profile of each family? This question can provide with ample detail, the characteristics that present an accurate picture of the family's social and home

life. This question also identifies the families who report to use drugs and/or alcohol. The research results are able to show what characteristics substance-involved families share, and what differences these families present.

The second research question asks: What are the families' pre-test and post-test scores? By looking at pre and post-test scores, overall family functioning and child well-being can be examined before and after the intervention was implemented. The NCFAS scores demonstrate the several important areas of family functioning. Statistical significance is determined for overall effectiveness of the Las Vegas IFP program.

The third question seeks to know: What are the differences in overall NCFAS scores between substance-involved families and their non-involved counterparts? Significant differences in substance-involved family scores are recognized with the degree of difference. Here, program effectiveness with substance-involved families is revealed. Significant differences represent a need for modification of services to better meet the needs of clients.

The fourth research question is concerned with discovering: What are the differences in social demographic

characteristics between substance-involved families and non-involved families? Several important demographic characteristics have been analyzed for the purpose of this question. It was practical to test these variables in order to better understand the challenges substance using caretakers face in everyday life.

Research Design

The research design that was used for this study is the A-B-A, single system design. Rubin and Babbie (1997) describe the single-system design as the application of time series designs and the analysis of the impact of interventions on client systems. The single system, also known as the one-group or single subjects design, is an analysis of the effectiveness of an intervention on a single system across three phases.

The first phase, baseline, is used to collect data on the subject or client system before the intervention was introduced. The next phase is used to gather data on the subject after the treatment intervention has been administered. While those two phases alone are sufficient for the purpose of this study, it is often practical to introduce a third, fourth, or fifth phase to the research

design. Additional phases will facilitate the measurement of long-term effects of the intervention.

Nevada's longitudinal study has utilized a 3, 6 and 12-month follow-up visit to gather data measuring long-term effects of treatment. The secondary analysis will look at pre-test and post-test scores before and after the treatment or intervention period, but will not include follow-up data in the analysis. As stated before, this period is generally 90 days with some cases receiving extensions and some cases terminating early. Early termination may occur if the family has moved, the family rejects services or if the children are removed from the home and family preservation services are no longer needed. If a case terminated early, it is probable that the post-test for the NCFAS and the Beach were not completed. For this reason, under 30-day cases are not used in the analysis of this research.

This research design is widely used in program evaluations because it is often not practical, or ethical, to establish a control group. In most state or federally funded programs, it is not possible to deny services to groups of people. Yet, in order to employ a control group, a group of people who will not receive services must be randomly selected. The fact that the single subject design

does not use a control group makes this design an easy target for criticism.

Rubin and Babbie (1997) explain that the factor of history must be ruled out. Is it possible that time itself made the difference in the progress of the family? Particularly with only two data points (pre-test and post-test), it is difficult to tell when progress began or if the progress was due to the intervention.

According to Williamson, Karp, Dalphin and Gray (1982), a secondary analysis is research around the reanalysis of data that has been previously collected by someone else and for another purpose. Williamson et al. are very accurate in that someone other than this researcher has collected the data at an earlier time. However, the purpose of the original data collection and the purpose of the secondary analysis are not far apart. This secondary analysis will build upon the information previously gathered by an original data analysis. This is one advantage of a secondary analysis. Other advantages include cost-efficiency, time-efficiency and issues around ethics.

For example, by using data previously collected, this study can avoid direct contact with families. This avoids the possibility of a break in confidentiality and other common risks of involving live subjects in research. A

major disadvantage of a secondary analysis is in the validity. Rubin and Babbie (1997) ask how can a researcher know if the data previously collected, for alternative purposes, is valid in an analysis for another purpose? This question has important implications, but can easily be answered for this study. This study seeks to build upon similar research questions as the original longitudinal study.

Instrumentation

The instrument that was used for this study is the North Carolina Family Assessment Scale (NCFAS), version 1.4. Kirk and Reed Ashcraft (1997) explain in the User's Guide for the North Carolina Family Assessment Scale that the North Carolina legislation of 1991 brought about a necessity for an instrument to measure program outcomes. The outcomes required by the state involved the prevention of out-of-home placements for the state's family preservation service program.

In the development of the NCFAS, Kirk and Reed Ashcraft (1997) explain, the interested parties needed to be satisfied with several different characteristics. The theory-driven instrument needed to: 1) demonstrate an ecological perspective on family functioning; 2) employ the concerns of not only child welfare, but juvenile justice

and mental health professionals; 3) demand little time and training from agency programs and workers; 4) detect small changes, improvement or regression; 5) and finally satisfy both practitioners and researchers. Then, through the collection and analysis of several tools already utilized throughout the country, an "anchor scale" was selected from southern California to guide the development of the NCFAS (Kirk & Reed Ashcraft, 1997, p. 5). Raymond Kirk and Kellie Reed Ashcraft used the Family Assessment Form from southern California because of the empirical research supporting the scale's validity.

The NCFAS was revised and tested several times before statewide implementation. Then after a full year of use by the state, version 1.4 was introduced. NCFAS version 1.4 was the latest version available when assessments were completed for the cases involved in this study. Three years after version 1.4's release, version 2.0 was making its way around and is now the most current version being used for family-centered research. Both version 1.4 and the latest version, 2.0, have 5 domains that focus on environment, parental capabilities, family interactions, family safety, and child well-being. Version 1.4 varied slightly from version 2.0 in the number of subcategories under the domains and the focus and name of two of the

domains. Parental Capabilities and Family Safety in version 2.0 replaced social Support and Family/Caregiver categories of version 1.4.

