Barriers and Facilitators to Use of Services Following Intensive Family Preservation Services

Marlys Staudt, Ph.D.

Abstract

The primary caregivers of 101 families that used short-term, intensive home-based services were interviewed 2 months after the services to ascertain use of the recommended aftercare services, perceived barriers to service use, and perceived facilitators of service use. While 88% of the families accessed at least some of the recommended services, more than 50% failed to access all of the recommended aftercare services. The most often noted barriers to service use were enabling factors at the agency or community level. Yet, many of the services were used, and the respondents indicated that professionals played a role in helping them link to services. Researchers should continue to study the use of recommended aftercare services and the relationship between aftercare service use and clinical outcomes.

It has been well over 20 years since the advent of family- and community-based programs that were designed as alternatives to child out-of-home placement. One of the most noted yet controversial home-based models is intensive family preservation services (IFPS). Many IFPS programs across the nation are based on the Homebuilders model.[1] Homebuilders began in 1974 in Tacoma, Washington, a program of Catholic Community Services with additional funding from the National Institute of Mental Health. The general purpose of Homebuilders is to "prevent the unnecessary out-of-home placement of children in state-funded foster care, group care, psychiatric hospitals, or corrections institutions" (p. 31).[2] Program goals are (1) to protect children, (2) to maintain and strengthen family bonds, (3) to stabilize the crisis situation, (4) to increase the family's skills and competencies, and (5) to facilitate the family's use of a variety of formal and informal helping resources.[3]

Several characteristics differentiate IFPS based on the Homebuilders model from other family- and home-based models. Namely, services are short term and intensive. Therapists carry small caseloads to provide intensive services. A variety of services are provided and are individualized to meet the unique needs of each family. Services are home based, and therapists work with families in their natural environments.

Homebuilders is based on crisis, social learning, and family system theories.[4,5] While Homebuilders most often is distinguished from other home-based models by its short-term and intensive services, it also is based on explicit values and principles. These include that families are doing the best they can do and that families, even when in crisis and need, bring resources to bear on problem solving.[2]

One of the reasons that IFPS programs have generated some controversy is because it is thought that short-term services are inadequate to meet the chronic and multiple needs that many families in the child welfare and mental health systems present.[6,7] Some suggest that the effectiveness of a short-term service delivery model depends on the system of services available within the

---

Address correspondence to Marlys Staudt, Ph.D., Assistant Professor, College of Social Work, University of Tennessee, Knoxville, TN 37996-3333; e-mail: mstaudt@utk.edu.

community.[8,9] In short, the assumption is made that short-term services alone cannot meet the needs of many families that receive IFPS. In light of these concerns, it is surprising that so little attention has been given to the IFPS program goal of facilitating service use. Given the assumption that many of the families that receive IFPS continue to need services, and given that IFPS therapists recommend the use of follow-up services, it is important to know whether families use the recommended aftercare services. This article reports on use of the recommended aftercare services and what families perceive to be the barriers and facilitators to service use after IFPS.

Background

Two published studies have examined the use of services following IFPS.[10,11] Wells and Whittington[11] examined the relationship between aftercare use and subsequent family functioning in a sample of families that received IFPS through a mental health agency, while Unrau[10] examined the correlates of service use in child welfare.

Wells and Whittington[11] tested a path model in an effort to predict family functioning at 1 year after discharge from IFPS. Two of the exogenous variables, formal support and informal support, were concerned with the postdischarge environment. Formal support was measured by the proportion of recommended aftercare services used. Informal support was measured by the number of supportive family members. The authors found that families that used fewer of the recommended aftercare services had better functioning at follow-up than did families that used more of the recommended aftercare services. As they suggested, this may reflect that families with better functioning at IFPS entry used fewer of the recommended services. Wells and Whittington also found that informal social support was positively related to family functioning at follow-up.

