# Improving the Well Being of At-Risk Families: Exploring Clients' Perceptions of Preventative Services

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**Abstract:** Low income and working poor families are exposed to tremendous stressors, which in turn can impede their ability to care for their children (Dyk, 2004). In 2000, reports of abuse and/or neglect of over five million children were made to Child Protective Services (CPS) Agencies (U.S. Department of Health and Human Services, 2002). These families are often termed "at-risk" because of the possibility that the children could be placed in foster care. One prevention strategy used to help at-risk families is in-home family therapy. The Young Investigator Award through the University of Kentucky Center for Poverty Research (UKCPR) enabled me to qualitatively study in-home family therapy services from the perspectives of the families themselves. Specific objectives of this project were: (a) to include a graduate student in the study of low-income, at-risk families; (b) to examine client's perspectives about the effectiveness of in-home family therapy; (c) to use the results of this study to inform larger scale quantitative investigations related to preventative treatment for at-risk, low-income families. This study explored the perceptions of 20 low-income and working poor families residing in Northeast Florida who have completed in-home family therapy services. Results indicate that although families unanimously expressed benefits of receiving in-home family therapy, they also found that the length of time services were provided was too brief to meet their long term needs. Families provided suggestions for the improvement of services. Implications for researchers and practitioners are provided.

Low income and working poor families are exposed to tremendous stressors, which in turn can impede their ability to care for their children (Dyk, 2004). The U.S. Department of Health and Human Services (2002) documented three million referrals to Child Protective Services (CPS) agencies involving approximately five million children in 2000. These families are often termed "at-risk" because of the possibility that the children could be placed in foster care. Florida has the 4th largest foster care population in the country (U.S. Department of Health and Human Services, 2002), the south has the highest poverty rates in the country (Dyk, 2004; Ziliak, 2003) and the links between poverty and foster care have long been demonstrated (e.g. Jenkins & Diamond, 1985; Jones, 1998; Pelton, 1987). In fact, models using poverty and deprivation as predictors of foster care rates accurately classified as much as 73.9% of the foster care cases (Jones, 1998).

One prevention strategy used to help at-risk families is in-home family therapy. In-home therapy services emerged from child welfare policies (e.g. PL 96-272) requiring that "reasonable efforts" be made to prevent the removal of children from the homes of at-risk families (Bagdasaryan, 2004). Typically, therapists providing in-home family therapy meet with families several times a week, over a six to eight week period, in the families' own homes. Research indicates that such services successfully lessen the number of out-of-home placements of children (Henggeler, Melton & Smith, 1992, Mosier, Burlingame, Wells, et al., 2001; Szykula & Fleishman, 1985, Walton, Fraser, Lewis, et al., 1993), lowers the risk of psychiatric hospitalizations, and reduces symptoms associated with the presenting problems in the clients served (Frazer, Nelson, & Rivard, 1997). Yet research examining factors related to outcome, such as diagnoses, income level, or whether or not clients were court-ordered into treatment have not been found to be predictive of treatment success (Yorgason, McWey & Felts, 2005).

Furthermore, randomized clinical trails of in-home family therapy indicate that the inability to predict treatment outcome might be related to factors such as lower than intended rates of family participation, linkages with community resources, and quality of services provided (Duggan, Fuddy, McFarlane, et al., 2004).

The experiences of therapists providing in-home family therapy also have been the focus of a number of studies (Thomas, McCullum, & Snyder, 1999; Zarski, Greenbank, Sand-Pringle, et al., 1991). From a clinical perspective, in-home family therapy services are often more intensive than traditional services in that therapists work with families at least two times a week and are available to families 24 hours a day (Bagdasaryan, 2004). Therapists report that conducting therapy in clients' homes presents unique issues compared to experiences of therapists providing therapy in more traditional contexts (Adams & Maynard, 2000; Christensen, 1995; Thomas et al., 1999; Zarski et al., 1991). Specifically, in-home family therapists struggle with feelings of inadequacy associated with helping multi-problem families, boundary issues associated with conducting therapy in the clients' homes, and timing and pacing of therapy (Thomas et al., 1999).