All five domains of the instrument operate with a 6-point scale ranging from a + 2 to - 3, with zero as a baseline. Therapist impressions of the family are recorded on each domain of the NCFAS shortly after intake and case closure, to maintain reliability and validity (Kirk & Reed Ashcraft, 1997). Each point on the instrument seeks to measure the degree to which each item is viewed as a problem or strength, with - 3 = serious problem; -2 = moderate problem; -1 = mild problem; 0 = baseline; +1 = mild strength; and +2 = clear strength. The NCFAS works well in measuring the short-term success of an intervention as well as long-term effect through follow-up visits.

Data Collection

The data used for this study was data that was previously collected for the longitudinal study performed by the Nevada State Department of Child and Family Services, Intensive Family Service Program. The longitudinal study involves 6 program sites, each having their own site supervisor and therapists. The data was collected from July 1, 1998 to June 30, 1999. During intake, the therapists gathered important demographic

information from the family. Within the first few visits with the family, the therapists were able to get a good clinical picture of the family and complete the pre-test on the NCFAS. Generally, if the case did not terminate early, the therapist could complete the post-test as soon as the case closed. Other outcome measures were then recorded, such as whether or not out-of-home placement was prevented.

Population Sample

There were a total of 79 families from the Las Vegas site who were involved in the sample within the time frame reported above. The families were from diverse ethnic, cultural, and social backgrounds. Nevada Child Protective Services, Nevada Department of Child and Family Services, child welfare services or Clark County Juvenile services, referred the families to Intensive Family Preservation services. The families were referred because of substantiated abuse, neglect, both, at-risk of placement due to serious behavior problems or other problems, status offense or delinquency.

Data Analysis

The data analysis was carried out by the utilization of SPSS, statistical software package 10.0. This software easily runs descriptive statistics and tests of significant difference. The descriptive statistics that were done are

the frequencies, including the mean and the standard deviation, as well as a crosstabulations on several of the variables.

To satisfy the first research question, several frequencies were computed to explore basic demographic information of the data set. The data were then examined for specific patterns in the characteristics of the population. For example, while identifying substance-involved families, it was practical to examine associations with other demographic information such as age, gender or minority status. Crosstabulation and the Chi-Square test were used to find statistical significance in the nominal demographic variable between substance-involved and non-involved families.

Finally, two kinds of t-tests were used to determine significant difference for continuous variables in the study. Independent-samples and paired-samples t-tests were used for the purposes of this study. The first was used to test for differences in continuous demographic variables and NCFAS scores between substance-involved families and their non-involved counterparts. The second, paired-samples t-test, was the tool for testing statistical differences in NCFAS pre and post-test scores for the second research question.

CHAPTER 4

FINDINGS

Research Question One

In response to the first research question of this study, the important demographic information of the families from the Las Vegas site has been analyzed (see Table 1.0 & 1.5).

Referral Source. Of the 79 families from the Las Vegas site, 65 (82.28%) were referred by Clark County Child Protective Services (CPS). DCFS - CW accounted for 11 (13.92%) of the referrals while DCFS - CPS referred only 3 (3.80%) to family preservation services. The Las Vegas site did not report any referral from Clark County Juvenile Services during the 1999 fiscal year.

Referral Type. Of the five different types of referrals (FPS, Reunification, Adoption, Foster Care, and Crisis Intervention), two of the types of referral did not occur in Las Vegas during the specified year. Family Preservation Services or FPS dominated the 79 cases with 64 (81.01%). Reunification referrals were far behind, but in

second place, at 14 (17.72%). Only 1 case was referred for Crisis intervention.

Reason for Referral. Although similar to referral type, Reason for Referral represents an incident or situation explaining why the case needed to be referred for specific services. Substantiated Abuse took precedence here with 30 (37.97%) cases. Substantiated Neglect by itself numbered 25 (31.65%) cases. There were 23 (29.11%) cases characterized with both Abuse and Neglect. Only 1 case was classified as At-Risk. There were no Status Offense or Delinquency cases.

Primary Caretaker Ethnicity. The ethnicity of the primary caretaker was often, but not always, the ethnicity of the primary or secondary victim. For the purpose of this research, the assumption will be made that the ethnicity on the majority of cases is similar in the entire family. A report of case frequencies revealed that 52 (65.82%) of the 79 cases reported to have a White or Caucasian primary caretaker (see Table 1.0). Black or African-American took up 21 (26.58%) of the 79 Las Vegas families. This study found only 1 American Indian or Native American and only 1 Asian American primary caretaker. While a mere 4 (5.06%) Hispanic or Latino cases showed up in the population.

Minority Status. The minority status should be quit clear from the data above. But to ensure that families were given proper classifications, minority status was questioned and recorded. In Las Vegas, 28 (35.44%) cases were considered to have minority status. Surprisingly, 51 (64.56%) cases reported no minority status.

Primary Caretaker Gender. An overwhelming number of primary caretakers were female, 71 (89.87%), who received family preservation services were female, leaving only 8 (10.13%) male primary caretakers.

