Family crisis intervention
Al, C.M.W.

Citation for published version (APA):

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5 This chapter has been submitted for publication as: Al, Stams, Asscher, & Van der Laan (2011). *A program evaluation of the Family Crisis Intervention program: Relating program characteristics to change.*
Abstract

This study evaluates the Family Crisis Intervention Program (FCIP), focusing on crisis, child safety, family functioning and child behavior problems. Questionnaires were completed by 183 families in crisis and their FCIP worker. After FCIP, the crisis had decreased and child safety had increased. Although problematic family functioning persisted after intervention, improvements were found in parent-child interaction, parenting stress, parental competence and child behavior problems. Crisis change, safety change and improved family functioning were associated with program characteristics, especially the therapeutic relationship, analysis of the crisis situation, duration of the intervention and the solution-focused approach. Clients confronted with temporary out-of-home care for a child during FCIP evaluated this mostly as functional and desirable. The discussion addresses implications of this study with regard to outcome measures in the evaluation of family crisis intervention and the importance of particular program characteristics and the function of respite care in clinical practice.
**Introduction**

When a family crisis occurs there is a need for intervention assuring safety of children, ending the crisis and improving family functioning, which is necessary for family preservation. The meta-analysis of Dagenais, Bégin, Bouchard and Fortin (2004) and narrative reviews of the impact of family preservation programs on out-of-home placement, family functioning and child behavior problems have shown both positive effects and absence of effects (Barlow, Simkiss, & Stewart-Brown, 2006; Henegan, Horowitz, & Leventhal, 1996; Lindsey, Martin, & Doh, 2002; Tully, 2008). Miller (2006) argued, based on a meta-analysis of Intensive Family Preservation Services (IFPS) programs in Washington State, that positive intervention effects depend on adherence to the program characteristics that are thought to promote positive outcomes. Program characteristics are therefore relevant to consider in evaluation research. The present study focuses on the association between program characteristics and changes in crisis, child safety, family functioning and child behavior problems.

Most interventions targeting families in crisis are based on the Homebuilders model (Kinney, Madsen, Fleming, & Haapala, 1977; Institute for Family Development, 1974), which refers to brief, intensive in-home intervention that aims to prevent out-of-home placement of children. Most family preservation programs are largely grounded in crisis theory, in which a crisis is defined as a sudden and time-limited disturbance of balance between resources and demands, while coping abilities as well as the support from the social environment are insufficient (e.g. Caplan, 1964; Golan, 1987; Istha & De Smit, 1977; Rapoport, 1962). During a crisis, families are expected to be more open to change, and more inclined to accept intervention (Schuerman, Rzepnicki, & Littell, 1994; Staudt & Drake, 2002). In the early 90s, the aims of crisis interventions have changed from *restoring base level family functioning* towards promoting *improved family functioning* (Kinney, Haapala, & Booth, 1991; Staudt & Drake, 2002).

Various specific program characteristics can be identified in family preservation programs. An immediate start and brief (4-6 weeks), intensive, in-home intervention are considered to be essential aspects of the intervention (e.g. Callahan, 1994; Tully, 2008). Moreover, a goal-directed, flexible and multimodal approach is considered appropriate for clients with severe and complex problems (De Bruyn, Berger, & Ten Berge, 2005; Kinney, Haapala, Booth, & Leavitt, 1990; Tabibian, 2006). The trained and supervised FCIP
workers, with high availability, serve small caseloads and can provide concrete services, advice, and referral to aftercare (e.g. Tully, 2008). Additionally, the therapeutic alliance has been identified as a therapeutic common factor that facilitates positive intervention outcomes (Karver, Handelsman, Fields, & Bickman, 2006; Martin, Garske, & Davis, 2000), also with regard to family crisis interventions (Dore & Alexander, 1996; Littell, 2001; Kinney, Haapala, & Booth, 1991; Mahoney, 1993).

