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Veerman, J.W.; de Kemp, R.A.T.; ten Brink, L.T.; Slot, N.W.; Scholte, E.M.

published in

Child Psychiatry and Human Development
2003

DOI (link to publisher)

[10.1023/A:1021456630670](https://doi.org/10.1023/A:1021456630670)

document version

Publisher's PDF, also known as Version of record

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citation for published version (APA)

Veerman, J. W., de Kemp, R. A. T., ten Brink, L. T., Slot, N. W., & Scholte, E. M. (2003). The Implementation of Families First in the Netherlands: A One Year Follow-up [IF: 0.725]. *Child Psychiatry and Human Development*, 33, 227-244. <https://doi.org/10.1023/A:1021456630670>

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The Implementation of Families First in the Netherlands: A One Year Follow-Up

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ABSTRACT: This study examined whether the American family preservation program Families First was successfully implemented in the Netherlands. Data were collected on 250 children of 177 families who received Families First. At the start of treatment 78% of the children appeared to have serious behavioral problems, 67% of the parents experienced a high level of parental stress, and 63% of the children went through a substantial number of life events during the year preceding the treatment. On average the treatments had the intended duration (about 4 weeks), intensity (about 10 hours a week) and availability (during working hours as well as in evenings and in weekends), and family workers did adhere to important guidelines of treatment delivery. One year after treatment 76% of the children were still living at home. Moreover, children's behavioral problems, parental stress and the number of life events turned out to be significantly decreased. It was concluded that Families First had reached its intended target group, delivered the treatment as intended, and achieved its intended outcomes, suggesting a successful implementation in the Netherlands.

KEY WORDS: family preservation; Families First; out-of-home placement; follow-up.

Within the Dutch child welfare system, there has been a tendency during the last two decades to develop programs intended to prevent

This study was financially supported by the NIZW (Netherlands Institute of Care and Welfare), Utrecht, The Netherlands. The authors wish to thank Hans Jagers for his support and encouragement, and are also grateful to Shelley Leavitt and James K. Whittaker for their helpful comments on an earlier version of this manuscript.

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out-of-home placement by strengthening the family system. Criticism of residential treatment was growing and out-patient services appeared to be unable to offer adequate help for multi-problem families. In 1984, The Ministry of Welfare, Health and Cultural Affairs advocated the shortest possible, and the most focused service, which should be offered as close as possible within the home environment.¹ These developments run parallel with developments that took place somewhat earlier in the United States^{2,3} and other countries in the Western world. Pioneering programs in the Netherlands were the Family Project Approach,⁴ a behavioral program aiming at families with conduct-disordered adolescents at risk of placement, and Video Home Training, which also appeared to be effective in Israel.⁵ At the end of 1993 Families First was introduced in the Netherlands. Families First is an intensive family preservation service based on the Homebuilders Model⁶ adapted to the Dutch situation.⁷ The program is meant for families in crisis and explicitly aims to prevent out-of-home placement of children. It focuses on enhancement of child and family competence and uses treatment techniques based on social learning theory, crisis intervention theory and systems theory.⁸ The present article presents the results of the study into the implementation of this program in the Netherlands.

Research on family preservation programs such as Families First has foremost been conducted in the United States. Most of these studies are summarized in the reviews of Bath and Haapala,⁹ Blythe, Patterson Salley and Jayaratne,² Fraser, Nelson and Rivard,¹⁰ Rossi,⁸ Schuerman, Rzepnicki and Little,¹¹ and Wells and Whittington.¹² The first studies from the seventies and the beginning of the eighties were primarily non-experimental and often showed favorable, thus low, child placement percentages at follow-up. On average, it was shown in these studies that approximately two-thirds to three-quarters of the children (with exceptions exceeding 90%) still lived at home one year after having completed the treatment. Studies from the second half of the eighties and the beginning of the nineties, which were more experimental in nature, showed that many children from the control groups stayed at home as well. These findings suggest that the effects of family preservation programs can be considered mixed at best. Hence, most reviewers warn against overestimating the utility of family preservation programs in child welfare. As Schuerman et al.¹¹ (p. 48) said: "We suggest that is not realistic to expect dramatic results in this area given the number and magnitude of the problems faced by