Primary Caretaker Employment. This group had 41 (59.42%) of the primary caretakers employed. Only 28 (40.58%) of the 69 respondents of this question were unemployed.

Household Income. The mean income for Las Vegas households served was $1,652.49 per month or slightly less than $20,000 in a year.

Primary Caretaker Age. The mean age for that same group of caretakers was 37.

Primary Caretaker Education. When asked for the number of years in education, the mean number given was 12 years, signifying a high school diploma, G.E.D., or full completion of high school.

Total Household Members. This question aimed to discover the total number of people living in the household. The mean number for this question was 4.

Drugs/Alcohol Use. The results of this defining question detailed that 21 (27.27%) use only drugs, 12 (15.58%) use only alcohol, 8 (10.39%) use both drugs and alcohol, and 36 (46.75%) reported that drug or alcohol use was not applicable to them.

Research Question Two

Research question number two seeks to know, what are the NCFAS pre and post-test scores of the families? This question entails obtaining the means and standard deviations as well as a test and statistical significance in pre and post-tests for this sample of Las Vegas (See Table 2.0, 2.1, 2.2 & Figure 1.0). For the purpose of the second and third research question, cases that were serviced under 30 days have been excluded from the analysis of NCFAS scores since they do not have a post-test.

Statistical significance between the pre and post-test on each of the domains was uncovered through a paired-samples t-test. This test provided several points of information. First, Table 2.0 demonstrates the number of respondents, mean scores, and the standard deviation for each domain pre and post-test. Table 2.1 displays

correlations of the paired variables. Table 2.2 contains valuable results of statistical significance with each domain.

The mean scores for the five domains of the NCFAS pre-test are: Environment -0.18; Social -.01; Caretaker -1.39; Fam Interaction -0.18; Child WB -1.04. NCFAS post-test scores were: Environment 0.20; Social 0.55; Caretaker -0.21; Fam Interaction 0.01; Child WB -0.21. The means can be more easily understood by a visual analysis of Figure 1.0.

The outcome of this t-test showed tremendous differences among each domain from pre to post-test. The largest difference is in the caretaker domain with a -1.18. The other four domains followed after with family interaction at -1.00, child well-being at -.79, social at -.57 and environment coming in last, but still significant at -.38. All five domains are statistically significant at the 0.05 level, meaning that there is less than a 5% chance of error. In all of the cases, statistical significance indicates that the difference in pre and post-test scores is not due to chance.

Research Question Three

Research question number three is; what are the differences between the scores of substance-involved

families and their non-involved counterparts? This question was answered with an independent-samples t-test. It was discovered that none of the NCFAS pre-test scores are significantly different from the two groups. In the post-test, mean overall scores were statistically significant in three out of five areas (see Table 3.0 & 4.0). Those cases serviced under 30 days, have been excluded in the analysis for this research question.

Environment Post. In this domain, non substance-involved families scored a mean of 0.79 while substance-involved families scored -0.25 ($F=1.54$, $p=0.024$).

Social Support Post. Substance-involved families reached a high score of 0.28 on this domain. This was still not close enough to the 0.92 mean of the non substance-involved family scores ($F=2.09$, $p=0.008$).

Family Caretaker Post. As in the environment domain, the mean scores in this domain yielded significant differences ($F=1.75$, $p=0.008$). The mean score of substance-involved families in this domain was at -0.56, yet the mean score for their counterparts remained above baseline at 0.25.

Research Question Four

The fourth research question asks, what differences exist, if any, in the social demographic characteristics

between substance-involved families and non substance-involved families? This question is an inquiry for closer examination of case characteristics that might also be effected by parental or caregiver substance use. All cases, including under 30-day cases were used in the analysis for this question.

To answer this question, two tests were employed using SPSS version 10.0. An independent samples t-test was utilized to check for statistical significance with the characteristics that were continuous; age and years of education of the primary caretaker, household income and number of household members (see Tables 5.0 & 6.0). Variable of nominal measurement were included in a cross tabulation with a chi-square test for statistical significance; gender, ethnicity, employment and minority status of the primary caretaker (see Tables 7.0-11.5, & Figure 2.0).

The results of the independent samples t-test revealed several significant associations. The analysis for this test revealed no difference in the amount of education or the age between substance users and non-users.

Income. The mean income of substance using households was $1303.17 while their counterparts earned a mean monthly income of $2108.13 ($F=0.218$, $p=0.005$).

Total Household Members. The mean number of members in substance-involved households was 4.56. While the mean number of household members for non-substance users was not far off (3.81), the standard deviation for both groups was between 1.56 and 1.58, making this variable statistically significant (F=0.003, p=0.039).

Variables with nominal levels of measurement revealed results very consistent with those mentioned above. While ethnicity in itself did not yield statistically significant data, the minority variable did have significant results.

Minority. An almost equal percent of minority caretakers (63%) do not use substances as those non-minorities (62%) that do use (see table 6.0). The variable was showed clear significant difference (Chi-Square=4.389, p=0.036).

Employment Status. The independent samples t-test results demonstrated significant differences in the monthly mean incomes of the two groups. An analysis of this variable discovered that a greater number of substance-involved caretakers are unemployed than their counterparts (Chi-Square=8.027, p=0.005).