The focus of the present evaluation study is on the Family Crisis Intervention Program (FCIP; Eijgenraam, Van Vugt, & Berger, 2007; Vogelvang, Melissen, & Vermeiden, 2005), which is derived from the Homebuilders model. However, FCIP does not include imminent risk of out-of-home placement as an intake criterion. Instead, the occurrence of a crisis and concerns about the safety of a child are the primary reasons for referral, which broadens the target group of the original Homebuilders model. Notably, there are crisis situations without an immediate risk of out-of-home placement or, on the contrary, where a child is already in out-of-home care (e.g. respite care). Therefore, interventions that are available to all families in crisis and not just to families experiencing risk of out-of-home placement have been developed (Berger & Hordijk, 2007), including FCIP.

FCIP contains the same program characteristics as other family preservation programs that were based on the Homebuilders model. Analysis of the crisis situation by the FCIP worker is an additional program characteristic, especially regarding child safety. Although in line with the family preservation model assuring safety of the child within the family is preferable according to the intervention targets of FCIP, if necessary, (temporary) out-of-home care for children during the intervention and even as a part of the intervention is possible (Eijgenraam et al., 2007; Vogelvang et al., 2005).

Although the role of crisis theory in family preservation programs is substantial and these programs target families in crisis, the degree to which clients experience a crisis and crisis change have largely been neglected in evaluation research (Al, Stams, Van der Laan, & Asscher, 2011). The present study therefore includes crisis change as an outcome measure of family crisis intervention. Whereas concerns about children’s safety and/or their long term development are reasons to refer families for family preservation programs, improvement of child safety has never been evaluated in family preservation research explicitly. Instead, avoiding out-of-home placement has been the focal point of most previous evaluation studies (Scannapieco, 1993; Tully, 2008), despite critical remarks on
using placement prevention as the sole success criterion (Cash & Berry, 2003; Rossi, 1992; Thieman & Dail, 1992; Tully, 2008; Wells & Tracy, 1996). A recent meta-analysis by Al et al. (2011) showed that the effect of intensive family preservation programs on prevention of placement were generally absent or even negative, while the effect on improvement of family functioning was found to be promising. As severe distortion of family functioning is associated with family crises (e.g. Caplan, 1964; Istha & De Smit, 1977; Myer & Conté, 2006) and promotion of better family functioning seems necessary for placement prevention, measures of family functioning are considered more and more important to address. Problems often associated with crisis are interpersonal conflicts, physical or verbal violence, child behavior problems and severe parenting stress (e.g. Günter, Kleefeld, Werning, & Klosinskit, 1999; Walsch, 2002).

The outcome measures selected for the present study are crisis change and safety change, consistent with the target group and aims of FCIP. In line with previous evaluation studies, four additional variables are examined that are expected to be related to crisis and child safety: child behavior problems and family functioning variables, specifically parenting stress, parental competence and the quality of parent-child interaction in terms of conflict management and acceptance of the child. Parenting stress influences parental behavior (e.g. Abidin, 1992) and feelings of parental competence are related to sensitivity towards children, positive parental strategies and problem solving (Dumka, Storitzer, Jackson, & Roosa, 1996; Seng & Prinz, 2008). In abusive families there are more negative and less positive interactions between parents and children (Seng & Prinz, 2008) and family conflicts were found to be essential in crisis situations with adolescents having psychiatric problems (e.g. Günter, Kleefeld, Werning, & Klosinski, 1999). Ineffective conflict management and a lack of feelings of acceptance from parents can cause low self-esteem (Putnick, Bornstein, Hendricks, Painter, & Suwalsky, 2008), child behavioral problems, emotional instability, drug abuse and delinquency (Khaleque & Rohner, 2002).