Unrau[10] studied correlations between client and service characteristics and the restrictiveness of child welfare services at 3 and 6 months following IFPS. The three categories of service use, ranging from most to least restrictive, were publicly funded placement of the child, child welfare services without placement, and no child welfare services. Unrau found that the number of child behavior problems, prior placement, number of child emotional problems, number of domestic problems, and more direct service time all were correlated with more restrictive services. The presence of child abuse was correlated with less restrictive services. Overall, at 3 months after IFPS, 56% of the families had terminated all involvement with child welfare. By 6 months, 63% of the families had no involvement with child welfare. Unrau's study was limited to use of services in public child welfare. It might have been that these families were using other types of services.

Given the lack of studies focusing on aftercare use following IFPS, it will be helpful to examine the literature on aftercare use following residential or inpatient treatment. However, as with IFPS, there is a lack of research on the use of aftercare services on discharge from residential treatment and psychiatric hospitalization. Pfeiffer and Strzelecki,[12] in a review of 34 articles on residential treatment and hospitalization outcomes published between 1975 and 1990, found 23 related to postdischarge functioning, and of these, only 4 investigated the relationship between aftercare and outcome. One of the earliest studies of postdischarge functioning found that functioning while in residential treatment was predictive of postdischarge functioning only when taking into account the postdischarge environment.[13] Children who made progress while in treatment maintained these gains when discharged to a supportive environment. In fact, children judged to make adequate gains while in treatment but discharged to an environment without the support to maintain these gains were functioning more poorly at follow-up than were children judged to make inadequate gains in treatment but discharged to a supportive environment. Findings from more current studies also support the importance of the aftercare environment to postdischarge functioning.[12,14,15]

Thus, although it still is not known which aftercare services work for whom,[16] it is generally accepted that the use of aftercare services and the quality of the aftercare environment are important to sustain and enhance treatment gains. Little is known, however, about the predictors of aftercare service use. A small sample of children and adolescents discharged from a state psychiatric hospital found that (1) child and parent involvement in developing the aftercare plan was related to aftercare use, (2) parents who took the first step in obtaining services were more likely to use services, (3) child or parent drug use/abuse resulted in a lower likelihood of service use, and (4) children with prior placement were more apt to receive services.[17]

This article presents the results of an exploratory research study that examined the barriers and facilitators to use of recommended aftercare services following IFPS. The findings presented here are part of a larger research study that examined the types of aftercare services that IFPS therapists recommended, the correlates of service use, and the correlation between use of aftercare services and subsequent child and family functioning.

Method

Design

Two agencies in a large midwestern city served as the research sites. One is a community mental health center that provides a range of services to children and adults including IFPS. The other is a multiservice children's agency that provides a range of services to children with severe emotional and behavioral problems and their families including IFPS. IFPS programs at each agency are based on the Homebuilders model. Specifically, services are provided for 4 to 6 weeks, and each therapist works with two families at any one point in time. At each agency, referrals come from both the child welfare and mental health sectors.

Children are referred to and accepted for IFPS only if it is thought that they will be placed out within 72 hours if the IFPS program is not provided. Each agency has its own at-risk status screening procedures. As with other IFPS research and programs, it is likely that some children were not at "imminent risk" of placement but were simply in need of services.[18]

Families that completed IFPS during the period from May 1996 through early August 1997 were eligible to participate in the research. This included families that completed the full length of the 4- to 6-week service period and those that terminated early because it was jointly determined between the families and therapists that the treatment goals were met. Families that dropped out early because they did not want the services and families that therapists terminated because they never were at home for appointments were not eligible for the research. By the very nature of not completing services, these families did not have aftercare plans.

IFPS therapists were responsible for explaining the research to families and for inviting their participation. Therapists at both agencies received training on how and when to inform families about the research, how to invite their participation, and how to complete the required forms. Families were informed about the research and were invited to participate on IFPS termination. Therapists obtained written informed consent from families that agreed to participate in the research. When families did not agree to participate in the research, the therapists completed a tracking form with basic demographic information. This allowed the researcher to compare participants to nonparticipants. The therapists then returned these forms to the researcher.