many child welfare clients and the short-term nature of family preservation services.” Most of the reviewers also agree that placement should not be the one and only outcome measure. For example, Wells and Wittington¹² argue that out-of-home placement is an ambiguous indicator of treatment failure. It may be affected by factors unrelated to the functioning of the child or the family, such as the availability of placement resources in a community. Therefore it is necessary to include other indicators of treatment success or failure in an empirical investigation of a family preservation program, preferably measures of child and family functioning, which are in many instances also a focus of the intervention.

Families First was originally designed and implemented in the United States of America and was evaluated as rather successful in that country.^{2,10} However, no known studies have evaluated the implementation of Families First programs outside the United States. The aim of the present study is to assess the implementation of Families First in the Netherlands. A rigorous study calls for an experimental design in which such subjects are randomly assigned to a treatment and a non-treatment condition. However, in clinical field settings it is usually not possible to apply this design. Withholding individuals a treatment they need is simply not ethical and practitioners are never willing to do so. In this kind of settings non-experimental designs are recommended which nevertheless permit to pose meaningful research questions that might yield useful information.^{13,14} To this end we introduced three features: (1) We used a quasi-experimental design in which the developmental measures of the treated children and families on the pre-test and the post-test are compared with normative samples of the normal Dutch population. In this way any bias due to age and gender is ruled out as these normative samples can be viewed as a control or reference group. (2) We used multiple measures by which we not only assessed the number of prevented out-of-home placements of the children, but also changes in child and family functioning; (3) We used a Theory of Change approach to evaluation¹⁵ to formulate a program theory, which states that *if* favorable outcomes are obtained *and* it could be demonstrated that the right target group is targeted, and also that the treatment is provided as intended, *then* we have evidence to assume that Families First is successfully implemented. This line of reasoning leads to three research questions: Does the program reaches the intended target group? Is the intended treatment provided? Does the Dutch Families First program achieve favorable outcomes?

Method

Program Setting

The Dutch Families First program was implemented at four different sites across the country. At each site a Families First program was affiliated to an institute for child welfare. A treatment always starts with a referral by a placement agency licensed by the Dutch government to place children out-of-home in residential settings. The family members are informed of the planned out-of-home placement of the child and if at least one of the parents expresses the wish to keep the child at home and is prepared to welcome a family worker, referral to Families First takes place. Families First will not be offered if the safety of the child cannot be guaranteed. During a Families First intervention, family workers visit the parents and children at home. Ideally, the intervention lasts about a month with an average intensity of at least seven hours per week. Treatment techniques encompass a mix of therapeutic techniques (e.g., family problem solving, skill training, re-establishment of daily routine, promotion of safety for the children and other family members) and practical help (e.g., provision of money or goods that are needed to soften the crisis).

Subjects

The study aimed to include all 320 children enrolled in the program in 1994. However, one site was excluded from the present study due to problems of data collection. Therefore the study group consisted of 250 children from 177 families of the remaining three sites: 148 boys and 102 girls (mean age 11.0 years, range: 1–18). The large number of single mothers was striking: More than half of the children did not have a caring father figure. The mean age of the mothers was 37 (range: 22–60), the mean age of the fathers was 40 (range: 21–63). About thirty percent of the children were from ethnic minorities, that is to say, at least one of the biological parents was not born in the Netherlands. For about one third of the children judicial measures applied, generally by placement under supervision.

Procedures

Data with regard to actual child placement were gathered on five different occasions: at the start of the treatment, at the end, and at three, six and twelve months after treatment was completed. Data with regard to child and family functioning were gathered at admission and at twelve months after treatment completion. To this end standardized checklists were used (see below). The study aimed to incorporate the research procedures and instruments as much as possible in clinical practice. Therefore, in the process of data collecting family workers played a central role. He or she handed over the checklists to the parents, assisted during the filling out, and checked for missing data. This was done during the regular visits at the beginning and at the end of the program. For collecting follow-up data at 3, 6, and 12 months after finishing the program the family worker scheduled extra visits.