Despite the extant knowledge about in-home family therapy and the therapists who provide such services, the voices of clients remain absent from this research. To date, there is no known research examining clients' perspectives of their clinical needs, their thoughts about in-home family therapy, and ideas for improving these services. We know that families seen by in-home therapists often are termed at-risk or multi-problem (Kaplan, 1986), but clients' perceptions the complexities of their problems and the treatment they received remains unstudied. Researchers have argued for additional research examining how families' involvement in treatment and their perceptions of the effectiveness of services contribute to positive treatment outcomes (Duggan,

Fuddy, McFarlane, et al., 2004; Zarski & Fluharty, 1992). The lack of attention to the families' experiences, coupled with inconclusive results about treatment effectiveness, have led some scholars to conclude that the mental health profession is not advanced in its capacity to effectively address the needs of at-risk families (Azar, Luretti, & Loding, 1998; Azar & Benjet, 1994; Brooks, 1996; Rosenfeld, Altman, Alfaro, & Pilowsky, 1994).

By learning about clients' perspectives about in-home family therapy as a preventative intervention, testable hypotheses about predictors of in-home family therapy effectiveness can be generated. Specific goals of this project were: (a) to include a graduate student in the study of low-income, at-risk families; (b) to examine client's perspectives about the effectiveness of in-home family therapy; (c) to use the results of this study to inform larger scale quantitative investigations related to preventative treatment for at-risk, low-income families. Understanding clients' perspectives has the potential to inform future research which could in turn lead to the improvement in the quality of services provided.

## Methods

### *Research Aim*

Seccombe (2000) asserts that policies and programs may be more successful if they reflect the needs as articulated by the families themselves. Thus, to gain a deeper understanding of the perspectives of at-risk, low-income clients, a qualitative investigation was conducted. The present study explored the perceptions of low-income or working poor families who have completed in-home family therapy services in Northeast Florida.

### *Participants*

The sample was drawn from a list of families who had been offered post-CPS-intervention services because they were considered "high-risk" for the placement of their children in foster

care. Families whose cases had not yet been closed by CPS were excluded from the sample because it was hypothesized that if their cases had not yet been closed, parents may not be as candid in their responses to questions, fearing that their comments could somehow be used against them.

The final sample consisted of 20 families deemed high risk, but who had ultimately retained custody of their children and had their cases closed by CPS. The mean age of the parents in the sample was 34 years (range 18 to 62). The sample was composed of those who self-identified as Caucasian ($n$ = 8), African American ($n$ = 9) and Hispanic ($n$ = 3). Eighty percent of the participants were employed (full time $n$ = 13; part time $n$ = 3) and 20% ($n$ = 4) were not employed. Of those that were employed, the average family income was $14,975 (range $5,000 - $23,000). All the participants reported that they rented ($n$ = 13) or owned a home ($n$ = 7). Education levels ranged from below an 8$^{th}$ grade education ($n$ = 1) to a graduate degree ($n$ = 1). See Table 1 for the frequencies of educational attainment and further characteristics of the sample such as marital status, number and age of children, and reasons for CPS involvement.

*Procedures*

The sample was drawn from a list of families who were provided in-home family therapy by an agency serving families across a four county area in North Florida. Once informed consent was obtained, the participants completed a demographic questionnaire and were interviewed. During the interview, participants were asked questions specifically related to their perceptions about the effectiveness of in-home family therapy services and factors they believe to be important to successful treatment outcome. All interviews were conducted by the primary investigator. The interviews were completed in the participants' homes (except one instance where the interview occurred at a neighborhood park at the participant's request). The

interviews, which ranged in length from one to 4.5 hours, were audio recorded then transcribed. Each family received a $20 gift card for their participation. Data collection continued until saturation of themes was reached.

Qualitative analytic techniques (Strauss & Corbin, 1990) were used to analyze the interview transcripts. Specifically, data were analyzed the data using open, axial, and selective coding methods associated with qualitative methods. Analyses were conducted by a research team consisting of the primary investigator and two graduate students. As a team, we looked at individual cases, discovered concepts in the raw data, organized these concepts into themes, and created categories related to preventative services offered to low-income at-risk families.