After receiving each informed consent form, the researcher reviewed the family's file and extracted the recommended aftercare plan. The mother (or other primary caregiver if the child did not live with the mother) was interviewed 2 months after IFPS termination. The interview took place in the family's home. The primary purpose of the interview was to obtain information about use of the recommended aftercare services, perceived barriers to service use, and perceived facilitators of service use. The interview was conducted using a structured interview guide. The interview guide was developed for the purpose of the research and was test-piloted prior to its use in the research.

The research presented minimal risk to children and families, and it was approved by human subjects committees at the sponsoring university and the host agencies. Each caregiver was given $10 for her participation in the research.

Measurement

A service was considered a recommended aftercare service if it was listed on the aftercare plan in the termination summary. The IFPS therapists at both agencies routinely documented the recommended aftercare services in the termination summaries. Examples of recommended aftercare services are individual child or adult therapy, office- or home-based family therapy, case management, psychiatric services for medication monitoring, support groups, child welfare, and juvenile justice services.

A recommended aftercare service was considered used if the respondent (or other family member) had at least one contact with the aftercare provider in the 2 months since IFPS termination. For the service to be counted as used, the contact with the provider had to be for the purpose of receiving services. For example, contacts for the purpose of scheduling or checking on an appointment time were not included as service contacts because they did not entail the receipt of services. Thus, one or more contacts indicates that the service was used.

Perceived barriers to service use were measured in two ways. The first was a general measure of perceived barriers to using services in the 2 months since IFPS termination, measured by Part 3 of the Survey of Parents' System of Care Experience.[19] This measure consists of 16 items designed to measure parental perception of system barriers (including cost, lack of transportation, and lack of information about services) to the delivery of community-based services on a scale of 1 (*major barrier*) to 4 (*no barrier*).

The Survey of Parents' System of Care Experience was used in an Illinois community for planning and developing a system of care. The authors of the instrument have described the process of instrument development.[20-22] After determining the type of information needed and reviewing the relevant literature, a sample instrument was developed and sent to six experts for review and critique. After incorporating the feedback of the experts, the revised instrument was test-piloted, and changes were made before it was adopted for use. Thus, although the authors of the instrument did not report empirical validity or reliability indexes, the process of its development enhances face validity. Based on the data collected in the research reported in this article, the Cronbach's alpha was .89, indicating good reliability.

Perceived barriers to service use also were measured in relation to each recommended aftercare service. For each recommended service that was not used, respondents were asked what stood in the way of using the service. Even when families used services, barriers might have limited the full or convenient use of services. Respondents who reported that they had used the service were asked what barriers or obstacles stood in the way of service use. In addition, when respondents had used the recommended aftercare service, they were asked how they became linked to the service. No categories were provided to the respondents for these three questions; rather, they were open-ended questions that required short responses. When respondents used the service, they also were asked whether it was used prior to IFPS.

Data Reduction and Analyses

For Part 3 of the Survey of Parents' System of Care Experience, the individual items were summed and divided by 16 to obtain an overall score. Service use may be influenced by a variety of demographic and service factors. *t* tests were used to test for differences in the total survey scores by referral source (child welfare or mental health), provider agency (mental health agency or children's agency), whether or not the family received case management, ethnicity (European American or African American), family structure (single-parent headed families or two-parent headed families), receipt of food stamps, and receipt of Aid to Families with Dependent Children (AFDC). Pearson correlations were used to determine whether there were significant relationships between the survey scores and maternal age, maternal years of education, and family income. The .05 level of probability is used when reporting findings as significant.

After reviewing a sample of responses to the open-ended questions about barriers, it became apparent that the responses could be categorized and summarized using the Andersen[23] framework of service use. According to the Andersen framework, need is a necessary condition for service use. Need for service consists of both an individual's perceived need for service and a professional's evaluated need for service. While need is necessary for service use, enabling variables also must be present. Enabling variables refer to personal factors (including income, insurance, and transportation) and community or agency factors (including availability of services and waiting periods) that can influence the use of services. Within the Andersen framework, a third category of variables, consisting of demographic and social structural variables, also can influence service use.