FCIP focuses on the whole family in line with the system approach, which assumes that the behavior of individual family members can only be understood from the perspective of family interactions that influence system balance (e.g. Watzlawick, Beavin, & Jackson, 1967). In addition, the intervention uses a network approach; taking into account that the family is an open system, which is influenced by, for example, the school and the neighborhood (Bronfenbrenner, 1979). Other approaches adopted by FCIP are the (empowering) competence approach and the solution focused approach. The competence
approach is aimed at empowerment and fostering skills and strengths of clients (e.g. Graves & Shelton, 2007; Masterpasqua, 1989). The solution-focused approach, in line with the latter, considers the client as the major source of solutions and is aimed at setting goals that are self-concordant and maximize the use of the client’s competencies (De Shazer & Berg, 1997; Gingerich & Eisengart, 2000; Gingerich, Kim, Stams, & Macdonald, 2011).

Besides establishing whether or not a program works, it is also important to establish what determines the effectiveness of a program (e.g. Kazdin, 2004; Kazdin, Bass, Ayers, & Rodgers, 1990; Peterson, Luze, Eshbaugh, Jeon, & Kantz, 2007). With regard to family preservation programs, some previous studies have addressed program characteristics in relation to intervention outcomes (e.g. Bagdasaryan, 2005; Berry, Cash, & Brook; 2000; Littel, 1997; Littell & Schuerman, 2002; Ryan & Schuerman, 2004). These studies, however, generally have addressed program characteristics related to the structure of the intervention, such as duration, rather than therapeutic components of the intervention, such as a solution-focused approach. Furthermore, these studies primarily included file data on out-of-home placement or substantiated reports of maltreatment as outcome measures, lacking information on family crisis, child safety and family functioning provided by the families and crisis intervention workers involved. In the present study considerable attention will therefore be directed at how therapeutic program characteristics of FCIP can be associated with changes in crisis, child safety and family functioning reported by clients and FCIP workers. Addressing this relation is important to gain insight in how family crisis intervention facilitates change.

We will examine whether crisis, child safety, family functioning and child behavior problems have changed after intervention (1) and whether changes in these outcome variables can be related to program characteristics of FCIP (2). Apart from therapeutic alliance and duration of the intervention, which have been addressed in previous research, the quick start of the intervention and the analysis of the family situation are addressed as program characteristics that might be related to the changes. Moreover, the following therapeutic program characteristics are examined in relation to the changes: the system approach, the network approach, the competence approach, the solution-focused approach and the practical approach (concrete services).

FCIP contains the possibility of temporal out-of-home care during the intervention. As respite care has been shown to be desirable for families in crisis with children with special needs (Boothroyd, Kupping, Evans, Armstrong, & Radigan, 1998;
Cole, Wehrmann, Dewar, & Swinford, 2005; Cowen, 1998; Dougherty, Yu, Edgar, Day, & Wade, 2002), it is interesting to examine how clients of FCIP experience such out-of-home care. We therefore explore how out-of-home care of children during FCIP is perceived from clients’ perspectives (3).

Method

Participants
This study included 183 families of which at least one family member participated. All families were referred for and participated in FCIP. It was confirmed that families who received FCIP were in crisis at the start of the intervention according to the child, the parents or the FCIPI worker (Al, Stams, & Van der Laan, 2009). Because each family member could participate individually in the study, single participation of either a parent or child and different combinations per family were possible. Participating mothers (n=114) and fathers (n = 59) had an average age of 39 years (SD = 9.08) and 43 years (SD = 8.87), respectively. A total of 88% of the mothers and 81.3% of the fathers were the biological parent. Furthermore, stepparents, foster parents and other caregivers participated. A total of 80 children participated, of which 55 girls and 25 boys. The average age of the children (0-18) in the participating families was 11.54 years (SD = 5.17). The majority had a Dutch ethnic background, 52.1%. Most ethnic minorities had a Surinamese (14.4%), Antillean (7%), Moroccan (5.6%) or Turkish (5.6%) background.

The non-response rate was 58%. Reasons for non-participation in the study were registered and analyzed, and file information was used to detect possible differences between participating and non-participating families. Primary reasons for not participating were lack of time, too much stress, or resistance to other involvement. The child was more often subject to a supervision order in non-participating families than in participating families at the start of the intervention ($\chi^2 = 12.93, p < .05$), which was only a weak relation (Cramér's $V = .14, p < .05$). No differences were found for sex, age, cultural background, education, place of living and recommended aftercare.