In the open coding phase, the research team reviewed the transcripts, and examined and compared the data for overlap and distinctions (Strauss & Corbin, 1990). We read through each transcript, line by line, and created codes, themes, and categories in the data. We proceeded with the open coding and constant comparative process past saturation as an effort to verify that the codes would continue to appear in the data (LaRossa, 2005). During axial coding, we continued to use a constant comparative method, where we created links in the data by comparing the raw data to the data derived from the open coding (Banks, Louie, & Einerson, 2000). The final phase involved selective coding. In this phase we generated specific and comparable categories about in-home family therapy services offered to families at-risk for the placement of their children in foster care.

*Trustworthiness*

A number of efforts were made to help control for researcher bias. First, the interviewer kept an interview log, where she recorded her thoughts, reactions, and opinions about the cases after the completion of each interview. The interview logs were made available to the research team

involved in the coding process. In addition, after each research team member coded a case, we recorded our thoughts and reactions to the transcript, as an effort to make explicit our own opinions and biases and how these may have influenced our interpretation of the data. Further, we instituted a team approach to coding, beginning with one of us coding the data using open coding, then passing our codes to the other research team member, who in turn would see if she agreed or disagreed with the open codes. In instances where we coded the same data differently, we met to discuss the discrepancies and potential biases, and worked to clarify the definitions of the themes. This process continued throughout the study until all cases were coded and verified.

## Results

The data suggested multiple aspects of in-home family therapy that participants found helpful. In addition, categories related to suggestions for the improvement of in-home services, and negative attributes of these services, were also apparent. Each of these categories is described below.

### *Positive Aspects of In-Home Family Therapy*

The participants unanimously ($n$ = 20) stated that they benefited, in one way or another, from in-home family therapy. Some, however, reported more benefits than others. Specific categories related to positive aspects of in-home therapy included: (a) support; (b) skill building; and (c) therapists factors.

Support. A majority ($n$ = 17) of the participants suggested that the “support” associated with in-home family therapy was a benefit of the therapeutic services. Participants stated that availability of the therapist was one aspect of in-home family therapy that helped them feel supported. As one parent shared:

> I even called him [therapist] on the phone a couple of times when I felt like I was in crisis…and there was never a time when I couldn't get a hold of him. Sometimes he would spend hours talking to me. I needed that level of support.

This theme was echoed by other participants as well, such as one mother stated "Anytime I needed something I just called her, and she be trying [sic] and she was helping." Yet another parent shared, "We were able to call him and ask him questions that maybe we couldn't think to ask him during the session and that was helpful." Thus, participants seemed to suggest that having someone readily available to them was one benefit of the in-home family therapy services.

Another aspect of support that participants appreciated was the advice offered by the therapists. Specifically, parents stated that their therapist "wasn't scared to say what he thought we needed to know, if we needed to quit something, he wasn't afraid to tell us that." One parent noted that her therapist "told me to do some things, and not do others, and I needed to hear those things." Thus, the directive stance of the therapist seemed to be appreciated by clients.

Skill building. Helping parents develop new parenting skills was another benefit noted by participants. As one parent shared, "He would have us all get together and write things down, things the kids wanted to do, and then the things the kids had to work on to get those goals and prizes. We still use it and it's working good." Likewise, this participant stated, "He showed us a lot of different ways, effective ways, of handling discipline without spanking or using physical punishment." Statements such as these reflect participants' suggesting that they learned new approaches to parenting and some parents even shared how they are still using the skills learned after the in-home family therapy services ended.

Therapist factors. The parents also appreciated specific attributes of the therapists themselves. The category of "therapist factors" was comprised of the personality or disposition of the therapist, the pacing of the therapist, and the therapists' non-judgmental position.

Statements such as "My therapist was just such a nice guy" exemplify the category of "personality or disposition of the therapist." Reflecting on her experience, one participant said, "She was so supportive, so understanding, and so awesome. She was just very sympathetic with [my stepson], very understanding." Another participant shared "She [therapist] was very polite, very helpful… She was really pleasant to work with. You don't find many people, strangers, coming into your home that are pleasant to work with." Similarly, a participant noted "I think her personality, experience, and her willingness to help made the difference for me and my family."