Barriers were coded into one of the following categories: perceived need, evaluated need, personal enabling, agency/community enabling, and miscellaneous. Perceived need included that the respondent did not perceive a problem that required help or did not think the service was needed, a family member did not want to participate in the service, and the respondent had simply not contacted the provider to arrange an appointment without mentioning a reason for not contacting the provider. Evaluated need included that the aftercare provider did not view the service as needed or recommended a type of service different from the recommended service (e.g., family counseling rather than individual counseling).

Personal enabling barriers included lack of transportation, lack of child care, affordability (service was too expensive or the family lacked insurance), and lack of required time given that participation in services was time-consuming. Agency/community enabling barriers included inconvenient agency hours, no contact with the respondent inititated by the aftercare provider, no discussion of the service by the IFPS therapist with the family (and so the family did not expect to receive it), distance to or inconvenient agency location, paperwork snags that delayed service, and the respondent's not qualifying for service. Responses that did not fit into a need or enabling category were classified as miscellaneous and included inclement weather as well as that the service was in the process of being set up, the respondent had surgery (and so service was delayed), and the respondent did not like the provider or the provider could not help.

Coding of the responses to the perceived barrier questions was completed by the primary researcher. The intra-reliability percentage agreement (approximately 2 weeks apart) was 88%.

After reviewing the responses to the question about what facilitated service use, nine categories were developed: (1) the IFPS therapist, (2) another professional other than the IFPS therapist, (3) respondent sought out service on his or her own, (4) a hotline call (report of suspected child abuse/neglect), (5) service was part of a hospital discharge or other service plan, (6) friend or relative recommended the service, (7) service was court-ordered, (8) a crisis event precipitated service use, and (9) respondent could not remember how he or she became linked to the service. The intrareliability for coding these (approximately 2 weeks apart) was 100%.

Findings

Sample

During the study period, 149 families completed IFPS and were asked to participate in the research. Of these, 113 (76%) agreed to participate. Eighty-nine percent ($n = 101$) of the 113 caregivers who agreed to participate were interviewed at 2 months after IFPS. The 101 caregivers who were interviewed represent 68% of those who were asked to participate. A total of 12 families that initially agreed to the research were not interviewed because of incomplete or late paperwork, moving out of the area, or having second thoughts about participation. There were no significant differences between the 101 participants and the 48 nonparticipants on age or gender of the at-risk children, family size, family structure, or ethnicity.

Of the 101 families that were interviewed, 30 were referred to IFPS through the mental health sector and 71 were referred through child welfare. In these 101 families, the typical identified child was a 12-year-old male living with a single parent. The average age of the primary caregiver was 36.5 years, with an age range of 22 to 64 years. While the mean net monthly income was $1,379 (*SD* = $1,037), it ranged from no income to $6,800. Just under half (49%) of the primary caregivers were employed, 23% received AFDC, and 36% received food stamps. Eighty-five percent of the identified children had some form of health insurance coverage.

Use of Aftercare Services

Of the 101 families, only 2 did not have recommended aftercare services. Across the 99 families with recommended aftercare services, there was a total of 260 recommended aftercare services. Of these 260 services, 65% ($n = 169$) were used by the families; that is, respondents reported at least one contact with the providers in the 2 months since IFPS termination. The remaining 91 services (35%) were not used by the families; that is, the families had no contact with the recommended providers in the 2 months since IFPS termination.

When the family was the unit of analysis, 12% ($n = 12$) were non-service users, having no contacts with any of the recommended aftercare services in the 2 months since IFPS termination. Eighty-eight percent ($n = 87$) were service users, having at least one contact with at least one of the recommended aftercare services in the 2 months since IFPS termination. Less than half of the families (46%, $n = 46$) used all of the recommended aftercare services, and 54% did not use all of the services that were recommended at IFPS termination.

Barriers to Service Use

Respondents to the Survey of Parents' System of Care Experience were asked to respond to each of 16 possible barriers to using services in the 2 months since IFPS termination. This was a general rating in that it did not refer to any specific service or agency; rather, respondents needed to think about the extent of each barrier to service use in general. Table 1 shows the 16 items and the mean score of each item.