It was discovered that no statistical difference exists in the gender of substance and non-substance users.

CHAPTER 5

DISCUSSION AND IMPLICATIONS

Demographic Information

Basic social demographic information and case characteristics are meaningless in themselves. However, when taken in the context of theoretical principles in an attempt to understand the world and human behavior, this information may prove to be of great value. As discovered in this secondary analysis, most of the cases referred to family preservation services were from Clark County Child Protective Services, specifically with the goal of preserving the family. Primary caregivers were primarily white females in their thirties, who work and use drugs and/or alcohol, yet are living in poverty while supporting at least 2 dependents.

Although Las Vegas is a growing and diverse community, the cases have an overwhelming status of non-minorities. The lack of diversity among the client population of the Las Vegas site should be concerning to child welfare professionals. After a careful look at family preservation

literature, Grack (1997) stated that minority status was a common characteristic of preservation populations. Potocky and McDonald (1996) studied substance-using mothers and found that 75% of the mothers were of minority status. The results of the current study are not consistent with these results.

In the Nevada Kids Count Data Book (2000), the data reveals that minorities only made up 38% of the children living in Clark county in 2000. Hispanic children accounted for a large 22% while African American children only made up 13% of Clark county. Still, the CPS 1999 report of substantiated victims reported a large 24.8% African American population and only 2.2% Hispanic. These over and under-representation are present in the family preservation.

Are minority populations misrepresented and underserved in family preservation services? On the other hand, do minority populations not need preservation services at the rate European Americans do? The significance of these questions raises the need for further research in the subject. Many similar questions may be answered in future program evaluations. Program evaluation may uncover how greater focus can be placed on meeting the needs of minority populations.

A result of this study supports current literature in that a great majority of the primary caretakers are female. This fact is consistent with child welfare numbers across the country. In Epstein and Madhavi (1998), a study involving children in a family preservation or reunification program, found that 60% of the households involved had only one parent. In that same study, less than half of the caretakers were employed. Cohn and Hinkle (2000) maintain that parent-child relationships deteriorate when single parents struggle with stress and poverty. Another study found that the average case was represented by a 12-year-old boy with a single mother and living in poverty (Staudt, 1999).

In a study of home-based, family preservation services of Las Angeles County, McCroskey and Meezan (1997) reported that less than 21% of all research participants had more than a high school diploma and less than 16 % made over $1,500.00 per month. Families receiving preservation services are consistently characterized with low education and economic status. Particularly in this study, it was discovered that substance-using caretakers had considerably lower employment rates and household income. This problem is further complicated with the fact that the number of household members rises with substance abusing families.

With less income and employment, caretakers supporting more dependents are in serious risk of losing their children.

One significant highlight of this study is that minority families have lower numbers of substance use. This fact is particularly interesting because of the increasing numbers of minority families who find themselves wrapped up in the child welfare system.

Implications For Practice

There are many implications that can be drawn from the conclusions of this study. First, the data clearly demonstrates that family preservation services in Las Vegas, Nevada work. As reported previously, the DHHS Office for the Assistant Secretary of Planning and Evaluation reported that family preservation programs from three states were not effective. Unlike these federal findings, the data from this research suggests success. However, some similar weaknesses of the program have been revealed. For instance, the lack of progress with children, poor families, and substance-involved families and children is related to this study.

Even with some weaknesses in the program, the results of the paired-samples t-test show significant differences in the time-series data from pre-test to post-test. The data results are very convincing that families have

improved from pre-test to post-test. This study presents the case that family preservation services should be continued and improved upon for greater success.

The second point worth mentioning is that there are significant differences between substance-involved families and their counterparts. Substance using caretakers have lower outcome scores and suffer from lower income and employment as well as a greater number of dependents. This does not mean however, that family preservation services do not work with substance-involved families, but rather the services need to be reformed to better meet the needs of this population.

Because the Las Vegas site has utilized the treatment principles and techniques of Functional Family Therapy, it can be assumed that this treatment model is effective. Still, FFT has some considerable limitations when working with substance-involved families. This is discovered with a comparison between the scores of the two groups. It is possible that therapists using FFT do not adequately serve substance-involved families, who have more dependents and less income. Perhaps FFT can be modified to meet more concrete needs of families involved with substances. Denby (2000) reported that the number of case management hours had a significant difference in the improvement of the

family. The implementation of more case management into the FFT treatment may be the solution. Although FFT has been designed to work effectively with at-risk families and youth, substance use in itself has not been isolated in the effectiveness of the therapy model.

Recommendations

The first recommendation of this author is that family preservation services be continued. Although there is much room for improvement, the services are effective and may be effectively used to lower out-of-home placement rates, decrease federal and state spending, and keeping families in tact. The recommendation continues in that there be further research to prove effectiveness as well as discover areas of needed reform. Further research should utilize a more complete experimental design in order to greatly decrease limitations of the research.

In the original study, Denby (2000) found that the two groups that presented the greatest challenges for treatment were the substance users and the children who were SED (severely emotionally disturbed). It is a recommendation of this author that further research be focused on the outcomes of these two groups within family preservation services. It is also relevant to mention the strong associations with poverty and unemployment of these groups.