In addition to personal attributes of the therapist, participants also said that the pacing of the therapist was important to their willingness to utilize services. According to one participant, "The way [the therapist] did it, he came on slow. He didn't jump onto the kids, and he didn't push me or the kids, which was real good." When talking about his experience, another parent said, "I think [the therapist] made us see the issues slowly, without really pushing it in our face. So I really didn't see [the therapist] as an intruder as I normally would have in the past." Such statements seem to reflect how therapists who took their time were appreciated by the families.

Participants also stated that they appreciated working with someone who was non-judgmental. For example, one participant shared "I wouldn't change anything that she [therapist] did…She didn't judge me, or look down on me. That would have been bad." Similarly, another participant expressed "[The therapist] was not blaming either parent, he was just trying to see both sides of the story, and you're also trying to figure out what is the best approach to handle problems like ours." Another suggested "What she did that was helpful was that she talked to me

like I was a human being. Sad, but true. During that whole ordeal, she was one of the only ones that looked at me like I was another human being." Thus, parents expressed that they responded well to therapists who did not judge or condemn them for being involved with CPS.

*Improvement of Services*

Participants were also asked to provide their recommendations for the improvement of in-home family therapy services. Suggestions fell into categories including: longer and more frequent services; therapists' lived experiences; and termination of services. Each of these categories is described in more detail below.

Longer and more frequent services. The clients expressed a demand for longer-term therapeutic services. Specifically, participants suggested "It's been a year and I could still use somebody to talk to *now*. I don't know that I'll ever be over this." Someone else stated:

> We saw him twice a week and that was good, but if this could have continued maybe even another, I know it's a lot, but at least another three or four months to actually get us through our case being closed with [CPS] would have been really good.

Another related, "I think they could give us more time, extra weeks of therapy, even after the case is closed with [CPS], I think they still should come out, even if it's once or twice a month, just come out for support." Additionally, another parent suggested that her in-home therapist:

> …was the one person who I felt could help me out of this mess, and she was great, don't get me wrong, but after the funding ran out and she had to close our case and [CPS] was still messing with us, I could have used her here. I would have liked for her to be able to keep coming out because she was the *only* one who was helping me, you know?"

This was the only sub-theme expressed unanimously ($n$ = 20) by the participants.

Participants also suggested that although they appreciated the therapist coming twice a week, that during the "crisis" they thought that the therapist visiting even more frequently would have been beneficial. As stated by one participant:

> I hate to say this, because he was here twice a week for hours, for six weeks, but I needed somebody *daily*. I needed somebody every night, when the kids went to bed and I was sitting here by myself with no one to talk to. I needed support…I needed somebody to tell me 'you are doing the right thing. You can do it.' That was what I needed. I needed support. I needed a friend, but you're friends don't want to hear this crap.

Similarly, another participant suggested "It could've been more, like instead of two, be at least three days a week, or every other day during the week." According to another parent, "I think during the first initial crisis situation, more than bi-weekly is needed." Thus, allowing therapists to make more frequent contact with families throughout the week, particularly as families work through the crisis of CPS involvement, may be beneficial for some families.

Therapists' lived experiences. Participants also suggested that the therapists' lived experiences were important to them. Specifically, participants stated that they found it helpful if the therapists themselves had children. As one participant stated, "She [therapist] has children of her own, so she knew what we were going through, it's a 'been there done that' kind of thing. So I think that was one of the best things." As for another participant, he shared, "The therapist who worked with us, he understands, he said his child was exactly like this, and believe it or not, that child has actually graduated from high school and gone on to college. So he kind of empathized with us with on that." Yet another participant stated:

> When advice comes from someone who's been in that situation explaining things, you're more apt to accept it from them, rather than someone with a Ph.D. saying 'you need to do

> this and this and this. And you're basically a lousy parent and that's why they're doing this behavior.' That's not what people need, they need someone to say, 'Okay look, two years ago I used to do this with my child. And my child then in turn did this. Now I'm addressing it this way…' I think that's more helpful than handing out a piece of paper, and looking your nose down at people, that's *not* helpful.

Parents seemed to express and appreciation for therapists who shared their lived experiences rather than simply their academic training.