Measures

Child Behavior Problems. Child behavior problems were measured with the Child Behavior Checklist (CBCL). The CBCL is a widely used questionnaire for the assessment of emotional/behavioral problems in children and adolescents, which has to be filled out by the parents.¹⁶ It includes questions about the child's competence in school or elsewhere and a list of 118 specific problems. Factor analysis by Achenbach revealed eight specific, narrow-band factors and two broad-band factors: Internalizing and Externalizing. The CBCL showed good reliability and discriminating validity. The factor structure of the 1991 version of the CBCL turned out to be equally applicable to the Dutch translation and the reliability and discriminating validity was corroborated. A Dutch CBCL-manual including Dutch norms is available.¹⁷ For the present analysis only the CBCL-Total Problem score is used.

Parental Stress. The Nijmegen Child-rearing Situation Questionnaire (NCSQ) was used to measure parental stress.¹⁸ The NCSQ is a Dutch instrument composed of several parts, each of which represents a different aspect of a problematic child-rearing situation. Only Part A, which focuses on subjective parental stress, was used. This part includes 46 items in eight sub-scales referring to different aspects of the parental stress. By filling out the items a parent reveals (1) whether she (or he) accepts the child, (2) the way she copes with the situation at home, (3) the amount of problems she has with the child, (4) her need for change, (5) the amount of strain from interacting with the child, (6) whether or not she has to manage in the parenting situation alone, (7) whether she derives pleasure from interactions with the child, and (8) whether she has a positive relationship with the child. Adequate internal consistency, test-retest reliability and adequate validity of these sub-scales have been demonstrated.¹⁸ Because of the high correlations among the eight subscales (mean $r = .63$), we used a total score to capture parental stress in one measure. A principal component analysis on the eight scale scores justified this approach. All but one scale loaded higher than .77 on one component, which explained 71% of the variance. Considering this component as an overall scale with the eight subscales as the items an alpha coefficient of 0.93 was found. Norms of the Dutch general youth population are available.¹⁸

Child Stress. Child stress was measured with the Questionnaire of Life Events (QLE). The QLE is an adaptation of an earlier Dutch version of the Social Readjustment Rating Questionnaire of Coddington.¹⁹ The QLE contains 37 life events and is considered to be a measure of the stress a child experiences. A parent is asked to indicate whether an event occurred during the life of a child and if so, when the event occurred and whether the child experienced that event as positive (good) or negative (bad). The QLE yields several scores, but only the total number of negatively experienced events in the preceding year was used in the present study. The manual reports moderate to good test-retest reliability and adequate validity. Again, norms of the Dutch general youth population are available.²⁰

Child Placement. Child placement was measured in an interview and coded as: living at home (which includes living independently or living with parents, family, friends, or acquaintances) or not living at home (placed in the care of a foster home or residential setting or homeless).

Treatment Characteristics. To record the treatment as it was actually carried out the Form for recording Family worker Techniques (FFT) was developed. After each contact with the family the family worker filled out: (1) when the contact took place; (2) how long it took place; (3) whether the contact was face to face or by telephone; and (4) which techniques were used during the contact. Regarding this last item the family worker was asked to choose from a list of 37 techniques, grouped in 7 categories (e.g., Active listening and Positive feedback are techniques in the category Basic techniques; Behavioral instruction and Providing a role model are techniques in the category Teaching social skills).