As mentioned previously, case management is a very successful component of treatment when working with families of lower socio-economic status. Although more research may uncover other shortcomings, it is recommended for now that therapists receive ample training on the provision of concrete needs, particularly with substance-involved families.

Many social workers are concerned with the degree of poverty that exists in the child welfare population. Poverty has been an issue for many decades and continues to plague the women and children in particular. It is possible that abuse and neglect of many of these poor families can be prevented when poverty is discovered. Single mothers applying for Temporary Assistance for Needy Families (TANF) dollars are eligible for many benefits. While TANF workers share client populations with child welfare workers, juvenile justice, mental health and substance abuse agencies also take a major part in the treatment of the family. All or most of these government programs provide counseling and/or concrete services. If family preservation services are enhanced, the provision of integrated services may be very practical, cost efficient and family-centered.

It is also a strong recommendation that research be continued to further validate the effectiveness of family preservation services. The opinions and ideas expressed above have political and philosophical conditions that take time, money and sacrifice. These conditions will never be reached unless scientific research continues to demonstrate the need for preservation services.

Although many study results may discredit their validity, positive results of program evaluations may be uncovered simultaneously. Families may only be preserved on the condition that services are refined, evaluated and maintained. The alternative is not pleasant to contemplate. Nelson (1992) advocates for the effective management of national resources in the direction of family preservation programs. Nelson also notes that plaguing social problems have affected the nation's call for services. Each discipline contends for more the consumption of more resources to be used in diverse systems. If IFP services are able to incorporate the ability to meet multiple needs of the family, they may become a valuable asset to many public programs.

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APPENDIX

TABLES 1.0 - 11.5 & FIGURE 1.0

Table 1.0

Las Vegas Data

Referral Source	frequency	percent
County CPS	65	82.28%
DCFS - CPS	3	3.80%
DCFS - Child Welfare	11	13.92%
Total	79	100.00%

Referral Type	frequency	percent
FPS	64	81.01%
Reunification	14	17.72%
Crisis	1	1.27%
Total	79	100.00%

Reason	frequency	percent
Abuse	30	37.97%
Neglect	25	31.65%
Abuse and Neglect	23	29.11%
At Risk	1	1.27%
Total	79	100.00%

Minority	frequency	percent
Yes	28	35.44%
No	51	64.56%
Total	79	100.00%

PC Ethnicity	frequency	percent
European American	52	65.82%
African American	21	26.58%
Amer. Indian	1	1.27%
Asian	1	1.27%
Hispanic	4	5.06%
Total	79	100.00%

PC Employed	frequency	percent
Yes	41	59.42%
No	28	40.58%
Total	69	100.00%

PC Gender	frequency	percent
Female	71	89.87%
Male	8	10.13%
Total	79	100.00%

Drugs/Alcohol	frequency	percent
Drugs	21	27.27%
Alcohol	12	15.58%
Both	8	10.39%
N/A	36	46.75%
Total	77	100.00%

Table 1.5

Demographics Continued

Statistics		INCOME	PC AGE	PC EDUCATION	TOTAL HOUSEHOLD MEMBERS
N	Valid	53	73	50	79
	Missing	26	6	29	0
Mean		$ 1,652.49	37.12	11.54	4.18
Std. Deviation		$ 1,016.08	9.29	1.68	1.61

Table 2.0 - Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	ENVIRONMENT PRE	-.18	56	1.54	.21
	ENVIRONMENT POST	.20	56	1.52	.20
Pair 2	SOCIAL PRE	-1.79E-02	56	1.18	.16
	SOCIAL POST	.55	56	1.08	.14
Pair 3	CARETAKER PRE	-1.39	56	.80	.11
	CARETAKER POST	-.21	56	1.11	.15
Pair 4	FAM INTERACTION PRE	-.98	56	1.02	.14
	FAM INTERACTION POST	1.79E-02	56	.86	.12
Pair 5	CHILD WEL FAM PRE	-1.04	56	1.04	.14
	CHILD WEL FAM POST	-.25	56	1.10	.15

Table 2.1 - Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	ENVIRONMENT PRE & ENVIRONMENT POST	56	.848	.000
Pair 2	SOCIAL PRE & SOCIAL POST	56	.721	.000
Pair 3	CARETAKER PRE & CARETAKER POST	56	.231	.087
Pair 4	FAM INTERACTION PRE & FAM INTERACTION POST	56	.269	.045
Pair 5	CHILD WEL FAM PRE & CHILD WEL FAM POST	56	.436	.001

Table 2.2 - Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower	Upper			
Pair 1	ENVIRONMENT PRE - ENVIRONMENT POST	-.38	.84	.11	-.60	-.15	-3.327	55	.002
Pair 2	SOCIAL PRE - SOCIAL POST	-.57	.85	.11	-.80	-.34	-5.032	55	.000
Pair 3	CARETAKER PRE - CARETAKER POST	-1.18	1.21	.16	-1.50	-.86	-7.303	55	.000
Pair 4	FAM INTERACTION PRE - FAM INTERACTION POST	-1.00	1.14	.15	-1.31	-.69	-6.540	55	.000
Pair 5	CHILD WEL FAM PRE - CHILD WEL FAM POST	-.79	1.14	.15	-1.09	-.48	-5.159	55	.000