Termination of services. Some participants also suggested that the termination of services caused them to feel some level of distress or discomfort. Specifically, participants described a sense of loss associated with the ending of therapeutic services. One participant expressed "After the six weeks was up, he had to leave, and my kids were asking him 'why ain't you coming back?' and I think that hurt them that they couldn't see him anymore." Another participant stated:

> With [CPS] you're in and out, I don't know how else to describe it. With [the therapist] we thought, finally we've got someone here that's going help us, and then *he's* gone, which isn't his fault, but just when we thought things would settle down and be okay, we could get this guy in here and he could help us instead of everything being crazy, but he was gone and that was really hard.

Another participant stated:

> They let [the therapist] come out for a short period of time, and then they're gone. And my son really wanted somebody like a big brother big sister type person, someone who would stay longer. Not somebody that'll come for a month and then go. Then [my son] is like,

> ‘Okay, well they don’t care about me anymore. They just wanted to come and ask me questions’.”

According to another parent, “Once you establish a relationship with somebody like that, and you trust them, and they know your personal *everything*, you kind of want to stay with them. And I told him that. I said I can’t call you anymore? And he said no I’m sorry, it’s over. So that sucked.” These families expressed how the cessation of treatment left some feeling alone, angry, or sad.

*Negative Perceptions about In-Home Family Therapy*

Although each participant suggested that they benefited from services, some participants (*n* = 4) also stated negative opinions about the services offered. Aside from aspects associated with the brevity of the services and termination of therapist-client realtionship, participants also suggested both general and specific negative aspects of in-home family therapy services.

General, negative assertions about services included “The [in-home] therapy is bullshit you have to go through, you sit there and look good, and cross one more thing off the list that they [CPS] are making you do.” Another parent stated “I’d rather the therapist stay out of my life. I’ve got a lot of family who wants to help me; I don’t need to be telling my business to a stranger.” Another parent said:

> Most of the time he [the in-home therapist] would just come and talk about stupid stuff…Once, he brought me this packet about parenting and I read it because he asked me to. And he was like, ‘Well, did you learn anything?’ I’m like, ‘No. I kind of already knew all those things.’ I mean, maybe some people don’t know that, but it seemed like pretty basic stuff…a waste of my time.

Lastly, one parent shared that her therapist "was pretty cool, but I don't know about helpful he was. It was just another one of those hoops I had to jump through. He just basically just kept joking around…It took me a little while to warm up and I was like what does he care he's gone in six weeks anyhow." Despite these statements, however, each of these participants noted that in the end, they believed they gained something beneficial from the in-home family therapy.

## Discussion

Participants in this study were all low-income parents who were at-risk for the removal of their children from their home. Each family in this study received in-home family therapy as a prevention to foster care placement and each family was ultimately successful in retaining custody of their children. Regarding household composition, only 20% of the sample was married and the average family consisted of a single mother with two children and a household income of $14,975.

Participants shared their perceptions about in-home family therapy services and most often those experiences were positive. The parents' assertion that "support" was a benefit of services is similar to outcome studies demonstrating that support is the most significant predictor of treatment outcome for in-home family therapy clients (Yorgason et al., 2005). Lower-income and working poor families are often typified as having only one parent, being socially isolated, and having limited access to community resources (Dyk, 2004). Similarly, the families in this study, many of whom were single parents, expressed either having no one else to turn to, or being too embarrassed by CPS involvement to involve their informal support network. Therefore, it is not surprising that families in this study expressed appreciation for having therapists that they could rely on in times of need.

Arguably be the best outcome of in-home family therapy is parents articulating that, through in-home family therapy, they learned new ways of disciplining their children without hitting them. Given that 13 of the 20 parents who participated in this study were at risk because of allegations of "physical abuse," hearing parents express that they now have new skills that they can use was encouraging. It seems important to acknowledge that parents in this study preferred to learn this content by hearing about the therapists own parenting experiences rather than their text-book training. As one parent suggested, the level of education of the therapist was not as important as the therapist's ability to join with the family and approach the situation in a non-accusatory, collaborative way. Parents may be more receptive to parent education if the therapists can attempt to relay information in an applied, informal manner.