Data Analysis

In order to test whether the intended target group was reached t-tests were used to compare the scores on the CBCL, the NCSQ and the QLE at admission to the Dutch norms of these instruments. Regarding the question whether favorable outcomes were obtained we used paired t-tests to compare the scores of the pre-test to the post-test on the CBCL, the NCSQ and the QLE. Each set of tests involved three specific t-tests. To keep the risk of chance findings within reasonable boundaries we used an overall alpha of .05 per set and applied a Bonferroni-correction with regard to the number of t-tests within each set. In this way alpha was set on .017 (.05/3) for each specific t-test. To answer the question whether the intended treatment was provided descriptive analyses were conducted. Finally, we conducted a logistic regression analysis to look for possible predictors of out-of-home placement. As this analysis was exploratory in nature we used no Bonferroni-correction.

Results

Child and Family Functioning at Admission

Table 1 presents the mean scores of the children and the families in the sample at the moment of admission to the program. All scores are expressed as so-called normative effect sizes (z-scores indicating deviations from the Dutch norms in standard deviation units). To make these scores more tangible the percentage of children whose scores are falling in the clinical range of the measures is calculated, with the 90th percentile of the normal populations corresponding with the cut-off score for clinical populations ($z > 1.28$). The concept clinical range is borrowed from the CBCL manual.¹⁶ Scores in the clinical range

Table 1
Child and Family Functioning at the Admission

	<i>N</i>	<i>z-Score</i> ¹	<i>t-Value</i> ²	<i>%Clinical Cases</i>
Behavioral problems	222	2.18 (1.90)	22.06	78
Parental Stress	223	2.08 (1.36)	22.82	67
Child Stress	191	2.31 (1.78)	17.95	63

¹Means and standard deviations (between brackets); all means are z-standardized in units of a standard deviation from the mean of the Dutch norms of the instrument, high scores indicate problems.

²All z-scores show a statistically significant deviations from Dutch population norms (one sample t-test), $p < .001$.

indicate severe problems that need treatment. Hence, children and parents showing these problems are called clinical cases.

Table 1 shows that the mean scores at admission on all three measures show a statistically significant deviance from the Dutch norms ($p < 0.001$). Transforming the scores into percentages of clinical cases results in 63% to 78% clinical cases. This shows that the behavioral problems of the children and the stress experienced by the parents and the children at the admission to the program is indeed considerable as this is 6.3 to 7.8 times higher than in the general Dutch youth population. Moreover, 44% of the children and families had to cope with clinical problems in all three domains. Another 33% had problems in two of these domains.

Was the Treatment Provided as Intended?

On average, the treatment lasted for 31 days, was very intensive (the family worker visited a family nearly 10 hours a week), and about one third of the services was provided in the evening or during the weekends (suggesting 24-hour availability).

Table 2 shows the mean number of techniques per category carried out per family and the percentage of families for which the category was used at least once. For instance, the mean number of techniques aimed at gathering information and setting goals is eleven. These techniques are used at least once in 100% of the families. Table 2 shows that the basic techniques are most often used. Material help is given least. Although the mean number of techniques for practical/material help per family is somewhat low, it can be observed that practical help is offered to 75% of the families and material help to

Table 2
Utilization of Techniques

<i>Category</i>	<i>Mean Number of Techniques per Family</i>	<i>Percentage of Families Category Was Used at Least Once</i>
A: Basic techniques	48	100
B: Information/setting goals	17	100
C: Social skills	18	96
D: Cognitive skills	5	94
E: Handling of emotions	2	61
F: Practical help	3	75
G: Material help	<1	15

15%. To most of the families therapeutic as well as practical/material help is offered. This means that an important theoretical characteristic of the treatment method, the combination of therapeutic and practical/material help, can be observed in practice. Moreover, it was shown that family workers did adhere to important guidelines of treatment delivery, e.g., formulating targets and work points within three days and sequencing of techniques.²¹

Outcomes

Living at Home or Not. Table 3 shows the percentages of children who were still living at home at the various follow-up moments. The table shows that the number of children living at home gradually decreases, varying from 93% at treatment completion to 76% at the last follow-up (one year after treatment completion).