Thirty-five FCIP workers participated in the study, of which 63% were female and 37% were male. They had an average age of 37 years (SD = 9.76). Their work experience was on average 3 years (SD = 2.00) within FCIP and 7 years (SD = 6.37) within the youth care organization.
**Procedure**

**FCIP.** Families with or without a supervision order for a child can be referred to FCIP (in this sample 29.5% had a supervision order), either on their own initiative or after interference of others, such as child protective services. Within 48 hours after referral, the start of the intervention is planned. In this first session, cooperatively with the family specific short-term intervention goals are formulated and a first (safety) assessment of the situation is made. In the remaining four weeks, the family situation and specifically child safety are assessed, mostly during home visits. Besides the two standard instruments in FCIP, the ‘safety checklist’ (based on Ten Berge & Bakker, 2005) and the ‘taxation scheme’ (based on the framework for the assessment of children in need and their families; Department of Health, Department of Education and Employment, Home Office, UK, 2000), other tools and techniques are available, such as a network analysis form, a daily routine list and circular questioning (a process of creating distinctions and connections, and promoting clients’ understanding of their context; e.g. Brown, 1997).

FCIP can organize additional care, such as financial support or individual training or therapy, if necessary. The social and professional support systems, such as the extended family, friends and possible professionals who are involved with the family, are mapped and activated. FCIP strengthens the competences that exist in the family and invests in the development of new competencies, for example parenting- or communication skills. The flexible approach, tailored to the family needs, allows planning visits and the use of techniques in accordance with clients’ preferences. Two or three visits a week are common, especially in the first phase of the intervention. In the third week of the intervention, based on clients’ needs and the collected information, an analysis is made and an advice is written by the FCIP worker, if necessary including a suggestion for aftercare. FCIP ends with a final session in which the goals are evaluated. Program fidelity was assessed and found to be considerably high (Al et al., 2009).

**Evaluation study.** Between November 2007 and December 2008, clients referred for FCIP were asked to participate by their FCIP worker during the first home visit. Participation of clients was voluntarily and clients received written and verbal information. The target child (from the age of 8) and its parents or caregivers could individually choose to participate and if so, one of the researchers approached them the next day by telephone to plan a home visit for the baseline test soon after the start of the intervention. After the intervention, the same researcher approached the client(s) to plan the post test visit. Clients...
received a small present at the first visit to show appreciation for their participation. All participants signed an informed consent form. After introduction and explanation by the researcher, clients filled out the questionnaire (individually, if possible in separate rooms).

Measures
Separate questionnaires were used for parents, children and FCIP workers. One questionnaire per family was completed by FCIP workers after the intervention and there were two self-report measurement waves for clients: baseline and post test. Standardized parent- and child self-report questionnaires, including clinical cut-off scores, were used to rate aspects of family functioning (i.e. parent-child interaction, parenting stress, and parental competence) and child behavior problems. If available, cut-off scores for clinical samples were used to establish the clinical significance of the therapeutic changes. Both clients and FCIP workers reported on extent of crisis and child safety, responding to questions that had been devised especially for the purpose of this study. Parents and children responded to questions about out-of-home care during FCIP. Finally, both FCIP workers and staff members reported on program characteristics of FCIP.

Parent-child interaction. The Parent-Child Interaction Questionnaire-Revised (OKIV-R; Lange, 2001) was used to measure the quality of the parent-child interaction both at baseline and post test. The questionnaire contains two dimensions, conflict management and acceptance. Parents (in 21 items) and children (in 25 items) reported on their dyadic parent-child relationship, where children filled out the questionnaire for their mother and father separately. Respondents expressed to what extent each item applied to their dyadic relationship on a scale of 1-5; higher scores reflect a more positive parent-child interaction. Internal consistency reliabilities of the subscales varied from $\alpha = .65$ up to $\alpha = .97$. Clinical range scores are available for both clinical and non-clinical samples, with different values for mothers, fathers and children.