Parents also shared suggestions for the improvement of in-home family therapy services. In-home family therapy services are labeled by researchers and practitioners as "intensive." Yet, parents expressed that they believe they could have benefited from services that were *more* intensive. Specific suggestions included lengthening the amount of time that they have access to the in-home family therapists and allowing for more frequent visits between the therapist and the families.

Some parents also expressed feeling abandoned or sad at the termination of in-home family therapy. These perceptions suggest that it may be beneficial to give further consideration to what happens with the families after cases are closed. Although every therapist was required to provide the CPS worker a list of resources that may further benefit the family, the families seemed to express that it wasn't referrals that they wanted, but rather the ability to continue to work with their therapists.

Yet all feedback about in-home family therapy services was not positive. Some parents noted negative aspects of the therapeutic experience. Specifically, some parents saw in-home family therapy as a "hoop" they had to jump through to fulfill their case plans. In such instances, the families expressed that they felt that in-home family therapy could be invasive and expressed a preference to be left alone. There is a growing body of literature demonstrating that families need to be "ready" for services before one tries to mandate that they receive them. In order to facilitate this, there are research-based treatment models for the engagement of reluctant clients in treatment. For example, the structural systems engagement model uses a structural family therapy approach for understanding patterns of families reluctant to engage in services and has devised interventions to engage families based on assessment of such patterns (Cornille, Mullis, & Mullis, 2004; Szapocznik et al., 1988). This model has been empirically shown to increase family engagement in services (Cornille et al., 2004; Szapocznik et al., 1988). Using empirically supported models when working with reluctant clients, or integrating such models in to in-home family therapy services, may be a means of helping at-risk families who arguably need such services the most.

## Implications for Policy

Seccombe (2000) indicates that policies and programs may be more successful if they reflect the needs as articulated by the low-income and working poor families themselves. Thus, this qualitative investigation served as a means for the voices of at-risk, low-income families to be heard. Dyk (2004) asserts that working poor families need policies that will support their parenting roles. Results from this investigation reveal parents' suggestions for how their roles can be supported through interventions aimed to increase parental involvement and support.

In-home family therapy services emerged as a result of policies aimed to improve the services offered to at-risk families. In-home family therapy programs are often state funded entities established to demonstrate that CPS agencies are complying with the legislative mandate that "reasonable efforts" be made to provide preventative services to families (Bagdasaryan, 2005). Therapists typically view these services, which include being available to families 24 hours a day and seeing families multiple times a week, as "intensive." Yet, the families themselves express that they believe they could have used longer term help. Thus, the definition of "reasonable effort" could be contingent upon who is asked. Clients' recommendations included both lengthening the time the families have to work with therapists and having therapists work with families more frequently across the week. Additionally, participants suggested that they appreciated therapists who "took their time" and didn't rush in to things. Yet, with time limited services, taking one's time may not be a luxury that all therapists can afford.

It would be beneficial to investigate issues related to length and frequency of services. Results from such research could help our understanding of how much time with families is needed in order to achieve desired outcomes. If lengthening services does indeed correlate with positive outcomes, then perhaps policies supporting longer term services can be passed to truly fulfill the obligation of providing services to families who are in need.

## Limitations

There are a number of limitations to this study that should be strongly considered. First, interviews are not neutral. The "active" nature of interviews is in and of itself biased (Fontana & Frey, 2005, p. 696). Thus, data gathered from interviews should not be interpreted as fact, but rather representations of the participant's perspective at that point in time. Further, it is unlikely that the results of this study are generalizable to a specific population given convenience

sampling method used and the small sample size. Regarding recruitment, every participant was paid $20. Therefore, the sample could be skewed to include families who were most in need of financial assistance. Given that there was no comparative group, it cannot be asserted that these experiences are unique to low-income, working poor families. Future studies could enhance these findings by obtaining a comparative sample. Lastly, all participants received services from one in-home family therapy agency; therefore, their responses may be more of a testimony about that specific agency than in-home services in general.