Changes in Child and Parental Functioning. Changes in child behavior problems and parental functioning are shown in Table 4. All scores are again expressed as normative effect sizes (z-scores indicat-

Table 3
Percentage of Children Living at Home After Treatment

At discharge (N = 250)	93
After 3 months (N = 244)	86
After 6 months (N = 244)	84
After 12 months (N = 246)	76

Table 4
Child and Family Functioning at Admission and Follow-Up

Variable	N	Admission			Follow-Up			t-Value ³	ES ⁴
		Mean ¹	(SD)	% CC ²	Mean	(SD)	% CC		
Behavior problems	146	2.97	(1.84)	83	1.83	(1.96)	53	7.75**	0.60
Parental stress	143	2.31	(1.32)	74	1.59	(1.24)	52	6.79**	0.56
Child stress	129	3.21	(2.73)	67	2.45	(2.67)	54	2.25*	0.28

¹All means are z-standardized in units of a standard deviation from the mean of the Dutch norms of the instrument, high scores indicate problems.

²% CC = percentage of clinical cases, i.e., the number of cases scoring above the 90th percentile of the Dutch normal population.

³The t-statistic is calculated from paired samples t-test with degrees of freedom N - 1; *p = 0.013; **p < 0.001 (one-tailed).

⁴ES = Effect size: the absolute value of the differences between means divided by their pooled SD's.

ing deviations from the Dutch norms in standard deviation units). The percentages of clinical cases are also presented (i.e., the percentages of cases scoring above the 90th percentile of the Dutch norm population).

Compared to the situation at admission, parents observe less behavioral problems in their children at follow-up. The percentage of children in the clinical range drops from 82% to 53%. The effect size is 0.60. According to Cohen,²² this is a medium effect size. Parents also experience a decrease of parental stress (percentage of clinical cases dropping from 74% to 52%, effect size: 0.56, indicating also a medium effect). In addition, parents report a smaller number of life events during the follow-up year compared to the year before treatment, suggesting less child stress (percentage of clinical cases dropping from 67% to 54%, effect size: 0.28, indicating a small effect).

It must, however, be noted that a considerable response loss existed at the follow-up. Forty-one percent of the cases were not able to participate in the follow-up measurements. The impact of this response loss was investigated by comparing the response and the nonresponse groups as for their demographic characteristics and the initial problem measures. No statistical significant differences were found regarding the mean age of the mothers and the fathers, or the gender and the ethnical background of the children. However, statistical significant differences existed with regard to the mean age of the chil-

dren at the admission, the family type, the initial levels of the problem behavior of the children and the parental stress index. These findings suggest that the non-response group included slightly younger and less problematic children from one-parent families experiencing less parental stress, while the response group comprised slightly older and more difficult children from intact families with parents experiencing more family stress. These findings imply that the outcome findings presented before must be appraised as conservative as they are derived from the most difficult cases that have participated in the Families First program.

Status of Child and Parental Functioning at Follow-up. At follow-up the scores on all variables in Table 1 still show a considerable deviance from Dutch norms (1.59 to 2.45 SD; indicating statistically significant deviations from Dutch norms at $p < 0.001$). This means that, notwithstanding the positive changes, these parents still report substantial problems compared to children or families who have not been referred for care. At follow-up 53% of the children showed behavioral problems, 52% of the parents experienced stress in the upbringing of their child, and 54% of the children experienced stressful life events. Since 10% of the general population is expected to have problems, the number of children or parents with problems is about five times higher than in a normative sample of well functioning children and parents.

Prediction of Child Placement.

The prediction of child placement, dichotomized as *living at home* or *not living at home*, was tested by means of logistic regression. First, six demographic variables were selected as predictors: gender of the child, child age at admission, the age of the mother, the age of the father, ethnic background of the child, and family type. In addition, nine clinical predictors were used: admission status and follow-up status of behavioral problems, parental stress and child stress (six predictors) and changes from admission to follow-up in these domains (three predictors). In this analysis the predictive value is expressed in terms of the odds ratio. The odds are the probability that an event (in this case out-of-home placement) will occur, divided by the probability that it will not occur. For dichotomous predictors (e.g., gender), the odds ratio is the ratio of the odds associated with one category of the

predictor (e.g., the probability of an out-of-home placement for boys) to the odds associated with the other category (e.g., the probability of an out-of-home placement for girls). For interval scaled predictors the odds ratio denotes the increase in odds (of out-of-home placement) for a unit increase in the predictor variable. Table 5 presents the results.