Parenting stress. The shortened version of the Nijmegen Parenting Stress Index, (NOSIK; De Brock, Vermulst, Gerris, & Abidin, 1992), was used to measure parenting stress both at baseline and post test. The scale consists of 25 items that were scored on a scale of 1-6; higher sum scores reflect a higher level of parenting stress. Internal consistency reliabilities were $\alpha = .96$ at baseline and $\alpha = .97$ at post test. Clinical range scores are available for both clinical and non-clinical samples, with different values for mothers and fathers.
**Parental competence.** The Parenting Self-Agency Measure (PSAM; Dumka, Stoerzinger, Jackson, & Roosa, 1996), assessing parental perceptions of effectiveness in the parental role, was used to measure feelings of parental competence both at baseline and post test. Using a 7-point scale (1 = I don’t agree, 7 = I agree), parents indicated to what extent they agreed on 5 statements on their parental competence. Internal consistency reliabilities were \( \alpha = .77 \) at baseline and \( \alpha = .79 \) at post test for mothers and \( \alpha = .84 \) and \( \alpha = .82 \), respectively, for fathers. No clinical range scores were available.

**Child behavior problems.** Parents and children filled out the Dutch version of the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997; Van Widenfelt, Goedhart, Treffers & Goodman, 2000) to indicate behavior problems of children both at baseline and post test. In the questionnaire (25 items) clients indicated whether the behavior was problematic using the scores: 0 = not true, 1 = a little true or 2 = absolutely true. For calculation of the total problem score, the subscale of pro-social behavior needs to be left out. Internal consistency reliabilities were \( \alpha = .74 \) at baseline and \( \alpha = .78 \) at post test for children and \( \alpha = .87 \) at both measurements for parents. Clinical range scores are available for both clinical and non-clinical samples, with different values for parents and children.

**Crisis.** Parents and children indicated the extent of crisis by answering the following question: “There is a crisis in our family” at the baseline and “There is a crisis in our family now” at post test, where at post test the word now was added to emphasize that the question was directed at the current situation. Possible answers were 1 (not at all), 2 (not really), 3 (a little), 4 (I think so) or 5 (very much). FCIP workers evaluated the extent of crisis in the family by answering: “To what extent was a crisis the case at the start?” and “To what extent was the crisis ended at the end of FCIP?” Both questions were scored on a scale of 1-5, in which 1 = not at all and 5 = very much.

Significant correlations in the expected direction between on the one hand crisis and on the other hand parent/child report on child safety (see below), family functioning and child behavior problems supported the concurrent validity of the single item assessing crisis. A higher level of crisis was negatively associated with child safety (\( r_{\text{parent-report}} = -.35, p < .001 \), \( r_{\text{child-report}} = -.54, p < .001 \)), parental competence (\( r = -.34, p < .001 \)), and both measures assessing quality of parent-child interaction (\( -.23 < r < -.43, p < .05 \)), and positively associated with parenting stress (\( r = .48, p < .001 \)) and child behavior problems (\( r = .50, p < .001 \)).
Child safety. To measure the extent of child safety, both at baseline and post test parents and children answered 7 questions: “There are clear rules in our family”, “I feel safe in our family”, “It is safe for everyone in our family”, “In our family everybody can say what he/she thinks”, “There are a lot of arguments in our family”, “There is violence in our family” and “I often feel scared in our family”. The items aim to address several aspects of safety, based on the aspects formulated by Ten Berge and Bakker (2005): continuity, predictability (i.e. rules), and physical and emotional safety. A series of Principal Component Analyses showed that these items formed one dimension, child safety, in all respondents (children and parents) and at both time points. The variances accounted for ranged from 43% to 64%, and the factor loadings ranged from .52 to .92. FCIP workers reported the extent of child safety by answering: “To what extent was the safety of family members at stake at the start of FCIP?” and “To what extent was it safe in the family at the end of FCIP?” Both questions were scored on a scale of 1-5, in which 1 = not at all and 5 = very much. Internal consistency reliabilities were $\alpha = .85$ at baseline and $\alpha = .90$ at post test for children and $\alpha = .85$ and $\alpha = .76$, respectively, for parents.