Despite these limitations, the results from this study indicate ways in which researchers and practitioners can examine the effectiveness of services offered. For example, if the length of services is expanded, does that indeed relate to better family outcomes? Similarly, does more frequent visits to the families homes by the therapists per week also result in indicators of success? Since support was the factor mentioned most by families, would a support group consisting of peers yield the same outcomes as in-home family therapy? Learning the clients' perspectives about services allows us to be able to integrate their suggestions into future services in order to begin to improve the quality of therapeutic services offered to at-risk, low-income families. Further, results can also serve as the beginning of policy related recommendations made by those directly impacted by current legislation and policy -- the families.

## Conclusions

Previous research has demonstrated the challenges in-home family therapists encounter when working with at-risk families (e.g. Thomas, McCullum, & Snyder, 1999), and that families receiving in-home family therapy services are often labeled "multi-problem" families (Kaplan, 1986), but clients' perceptions the complexities of their problems and the treatment they received remained unstudied. This project, however, marked an attempt to bring the voices of the clients

into discussions about treatment. Results of this study show that families view in-home family therapy as a useful intervention. They expressed appreciation for the therapists, their availability, and the support offered. Participants also expressed that they wished services could have been more frequent and longer-term. It seems that by hearing the parents' opinions, questions about perspective can be raised. Are services *really* intensive? From the perspective of the therapist -- perhaps they are, but what about from client's point of view? By including the voices of the recipients of in-home family therapy services, we gain another perspective about the effectiveness of preventative services offered to at-risk, low-income families.

Specific objectives of this project were: (a) to include a graduate student in the study of low-income, at-risk families; (b) to examine client's perspectives about the effectiveness of in-home family therapy; (c) to use the results of this study to inform larger scale quantitative investigations related to preventative treatment for at-risk, low-income families.

Funding from UKCPR enabled me to involve a doctoral student in this project and she and I will be both publishing and presenting the findings from this study. The goal of collecting data from 20 families was met and I now have a wealth of data related to parents' perceptions of their experiences with CPS, the hardships they have faced, as well as their suggestions for in-home family therapists. By disseminating these results through publications and national presentations, this project can be used to inform future research aimed to improve preventative services for at-risk families. Further, through this investigation, a collaborative relationship with an agency providing services to at-risk families was established and the agency has expressed a willingness to participate in a larger scale investigation as an effort to improve the quality of the services that they themselves provide to at-risk families.

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Table 1. Description of the Sample.

| Marital Status | Annual Income | Highest Grade Completed | Children's Ages | Reasons for CPS Involvement |
|---|---|---|---|---|
| Single | $22,000 | Bachelor's Degree | 2, 4 | Mental Health |
| Married | $10, 400 | Below 8th Grade Education | 3, 7 | Physical Abuse, Domestic Violence |
| Married | $23,000 | Associates Degree | 8, 9, 14 | Physical Abuse |
| Living with partner | Not Employed | Graduate Degree | 15 | Physical Abuse, Domestic Violence |
| Single | Not Employed | High School Diploma | 13 months | Physical Abuse, Mental Health |
| Divorced | $20,000 | High School Diploma | 12 | Physical Abuse |
| Married | $18,000 | High School Diploma | 12, 18 | Physical Abuse |
| Divorced | $12,000 | High School Diploma | 2 | Domestic Violence |
| Divorced | $22,000 | Bachelor's Degree | 18 | Physical Abuse |
| Separated | $20,000 | High School Diploma | 4, 7, 10 | Physical Abuse |
| Single | Not employed | Some High School | 2, 10, 14, 15, 16 | Neglect, Domestic Violence |
| Single | $14,000 | Associates Degree | 6 | Abandonment |
| Widowed | $12,000 | High School Diploma | 2, 6 | Physical Abuse, Domestic Violence |
| Single | Not employed | Some High School | 5, 5 | Domestic Violence |
| Divorced | $12,000 | High School Diploma | 15, 16 | Physical Abuse |
| Single | $5,000 | Some High School | 10 months | Alcohol Abuse, Mental Health |
| Single | $12,000 | Some High School | 5, 10 | Neglect, Physical Abuse |
| Separated | $12,000 | High School Diploma | 9, 13, 15 | Physical Abuse |
| Separated | $7,200 | Some High School | 2, 4 | Alcohol Abuse, Domestic Violence |
| Married | $18,000 | High School Diploma | 9, 12, 14 | Physical Abuse |