Of the demographic predictors only gender of the child at admission was statistically significant. Being a girl increases the odds of placement with almost a factor two. With regard to the clinical predictors for child placement parental stress at follow-up, child stress at admission and a change in child stress from admission to follow-up turned out to be statistically significant. More parental stress at follow-up

Table 5
Predictors of Out-of-Home Placement at Follow-Up

<i>Predictor</i>	<i>N</i>	<i>Odds Ratio</i>	<i>[95% CI]⁴</i>
<i>Demographic</i>			
Child gender ¹	246	1.81	[1.01–3.26]*
Child age ²	246	1.11	[0.71–1.73]
Child ethnicity ¹	232	2.03	[0.95–4.32]
Mother age ²	239	1.00	[0.96–1.05]
Father age ²	116	1.00	[0.95–1.06]
Stepfamily ³	246	1.54	[0.65–2.71]
One parent family ³	246	0.80	[0.42–1.52]
<i>Behavioral problems²</i>			
At admission	218	1.02	[0.87–1.20]
At follow-up	147	1.20	[0.98–1.48]
Change	146	1.10	[0.86–1.40]
<i>Parental stress²</i>			
At admission	219	1.02	[0.82–1.29]
At follow-up	144	1.52	[1.08–2.15]*
Change	143	1.21	[0.86–1.70]
<i>Child stress²</i>			
At admission	187	0.83	[0.72–0.96]*
At follow-up	148	1.17	[0.99–1.30]
Change	129	1.23	[0.73–0.94]**

¹Child gender, Child ethnicity are categorical predictors with two categories, with Boy and Dutch as referent categories.

²These predictors are interval scaled.

³Step family and One parent family are two categories of the variable Family type, a predictor including also a third category: Natural (two parent) family. This last category is taken as the referent category for calculating the odds ratio.

⁴CI = confidence intervals, *p < 0.05, **p < 0.01.

and less positive change in child stress increased the odds of out-of-home placement. Remarkably, less child stress in the year preceding Families First increased the odds of placement.

To explore this latter outcome a little further we took a closer look at child stress at admission. Child stress was defined as the number of negatively experienced events during the year preceding Families First. The number of events for children for whom also follow-up placement data were available ($N = 187$) ranged from 0 to 8, with a mean of 2.30 (which was far above the 0.21 to 0.36 range of the means in the general population for different age groups²⁰). We divided the number of events in three categories: *small* (0 or 1 event; $N = 69$), *medium* (2 or 3 events; $N = 40$) or *large* (4 or more events; $N = 78$). Subsequently, we counted the number of children in these categories who were placed out of home at the moment of follow-up. In the group experiencing a small number of life events this was 33%. In the group experiencing a medium number this was 21.8% and in the group experiencing a large number of life events 17.5% was placed out of home. Thus, the risk of an out-of-home placement for children who experience a small number of events is almost twice as high compared to the risk of those who experienced a large number of events (risk ratio $33.3/17.5 = 1.89$).