Significant correlations in the expected direction between on the one hand child safety and on the other hand parent/child report on crisis (see above), family functioning and child behavior problems supported the concurrent validity of the single item assessing child safety. Child safety was negatively associated with crisis ($r = -.35$, $p < .001$), parenting stress ($r = -.37$, $p < .001$) and child behavior problems ($r = -.22$, $p < .01$) and positively associated with parental competence ($r = .44$, $p < .001$) and both measures assessing quality of parent-child interaction ($.32 < r < .63$, $p < .01$).

Perceptions of clients on out-of-home care during FCIP. How clients confronted with temporary out-of-home care of children experienced this, was addressed by the following questions for parents and children: whether they agreed with the out-of home care, whether it was better for the child than staying with the family for the entire period and whether it was better for the parent, whether the out-of-home care was a part of FCIP and whether it resulted in some respite in the family (possible answers: 1 = not at all, 2 = not really, 3 = a little, 4 = I think so or 5 = very much). As we wanted to examine whether clients evaluated the out-of-home care desirable to any extent, scale points designating “a little” up to “very much” agreement were considered to reflect at least some positive evaluation of the out-of-home care.
Program characteristics of FCIP. FCIP workers reported on the specific approach in FCIP for each family by answering: ‘To what extent there was a clear analysis of the family situation?’, ‘To what extent the approach was system-directed?’, ‘To what extent the approach was network-directed?’, ‘To what extent the approach was competence-directed?’, ‘To what extent the approach was solution-focused?’, ‘To what extent the approach was practical?’ (1 = not at all, 5 = very much), and whether FCIP started within 48 hours after referral. Staff members reported for each case whether FCIP exceeded 4 weeks.

Therapeutic alliance. Social workers reported on the quality of the therapeutic alliance by responding to the question to what extent a good therapeutic alliance with the client existed (1 = not at all, 5 = very much).

Results

Preliminary analyses
First, it was tested to what extent mothers and fathers agreed and differed on the selected variables. Their scores were generally moderately correlated and no mean differences were found, except for parenting stress at baseline as well as child behavior problems, for which fathers (M = 85.61, SD = 31.58) had higher scores than mothers (M = 77.44, SD = 29.73): t (34) = -2.14, p < .05. We performed all analyses separately for mothers and fathers as well as for the aggregated parent scores. The parents’ scores are presented below, unless effects were different for mothers and fathers. Sample sizes differed per analysis in accordance with the availability of scores. Second, the situation at baseline was examined. Family functioning and child behavior problems were substantially disturbed at baseline, as the scores of parent-child interaction, parenting stress and child behavior problems were in the clinical range (See Table 1).

Changes in crisis, child safety, family functioning and child behavior problems
Table 1 shows that after intervention, crisis had decreased and child safety had increased. With respect to changes in family functioning it can be concluded that family functioning had improved after intervention, as the level of ‘parenting stress’, and ‘crisis’ as well as ‘child behavior problems’ (according to parents) had decreased and ‘child safety’ had
increased. Only for mothers, improvements in parental competence and parent-child-interaction were found.
Table 1.

Crisis, Child Safety and Family Functioning at Baseline and Changes in Crisis, Child Safety, Family Functioning and Child Behavior Problems between Baseline and Posttest, according to Parents, Children and FCIP workers.