In Table 1, it can be seen that the respondents generally indicated that most items were, at most, minor barriers to service use. The most problematic items were the lack of a central place for children and families to receive information about services, children's and parents' lack of information about community services, lack of availability of the service, and agency constraint on the type of service that could be provided. Lack of culturally competent staff and the inability of agencies to share records with one another generally were not seen as barriers to service use.

The mean barrier score was 3.13 (*SD* = 0.71). There were no statistically significant differences in the total barrier scores by referral source (mental health or child welfare), agency through which IFPS was provided, ethnicity, family structure, or receipt/nonreceipt of food stamps or AFDC. Neither were there significant differences in the barrier scores among families that used none, some, or all of the recommended aftercare services. Similarly, there were no significant correlations between the scores and maternal age, maternal years of education, or family income. A significant difference did emerge according to whether the families had case managers. Families with case managers had an average total score on the barrier scale that indicated lower perceived service barriers ($M = 3.32$) compared to families without case managers ($M = 3.06$), $t(69) = -1.99$, $p = .0505$.

Anecdotal comments provided by the respondents illustrate how respondents were affected by the lack of information about services and the difficulty of accessing services. One mother told of initially locating service for her child by taking a day off from work and sitting down with the yellow

Table 1
Mean Item Scores on Survey of Parents' System of Care Experience

Barrier	Mean Score
Lack of central place to find information about services	2.6
Parents and children do not have information about community services	2.7
Agency will provide only certain types of services because of agency roles	2.8
Long waiting periods	2.9
Services for my child are not available locally	2.9
Number of forms to fill out	3.1
Lack of transportation to services	3.1
Services do not address family needs	3.2
Cost of services is too high	3.2
Lack of ability to use funds in a creative manner	3.2
Inconveniently located services	3.2
Lack of evening/weekend hours	3.3
Agency staff do not have information about community services and resources	3.3
Lack of qualified staff	3.4
Lack of culturally competent or bilingual staff	3.6
Inability to share records between agencies	3.6

NOTE: On 4-point scale, 1 = *major barrier*, 2 = *moderate barrier*, 3 = *minor barrier*, 4 = *no barrier*.

pages of the telephone book. Another told a similar story but started her search by calling the chamber of commerce. She indicated that she knew that the chamber could not provide service to her child but was hopeful that it could provide her with information about who to contact because she did not know where to start in finding help. Both of these mothers reported that it took numerous phone calls before locating the appropriate agencies. These two mothers recalled how they found initial service contacts prior to IFPS or other agency involvement. A third mother, who had already received IFPS, had the phone number of an agency and wanted to call it but indicated that she did not know for sure what the agency did and did not know what to say or ask when she called. Her IFPS worker had helped her connect with other services and had left her the number of this other service that she had not yet contacted.

Barriers to Use of Recommended Aftercare Services

For each recommended aftercare service, whether or not it was used, respondents were asked what barriers or obstacles stood in the way of using the service. For each service, up to two barriers could be coded. For 100 of the 169 services used, respondents indicated no barriers to service use.

Table 2 shows the number of times need and enabling factors were mentioned as barriers to using recommended aftercare services. In general, the same types of barriers were noted when services were used as when services were not used in the 2 months after IFPS. The lack of enabling factors was mentioned most often as a barrier to service use. Respondents noted agency and community factors more often than they did personal enabling factors. The agency/community enabling responses consisted of inconvenient agency hours and scheduling problems, waiting lists, and the provider's not contacting the respondent or calling the respondent after a missed appointment. These barriers were mentioned both by those who used the service and those who did not use the service. Enabling

Table 2
Barriers to Using Recommended Service:
Numbers and Percentages of Mentions

Barrier	Service Not Used in 2 Months since IFPS		Service Used in 2 Months since IFPS	
Enabling: agency/community	38	(35)	27	(36)
Enabling: personal	28	(26)	22	(30)
Total enabling	66	(61)	49	(66)
Perceived need	27	(25)	10	(14)
Evaluated need	4	(3)	4	(5)
Total need	31	(28)	14	(19)
Miscellaneous	12	(11)	11	(15)

NOTE: Percentages are in parentheses. IFPS = intensive family preservation services.

factors at this level for those who did not use the service included that they did not expect to receive the aftercare service, that they needed more information about the service before they contacted the provider, and that they no longer qualified for the service. Barriers experienced by those who used the service were the provider's limited time or excessive caseload and inconvenient agency location.