Discussion

This study was one of the first studies showing that Families First based on the American Home Builders model can also be implemented outside the United States. Summarizing the results, it was shown firstly that the intended target group was largely reached. In the Netherlands the high levels of child behavior problems, family stress and child stress that were found in the present study are considered indicative for an out-of-home placement of the child in a residential treatment center.^{23,24} The problems of the children in our sample were therefore serious enough to entail the risk of an out-of-home placement.²⁵ Given that these children were admitted to Families First, these findings suggest that the program to a large extent do have reached its target population of children "at risk" for out-of-home placement. Secondly, the results of our study suggest that the treatment of families First meets the characteristics that were intended (both therapeutic and practical/material help, short and intensive, available). In addition, family workers appear to follow the guidelines

for the sequence of techniques during treatment. Thirdly, favorable outcomes could be assessed as well. It appeared that one year after treatment, 76% of the children still live at home. Moreover, positive changes in behavior problems, parental stress, and child stress can be observed after one year. However, at follow-up, the prevalence of problems in all three domains is still about five times higher as might be expected in the normal population. Although apparently the problems are not completely solved, in most families the situation has improved to the extent that the child is safe in the home and is not in imminent danger of being placed out of home. Living at home at follow-up was predicted by the gender of the child (unfavorable prediction for girls), parental stress at follow-up (the more stress, the greater the chances of placement), child stress at admission (a larger number of life events in the year preceding admission decreases the chances of placement), and positive change in child stress (more positive change were associated with fewer chances of placement).

Reviewing the results, it appears that Families First was successfully implemented in the Netherlands. Moreover, the results are very similar to those obtained in other family preservation programs (see several reviews).^{2,8,9,10,11,12} Given the initial levels of behavioral problems and child and family stress, it was expected that most of the children in the program would inevitably be placed out-of-home.²⁴ The figure of 76% of the children still living at home one year after having finished the Families First program is therefore quite favorable. This figure thus suggests that the main goal of the program (preventing out-of-home placement of the children) was largely met. The level of behavioral problems at follow-up (mean level: 1.8 SD above the Dutch general population norm) is comparable to findings in other Dutch studies. Ten Brink²⁶ reported a mean of 1.6 SD above the norm for children treated for about two years in a Dutch child psychiatric clinic. In a longitudinal study of Dutch children in day treatment Kloosterman and Veerman²⁷ reported one year and two years after admission a mean of 1.7 SD and 1.4 SD respectively above the norm. The behavioral problems of the children in the Wells and Whittington¹² follow-up study after intensive family preservation looked somewhat less deviant (1.2 SD above the mean of the nonclinical group), but were still considerable.

The finding that a high number of negatively experienced life events in the year preceding Families First increase the chances of living at home at follow-up is remarkable. Further analysis showed that children in the low, medium or high stress group did not differ statisti-

cally significant in their level of behavioral problems or in the level of parental stress. Perhaps here we have come across a group of children who not only display behavior problems and (as a consequence) whose parents experience a lot of child rearing stress, but who, in addition, experience quite a number of negative life events in the year preceding admission. This child stress might be interpreted as an indicator of the crisis, which was a reason to refer these children to Families First. Maybe this is the type of crisis that could be dealt with successfully within the month of treatment. Consequently, when child stress decreases the chances of staying at home increases. In other words: when the sting is taken out of the crisis the need for placement diminishes.

On the practical level it can be concluded that in the case of impending out-of-home placement of children Families First is certainly worth considering. Keeping in mind the finding that one year after treatment child and family problems are still considerable, the most significant recommendation for practice pertains to supply follow-up treatment. By its very nature (short term, crisis oriented) Families First should be conceptualized as an early step in a continuum of care, which can take on several further directions, depending on the needs of the child and the family. On the basis of these needs it might be possible to conceive a number of predetermined paths of care, which can be realized in negotiations among care providers, insurance companies, and client organizations. For some families, a few short contacts with care workers will probably suffice after finishing Families First, suggesting a very efficient (and cheap) after-care treatment path. Kazdin²⁸ suggests such a chronic care model with serious behavioral problems and with a major dysfunctional parenting situation. Other families, however, will need more intensive after care services.

The present study has strengths and limitations. Strengths include (1) the use of a longitudinal design; (2) the collection of data on child placement three, six, and twelve months after discharge; (3) the use of standardized measurements of behavior problems and family functioning, both at admission and at follow-up one year after discharge; (4) a fairly large sample size ($N = 250$ at the pretest) from a clinical setting; (5) the multi-site character of the study.