Figure 1.0

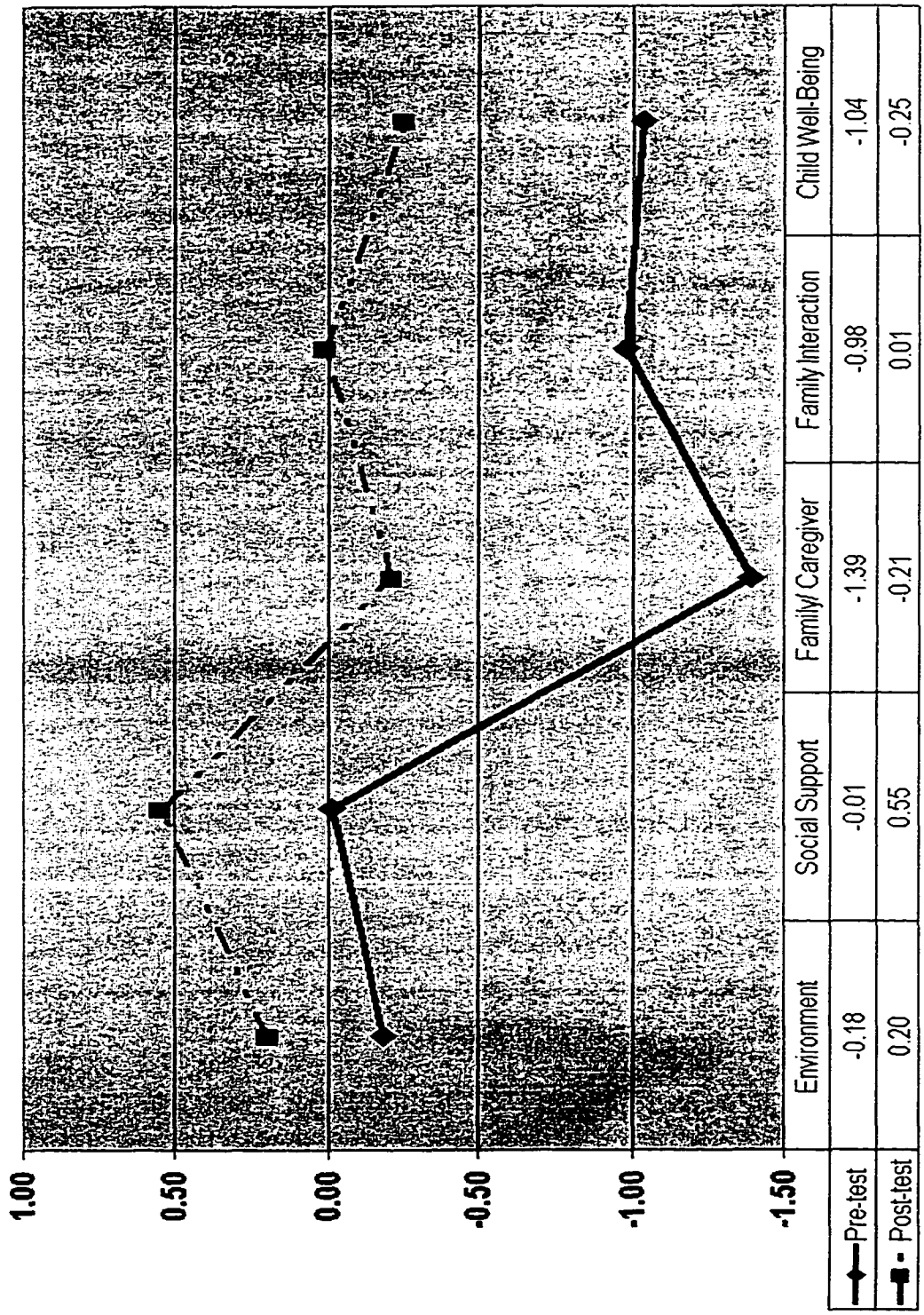

Table 3.0

New drug variable		N	Mean	Std. Dev.	Std. Error Mean
ENVIRONMENT PRE	Group 1	32	-0.50	1.50	0.27
	Group 2	24	0.25	1.51	0.31
SOCIAL PRE	Group 1	32	-0.19	1.12	0.20
	Group 2	24	0.21	1.25	0.26
CARETAKER PRE	Group 1	32	-1.34	0.65	0.12
	Group 2	24	-1.46	0.98	0.20
FAM INTERACTION PRE	Group 1	32	-1.00	0.76	0.13
	Group 2	24	-0.96	1.30	0.27
CHILD WEL FAM PRE	Group 1	32	-0.97	0.97	0.17
	Group 2	24	-1.13	1.15	0.24
ENVIRONMENT POST	Group 1	32	-0.25	1.57	0.28
	Group 2	24	0.79	1.25	0.26
SOCIAL POST	Group 1	32	0.28	1.11	0.20
	Group 2	24	0.92	0.93	0.19
CARETAKER POST	Group 1	32	-0.56	0.91	0.16
	Group 2	24	0.25	1.19	0.24
FAM INTERACTION POST	Group 1	32	-0.06	0.76	0.13
	Group 2	24	0.13	0.99	0.20
CHILD WEL FAM POST	Group 1	32	-0.41	0.95	0.17
	Group 2	24	-0.04	1.27	0.26

Group 1 = Substance-involved famillies, Group 2 = Non-involved families.