The personal enabling mentions consisted of service use being too time-consuming, affordability, lack of transportation, and lack of child care. These were consistent responses across both groups (i.e., those that used the service and those that did not). The most frequently noted need factor was that respondents did not view the recommended aftercare service as needed or that a family member did not want to participate in the service. Perceived need was mentioned more frequently (25% of all mentions) when the families had not used the service in the 2 months since IFPS termination than when families used the service (14% of all mentions). In the miscellaneous category, for respondents who used the service, responses included that they needed or wanted the service but that the providers simply could not help them.

Facilitators to Use of Recommended Aftercare Services

When respondents reported that the service was used, they were asked how it was that they were able to connect to and use the service. Again, up to two facilitators were coded for each service. Of the 169 recommended aftercare services that were used, 88 (52%) were used prior to IFPS. Table 3 shows the facilitators to use of the recommended aftercare services (including those used prior to IFPS).

It is apparent that families most often came to initially use the service through the IFPS therapists or through other providers recommending the service and helping them link to the service. In addition, a number of services were sought out by the respondents without the assistance of professionals. Families also became connected to services because they were court-ordered or the result of recommendations that were made following reports and investigations of child abuse/neglect. It is not surprising that families used services either because they perceived a need for service or because professionals encouraged service use.

Anecdotes from the interviews indicated that some caregivers had sought out services prior to crises but that it took the crises to obtain or qualify for the service. One mother sought out services for her teen daughter and was told by public agencies that she did not qualify for services. She could not

Table 3
Facilitators to Using Recommended Aftercare Service

Facilitator	Number of Times Mentioned	Percentage of Mentions
IFPS therapist	54	30
Other professional (besides IFPS therapist)	52	29
Sought out on own	22	12
Hotline call	14	8
Part of hospital discharge plan or other service plan	12	7
Friend or relative recommended	8	4
Court-ordered	6	3
Crisis (e.g., mother would not pick up child after child was arrested, child refused to come home)	3	2
Don't recall how initially connected	10	5

NOTE: IFPS = intensive family preservation services.

afford services from a private agency or provider. When she received a call from the police to come and get her daughter after the daughter was picked up for shoplifting, she refused to do so until she was guaranteed some help; that is how she connected with IFPS. A grandmother, caring for her grandson, reported asking for help but being unable to obtain or qualify for services. She reported that the services received from IFPS were "too little, too late." This theme also was reported by some who were investigated for abuse/neglect—that it sometimes opened the door to services that they had wanted earlier but had been unable to obtain. Thus, some of the families perceived a need for services prior to the actual receipt of services.

When the recommended aftercare service was not used prior to IFPS, the percentage of mentions for the IFPS therapists facilitating service use was 51%. This suggests that IFPS therapists may be instrumental in helping families access new services. This is an intermediate outcome that is worthy of further study and one that has been given little attention in the IFPS literature.

Discussion and Summary

Limitations of this research must be considered prior to a discussion of the findings. The families in this sample were those that completed IFPS and were possibly more motivated to change and make use of services than were families that began IFPS but had premature termination. The sample is, no doubt, biased because the sample families are likely the more functional families, at least in terms of their ability to engage in and use services. The findings cannot be generalized to all families that receive IFPS because the sample includes only those that completed IFPS. Little is known about the service trajectory of families that did not complete IFPS or the specific reasons for premature termination. It is important that future studies include dropouts to determine what barriers exist to the receipt of IFPS. IFPS has many aspects (including being home based and focusing on family strengths) that, at first glance, make it easy to use. Yet, some families are unable to sustain use of these services. It is likely that these are the most vulnerable children and families. Increased understanding of their perceptions of service barriers will aid in the provision of services to these families.