Limitations are (1) the omission of a randomized experimental-control group design; (2) the reliance on self-report data of parents; (3) having family worker administer the assessment; (4) a considerable response loss at the follow-up.

The inclusion of a control group in the research design is needed to

demonstrate robustly the effectiveness of Families First in the Netherlands. Such a design is not easy to accomplish in real world settings. However, according to the Theory of Change approach to evaluation one might argue that if the right group is targeted, *and* the treatment is implemented as intended, *and* favorable outcomes occur *then* we have some evidence of a successfully implemented program.¹⁵ This is exactly what seemed to happen in the Dutch Families First program. Of course, this line of reasoning does not provide us with the ultimate proof of effectiveness, nor does it prove that Families First is equal to or better than other types of interventions programs for families in crisis. However, it certainly yields a suggestion of causality that should be followed by a more experimentally controlled study.

The reliance on self-report data had to do with an important starting point of the study, which was to make as much use of standardized instruments with population norms as possible. Regarding children's behavior problems and parental and family functioning, most of these instruments are meant to be used with parents as informants. We did include some instruments on parental and family functioning that were filled out by professionals. The results on changes from admission to follow-up were in the same direction as those presented here. However, in the absence of population norms the follow-up status is more difficult to interpret.

Having the family worker administer the assessments might have introduced an experimenter bias. Perhaps parents are inclined to demonstrate that at admission problems are severe enough to warrant treatment, while at follow-up they seek to please the family worker by indicating know that problems have decreased. In psychotherapy research this is known as the "hello-goodbye effect". This effect could not completely be excluded. This was inherent in another starting point of the study, namely to incorporate the research procedures and instruments as much as possible in practice. In this way research may contribute to strengthening the program. The importance of this starting point leads us to accept the risk of an experimenter bias.

The loss of cases is always a problem in a longitudinal study and in particular in clinical settings. In our study this was partially caused by the fact that all data, including follow-up data, were gathered by family workers themselves. The response loss in this study turned out to be related to the least difficult cases, suggesting that the presented outcomes reflect a conservative estimate. It may be clear that further research should take measures to increase the response.

Summary

This study examined the implementation of Families First in the Netherlands. Families First is an intensive family preservation program based on the Homebuilders model that was originally developed in the United States. The goal of this program is to prevent out-of-home placement of children of families in crisis by enhancing parents' and children's competencies. Within a Theory of Change framework it was assumed that the program was successfully implemented if it could be shown that (1) the intended target group was reached, (2) the treatment was delivered as intended, and (3) the desired outcomes were achieved. To answer these questions data were collected of 250 children of 177 families who received Families First. At the start of the program 78% of the children appeared to have very serious behavioral problems, 67% of the parents experienced a high level of parental stress, and 63% of the children went through a substantial number of life events during the year preceding the treatment. These figures were considered indicative for an out-of-home placement, suggesting that the intended target group was reached. With regard to the delivery of the treatment it was shown that on average the program had the intended duration (about 4 weeks), intensity (about 10 hours a week) and availability (during working hours as well as in evenings and on weekends). Also, family workers did adhere to important guidelines of treatment delivery. One year after treatment 76% of the children were still living at home. Moreover, behavioral problems had significantly decreased (effect size = 0.60), parental stress was significantly reduced (effect size = 0.56), and children experienced significantly less life events in the year after treatment than in the year preceding the program (effect size = 0.28). Exploring factors that might predict out-of-home placement significant relations were found with regard to gender of the child (unfavorable prediction for girls), parental stress at follow-up (the more stress, the greater the chances of placement), child stress at admission (a larger number of life events in the year preceding admission decreases the chances of placement), and positive change in child stress (more positive change leads to a smaller chance of placement). The results of this study are very similar to those obtained in other family preservation programs. It was concluded that the intended target group was reached, that the treatment was delivered as intended, and that the intended outcomes were achieved. These results strongly suggest that Families First was successfully implemented in the Netherlands.

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