Table 4.0

Independent Samples Test
t-test for Equality of Means

Levene's Test for Equality of Variances		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
ENVIRONMENT PRE	Equal variances assumed	0.097	0.757	-1.844	54.000	0.071	-0.750	0.407	-1.565	0.065
	Equal variances not assumed			-1.843	49.552	0.071	-0.750	0.407	-1.568	0.068
SOCIAL PRE	Equal variances assumed	0.262	0.611	-1.245	54.000	0.218	-0.396	0.318	-1.033	0.241
	Equal variances not assumed			-1.225	46.509	0.227	-0.396	0.323	-1.046	0.254
CARETAKER PRE	Equal variances assumed	6.370	0.015	0.526	54.000	0.601	0.115	0.218	-0.322	0.552
	Equal variances not assumed			0.497	37.840	0.622	0.115	0.230	-0.352	0.581
FAM INTERACTION PRE	Equal variances assumed	7.665	0.008	-0.150	54.000	0.881	-0.042	0.277	-0.598	0.514
	Equal variances not assumed			-0.140	34.648	0.890	-0.042	0.298	-0.647	0.563
CHILD WEL FAM PRE	Equal variances assumed	0.734	0.395	0.551	54.000	0.584	0.156	0.284	-0.412	0.725
	Equal variances not assumed			0.537	44.448	0.594	0.156	0.291	-0.430	0.743

Table 4.0 Continued

Independent Samples Test
t-test for Equality of Means

Levene's Test for Equality of Variances		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
ENVIRONMENT POST	Equal variances assumed	2.090	0.154	-2.679	54.000	0.010	-1.042	0.389	-1.021	-0.262
	Equal variances not assumed			-2.767	53.752	0.008	-1.042	0.377	-1.797	-0.287
SOCIAL POST	Equal variances assumed	1.538	0.220	-2.265	54.000	0.028	-0.635	0.281	-1.198	-0.073
	Equal variances not assumed			-2.325	53.340	0.024	-0.635	0.273	-1.184	-0.087
CARETAKER POST	Equal variances assumed	1.753	0.191	-2.894	54.000	0.005	-0.813	0.281	-1.375	-0.250
	Equal variances not assumed			-2.788	41.805	0.008	-0.813	0.291	-1.401	-0.224
FAM INTERACTION POST	Equal variances assumed	1.067	0.306	-0.802	54.000	0.426	-0.188	0.234	-0.656	0.281
	Equal variances not assumed			-0.772	41.690	0.445	-0.188	0.243	-0.678	0.303
CHILD WEL FAM POST	Equal variances assumed	0.299	0.587	-1.234	54.000	0.223	-0.365	0.296	-0.957	0.228
	Equal variances not assumed			-1.184	40.916	0.243	-0.365	0.308	-0.987	0.258

Table 5.0

	Groups	N	Mean	Std. Dev.	Std. Error Mean
INCOME	Group 1	30	1303.17	852.45	155.63
	Group 2	23	2108.13	1048.3	218.58
PC AGE	Group 1	38	35.63	4.9725	0.81
	Group 2	33	38.70	12.539	2.18
TOTAL HOUSEHOLD MEMBERS	Group 1	41	4.56	1.5819	0.25
	Group 2	36	3.81	1.5642	0.26
PC EDUCATION	Group 1	28	11.46	0.9222	0.17
	Group 2	22	11.64	2.3411	0.50

Group 1 = Substance-involved families, Group 2 = Non-involved families.

Table 6.0

Independent Samples Test

Levene's Test for Equality of Variances		t-test for Equality of Means								
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
INCOME	Equal variances assumed	0.218	0.643	-3.083	51.000	0.003	-804.964	261.057	-1329.057	-280.870
	Equal variances not assumed			-3.000	41.809	0.005	-804.964	268.330	-1346.549	-263.378
PC AGE	Equal variances assumed	16.015	0.000	-1.388	69.000	0.170	-3.065	2.209	-7.472	1.341
	Equal variances not assumed			-1.317	40.681	0.195	-3.065	2.327	-7.766	1.635
TOTAL HOUSEHOLD MEMBERS	Equal variances assumed	0.003	0.954	2.102	75.000	0.039	0.755	0.359	0.039	1.471
	Equal variances not assumed			2.103	73.924	0.039	0.755	0.359	0.040	1.471
PC EDUCATION	Equal variances assumed	6.998	0.011	-0.356	48.000	0.723	-0.172	0.483	-1.144	0.799
	Equal variances not assumed			-0.325	26.131	0.747	-0.172	0.529	-1.259	0.914

Table 7.0 - Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
PC ETHNICITY * Substance Users Vs. Non-Users	77	97.5%	2	2.5%	79	100.0%
MINORITY * Substance Users Vs. Non-Users	77	97.5%	2	2.5%	79	100.0%
EMPLOYED * Substance Users Vs. Non-Users	68	86.1%	11	13.9%	79	100.0%
PC GENDER * Substance Users Vs. Non-Users	77	97.5%	2	2.5%	79	100.0%