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Note. * p < .05. ** p < .01. ***p < .001 ° trend.
Note¹. Score in the clinical range. NA = not available. B = Borderline

Associations between the program characteristics of FCIP and the changes

Correlations and t-tests indicated that the program characteristics of FCIP were related to the changes in family functioning and child behavior problems (see Table 2). ‘Therapeutic alliance’, ‘analysis of the situation’, ‘extended duration’ and ‘solution-focused approach’ were most consistently associated with positive changes in crisis, child safety, family functioning and child behavior problems, followed by ‘system approach’. Furthermore, the associations differed for the various respondents - mothers, fathers, children and FCIP workers - showing an inconsistent pattern.
Table 2.

Associations between Program Characteristics and Changes in Crisis, Child Safety, Family Functioning and Child Behavior Problems.

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*Note. *p < .05. **p < .01. ***p < .001. ° trend.
Note¹ x = not tested. - = not significant.
Note² The t-test findings were recalculated into correlations.
Clients’ perspectives on temporary out-of-home care during FCIP

Of the families that participated in the study, 40% experienced out-of-home care of a child during FCIP. A total of 46% of the parents reported that they agreed at least a little with the out-of-home care for their child, 74% indicated that it was better for the child than staying with the family for the entire period and 63% indicated that it was better for himself or herself as a parent. Additionally, 46% of the parents considered the out-of-home care as part of FCIP and 61% reported that the out-of-home care of the child resulted in some respite in the family. A total of 83% of the children agreed with their out-of-home care, 90% reported that it was better for him or her than staying home the entire period and 77% indicated that it was better for their parents. Additionally, 57% considered the out-of-home care as part of FCIP and 67% reported that it resulted in some respite in the family.

Discussion

This study showed improvements in family functioning. At the start of FCIP, family functioning was substantially disturbed. After intervention, the level of crisis had decreased and the level of child safety had increased. Additionally, although the problems had not disappeared, improvements were found in parent-child interaction, parenting stress, feelings of parental competence and child behavior problems. Furthermore, associations were found between program characteristics of FCIP and crisis change, safety change, improvements in family functioning and child behavior problems, indicating that the therapeutic alliance, situation analysis, and the solution-focused approach may be especially important for positive changes in these families. An extended duration of the intervention was also associated with positive changes. The perceptions of clients confronted with out-of-home care of children during FCIP point out that out-of-home care, rather than just being perceived as a negative outcome, could be viewed as a temporal solution in some cases, as part of the intervention, and as desirable and helpful.

The decreased level of crisis and the increased level of child safety that were found are in accordance with the aims of FCIP. Improvements in parenting stress, feelings of parental competence and child behavior problems were found in previous studies of family crisis interventions too (e.g. Evans et al., 2003; Lewis, 2005; Van Puyenbroek et al., 2009; Veerman, Janssens, & Delicat, 2005). The results showing that there were still substantial problems in family functioning after intervention are also comparable with
findings of previous studies (e.g. Dagenais et al., 2004). In contrast, parent-child interaction did not improve as expected, although some changes in conflict behavior were reported by mothers. One explanation might be that more time is needed for interaction patterns to change. The phenomenon that the effects of a specific intervention are likely to be visible only in the long term has been called a ‘sleeper effect’ (Hinshaw, 2002). Alternatively, the instruments used in the present study might not have been sufficiently sensitive to detect all changes. Notably, perception differences need further attention, as different family members may not perceive the same changes.

The finding that there were still substantial problems after intervention may indicate that additional intervention is needed for at least the families that could relapse into crisis if substantial problems remain unsolved. It was found that an extended duration of the intervention (of more than four weeks) was positively associated with changes in crisis, child safety, family functioning and child behavior problems, which raises important questions about the optimal duration of family crisis intervention. In accordance with other research suggesting the necessity of expending the duration of these interventions (e.g. Besharov, 1994) and previous evaluation findings showing better results with a longer duration (Bagdasaryan, 2005; Berry, Cash, & Brook; 2000), our findings suggest that four weeks of intervention may be too short for some families. It must be noted that FCIP families did not receive the extended intervention for longer than three months. The optimal duration of the intervention may depend on the actual duration of the family crisis, which has recently been demonstrated to exceed the assumed four week period at times (Al, Stams, Van der Laan, & Asscher, 2011), or on the availability of aftercare (Staudt, Scheuler-Whittaker, & Hinterlong, 2001), offering at least two reasons for addressing the issue of duration of family crisis intervention in future research.