A second study limitation is that service use was operationalized as at least one contact with the recommended aftercare provider in the 2 months since IFPS. Based on this definition, there probably is a blur between service users and non-service users. For example, if the needed and appropriate quantity of service use was one time per week, then one contact in 2 months does not approximate optimal service use. However, counting service use as one contact differentiated those who initially accessed and used the service—even if only once—from those who never used the service in the 2-month study period. This distinction is important when studying service use and is one of two components of service use, the other being the amount of service use.[24] Current knowledge provides little guidance in determining what amount of service or what mix of services is needed for particular referral problems.

Findings from this study closely replicate those of Soderlund, Epstein, Quinn, et al.[22] They found that parents of children receiving special education due to emotional and behavioral disorders reported inconveniently located services, service cost, lack of information about services, lack of a central place to find out about services, agency constraints on types of services provided, lack of evening/weekend hours, and long waiting periods as the main barriers to service use. In addition, the two least noted barriers in their sample were the inability of agencies to share records with one another and the lack of culturally competent staff.

Respondents who reported that their families had case managers reported lower perceived barriers than did respondents whose families did not have case managers. The present research also found that perceived barriers did not relate to actual use of services,[25] casting doubt on the efficiency of interventions that may decrease barriers to service use. However, it might be that over a longer period of time, even barriers perceived as minor may affect service use and service outcomes.

While the previously mentioned perceived barriers to services should not be trivialized, it also must be remembered that many of the services were used by the families and that 88% used at least some of the recommended services. Most frequently, it was the IFPS therapists or other professionals who helped link the families to the services. Also, several respondents indicated that they would have provided different answers to the survey items prior to the IFPS intervention but that the IFPS therapists had informed them about available services. Future research should consider measuring service use as an intermediate outcome of IFPS. In addition, it is important to know whether service use actually leads to desired ultimate outcomes such as change in child and family functioning.

Implications for Behavioral Health Services

IFPS therapists routinely recommend aftercare services. While linkages to other services can be conceptualized as an outcome of IFPS, the provision of these services also is an intervention. More research is needed that examines whether families access the recommended services and sustain use of the services. The relationship between service use and attainment of ultimate outcomes also is in need of study.

Practitioners might want to consider giving focused and systematic attention to helping families use services by assessing their perceived need for services and potential barriers to service use. The assessment could include data on prior service use, the families' current willingness to use services, and barriers to use of ongoing services. IFPS therapists frequently use genograms, which are diagrams of family trees that include information about the quality of relationships among family members. The routine use of ecomaps, or diagrams of families' relationships with social systems in their environments (including church, school, and social agencies), might shed light on families' linkages with and attitudes toward providers as well as potential barriers to service use. IFPS also might consider conducting follow-ups after IFPS termination for the purpose of helping families troubleshoot barriers to service use.

These findings can be added to those of other studies that suggest multiple influences on service use. These include clients' perceived need for services and enabling factors at the client and community levels.

Acknowledgments

This research was funded by the National Institute of Mental Health (1RO3MH56297-01). The author thanks Terri Combs-Orme and three anonymous reviewers for their suggestions on earlier drafts of this article.