Table 8.0 - Crosstab

			Substance Users Vs. Non-Users		
			1.00	2.00	Total
PC ETHNICITY	White	Count	32	19	51
		% within PC ETHNICITY	62.7%	37.3%	100.0%
		% within Substance Users Vs. Non-Users	78.0%	52.8%	66.2%
		% of Total	41.6%	24.7%	66.2%
	Black	Count	7	13	20
		% within PC ETHNICITY	35.0%	65.0%	100.0%
		% within Substance Users Vs. Non-Users	17.1%	36.1%	26.0%
		% of Total	9.1%	16.9%	26.0%
	Am Indian	Count	1		1
		% within PC ETHNICITY	100.0%		100.0%
		% within Substance Users Vs. Non-Users	2.4%		1.3%
		% of Total	1.3%		1.3%
	Asian	Count		1	1
		% within PC ETHNICITY		100.0%	100.0%
		% within Substance Users Vs. Non-Users		2.8%	1.3%
		% of Total		1.3%	1.3%
	Hispanic	Count	1	3	4
		% within PC ETHNICITY	25.0%	75.0%	100.0%
		% within Substance Users Vs. Non-Users	2.4%	8.3%	5.2%
		% of Total	1.3%	3.9%	5.2%
Total		Count	41	36	77
		% within PC ETHNICITY	53.2%	46.8%	100.0%
		% within Substance Users Vs. Non-Users	100.0%	100.0%	100.0%
		% of Total	53.2%	46.8%	100.0%

1.00 = Substance-Involved Families, 2.00 = Non-involved Families.

Table 8.5 - Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.822[a]	4	.098
Likelihood Ratio	8.673	4	.070
Linear-by-Linear Association	4.114	1	.043
N of Valid Cases	77		

a. 6 cells (60.0%) have expected count less than 5. The minimum expected count is .47.

Table 9.0 - Crosstab

			Substance Users Vs. Non-Users		
			1.00	2.00	Total
MINORITY	Yes	Count	10	17	27
		% within MINORITY	37.0%	63.0%	100.0%
		% within Substance Users Vs. Non-Users	24.4%	47.2%	35.1%
		% of Total	13.0%	22.1%	35.1%
	No	Count	31	19	50
		% within MINORITY	62.0%	38.0%	100.0%
		% within Substance Users Vs. Non-Users	75.6%	52.8%	64.9%
		% of Total	40.3%	24.7%	64.9%
Total		Count	41	36	77
		% within MINORITY	53.2%	46.8%	100.0%
		% within Substance Users Vs. Non-Users	100.0%	100.0%	100.0%
		% of Total	53.2%	46.8%	100.0%

1.00 = Substance-Involved Families, 2.00 = Non-involved Families.

Table 9.5 - Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.389[b]	1	.036		
Continuity Correction[a]	3.443	1	.064		
Likelihood Ratio	4.419	1	.036		
Fisher's Exact Test				.055	.032
Linear-by-Linear Association	4.332	1	.037		
N of Valid Cases	77				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 12.62.

Table 10.0 - Crosstab

			Substance Users Vs. Non-Users		
			1.00	2.00	Total
EMPLOYED	Yes	Count	16	25	41
		% within EMPLOYED	39.0%	61.0%	100.0%
		% within Substance Users Vs. Non-Users	44.4%	78.1%	60.3%
		% of Total	23.5%	36.8%	60.3%
	No	Count	20	7	27
		% within EMPLOYED	74.1%	25.9%	100.0%
		% within Substance Users Vs. Non-Users	55.6%	21.9%	39.7%
		% of Total	29.4%	10.3%	39.7%
Total		Count	36	32	68
		% within EMPLOYED	52.9%	47.1%	100.0%
		% within Substance Users Vs. Non-Users	100.0%	100.0%	100.0%
		% of Total	52.9%	47.1%	100.0%

1.00 = Substance-Involved Families, 2.00 = Non-involved Families.

Table 10.5 - Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	8.027[b]	1	.005		
Continuity Correction[a]	6.682	1	.010		
Likelihood Ratio	8.283	1	.004		
Fisher's Exact Test				.006	.004
Linear-by-Linear Association	7.909	1	.005		
N of Valid Cases	68				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 12.71.

Table 11.0 - Crosstab

			Substance Users Vs. Non-Users		
			1.00	2.00	Total
PC GENDER	Female	Count	39	31	70
		% within PC GENDER	55.7%	44.3%	100.0%
		% within Substance Users Vs. Non-Users	95.1%	86.1%	90.9%
		% of Total	50.6%	40.3%	90.9%
	Male	Count	2	5	7
		% within PC GENDER	28.6%	71.4%	100.0%
		% within Substance Users Vs. Non-Users	4.9%	13.9%	9.1%
		% of Total	2.6%	6.5%	9.1%
Total		Count	41	36	77
		% within PC GENDER	53.2%	46.8%	100.0%
		% within Substance Users Vs. Non-Users	100.0%	100.0%	100.0%
		% of Total	53.2%	46.8%	100.0%

1.00 = Substance-Involved Families, 2.00 = Non-involved Families.

Table 11.5 - Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.883[b]	1	.170		
Continuity Correction[a]	.951	1	.330		
Likelihood Ratio	1.920	1	.166		
Fisher's Exact Test				.242	.165
Linear-by-Linear Association	1.859	1	.173		
N of Valid Cases	77				

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.27.

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