The analysis of the relation between the program characteristics of FCIP and the positive changes revealed that, besides an extended duration, ‘therapeutic alliance’, ‘analysis of the family situation’ and the ‘solution-focused approach’ seem to be important program characteristics of family crisis intervention. The results tend to favor an approach in which the FCIP worker invests in a good relationship with the client, analyzes the family situation and approaches the family as the source of change and solutions (i.e., solution-focused). This apparently vital cooperation with the family system requires that FCIP workers be trained in skills needed for cooperation, such as communication techniques. MacLeod and Nelson (2000) found in their meta-analysis of interventions targeting families...
with child abuse and neglect, which is a group that partly overlaps with the target group of FCIP, that a strengths-based competence approach was important for effectiveness. Effective intervention may require different emphases on the therapeutic characteristics for different subgroups of clients. In the present study, different patterns of associations were observed for children, mothers and fathers, suggesting that change processes may operate differently for the various family members involved.

To explore the role of out-of-home care of children during family crisis intervention, we addressed clients’ perceptions on this matter. Their scores indicate that out-of-home care in many cases was perceived as desirable and helpful. Both parents and children reported a positive role of the out-of-home care, expressing that it created a better situation for all family members, that it was part of FCIP and that it was agreed on or even desired by parents. It is necessary to investigate how the organization and duration of such care and the type of crisis relate to these perceptions. The possibility of respite care and how such a possibility is used seem worth exploring in family crisis interventions. An implication could be that besides, before or even instead of assessment of imminent risk of placement, crisis and child safety assessment is necessary at the time of intake. Furthermore, respite care may be welcomed as a viable option, when indicated, in more family crisis interventions. Although the findings of the present study cannot be considered conclusive, FCIP could be a promising broadened model of family crisis intervention, allowing all families in crisis to benefit from the Homebuilders approach, regardless of an existing threat of out-of-home placement of children. The finding that the families were in crisis at the start of FCIP shows that the intake criterion of families being in crisis was met. Such an intake criterion might gain importance when the role of out-of-home care shifts from solely being a negative final outcome to a, in some cases, useful instrument to achieve family preservation in the long term.

A number of limitations can be identified in this study. As it was not possible to include a control group in our evaluation study, no conclusions about the effectiveness of FCIP can be drawn. The results suggest that the intervention contributed to change, but additional research is needed to find out whether this change can be attributed to FCIP. A substantial percentage of non-response must be acknowledged due to voluntary study participation. The non-response analyses, however, showed only one difference between participating and non-participating families, which diminishes the chance of a non-response
bias. In the study substantially more mothers participated than fathers. An explanation can be that in single-parent families more often the mother is the caregiver.

Several constructs were measured by means of self-constructed instruments. These instruments, several one-item questions, were not validated and the results therefore cannot be compared to other evaluation studies. However, the scores on crisis and child safety showed associations in the expected direction, with scores on validated instruments that were used to measure parenting stress, parental competence and child behavior problems, indicating concurrent validity. Furthermore, clients’ definitions of crisis were found to be in accordance with crisis definition in literature (Al et al., 2011). The lack of norm-referenced standard scores for crisis, child safety and parental competence complicates the interpretation of the severity of the disturbed family functioning both at the start and at the end of FCIP. Including these constructs in future research would facilitate a better comparison of scores.

Despite these limitations, the present study has important theoretical and practical implications. The positive changes that were found seem promising for FCIP and a focus on crisis, child safety, family functioning and child behavior problems in evaluation research seems useful in line with the essential aims of family crisis interventions. Addressing the role of out-of-home care for children in family crisis intervention and the impact of program characteristics on changes in family functioning may therefore be considered as urgent as the urgency of intervention in a family crisis.