References

1. Forsythe P: Homebuilders and family preservation. *Children and Youth Services Review* 1992; 14:37-47.
2. Kinney J, Haapala D, Booth C, et al.: The Homebuilders model. In: Whittaker JK, Kinney J, Tracy EM, et al. (Eds.): *Reaching High-Risk Families: Intensive Family Preservation in Human Services.* New York: Aldine de Gruyter, 1990, pp. 31-64.
3. Whittaker JK, Tracy EM: Family preservation services and education for social work practice: Stimulus and response. In: Whittaker JK, Kinney J, Tracy EM, et al. (Eds.): *Reaching High-Risk Families: Intensive Family Preservation in Human Services.* New York: Aldine de Gruyter, 1990, pp. 1-11.
4. Barth RP: Theories guiding home-based intensive family preservation services. In Whittaker JK, Kinney J, Tracy EM, et al. (Eds.): *Reaching High-Risk Families: Intensive Family Preservation in Human Services.* New York: Aldine de Gruyter, 1990, pp. 89-112.
5. Grigsby RK: Theories that guide intensive family preservation service: A second look. In: Morton ES, Grigsby RK (Eds.): *Advancing Family Preservation Practice.* Newbury Park, CA: Sage, 1993, pp. 16-27.
6. Besharov DJ: Looking beyond 30, 60, and 90 days. *Children and Youth Services Review* 1994; 16:445-452.
7. Yelton SW, Friedman RM: Family preservation services: Their role within the children's mental health system. In: Wells K, Biegel DE (Eds.): *Family Preservation Services: Research and Evaluation.* Newbury Park, CA: Sage, 1991, pp. 223-240.
8. Adams P: Marketing social change: The case of family preservation. *Children and Youth Services Review* 1994; 16:417-431.
9. Stroul BA: *Series on Community-Based Services for Children and Adolescents Who Are Severely Emotionally Disturbed,* Vol. 1: *Home-Based Services.* Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center, 1988.
10. Unrau YA: Predicting use of child welfare services after intensive family preservation services. *Research on Social Work Practice* 1997; 7:202-215.
11. Wells K, Whittington D: Child and family functioning after intensive family preservation services. *Social Service Review* 1993; 76:55-83.
12. Pfeiffer SI, Strzelecki SC: Inpatient psychiatric treatment of children and adolescents: A review of outcome studies. *Journal of American Academy Child and Adolescent Psychiatry* 1990; 29:847-853.
13. Allerhand M, Weber R, Haug M: *Adaptation and Adaptability: The Bellefaire Follow-up Study.* New York: Child Welfare League of America, 1966.
14. Blotcky MJ, Dimperio TL, Gossett JT: Follow-up of children treated in psychiatric hospitals: A review of studies. *American Journal of Psychiatry* 1984; 141:1499-1506.
15. Gossett JT, Lewis SB, Lewis JM, et al.: Follow-up of adolescents treated in a psychiatric hospital: I. A review of studies. *American Journal of Orthopsychiatry* 1973; 43:602-610.
16. Meyerson AT, Herman GS: What's new in aftercare? A review of recent literature. *Hospital and Community Psychiatry* 1983; 34:333-342.
17. Solomon P, Evans D, Delaney MA: Use of aftercare services by children and adolescents discharged from a state hospital. *Hospital and Community Psychiatry* 1993; 9:932-934.
18. Schuerman J, Rzepnicki TL, Littell JH: *Putting Families First: An Experiment in Family Preservation.* New York: Aldine de Gruyter, 1994.
19. Epstein MH, Quinn K, Cumblad C: *Needs Assessment Procedures and Measures.* DeKalb, IL: Educational Research and Services Center, 1993.
20. Quinn KP, Epstein MH, Cumblad CL: Developing comprehensive, individualized community-based services for children and youth with emotional and behavior disorders: Direct services providers' perspectives. *Journal of Child and Family Studies* 1995; 4:19-42.
21. Quinn K, Epstein MH, Cumblad C, et al.: Needs assessment of community-based services for children and youth with emotional or behavioral disorders and their families: II. Implementation in a local system of care. *Journal of Mental Health Administration* 1996; 23:432-446.
22. Soderlund J, Epstein MH, Quinn KP, et al.: Parental perspectives on comprehensive services for children and youth with emotional and behavioral disorders. *Behavioral Disorders* 1995; 20:157-170.
23. Andersen RM: Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior* 1995; 31:1-10.
24. Hu T-W, Snowden LR, Jerrell JM, et al.: Ethnic populations in public mental health: Services choice and level of use. *American Journal of Public Health* 1991; 81:1429-1434.
25. Staudt M: *The Use of Aftercare Services following Intensive Family Preservation Services.* Paper presented at the Tenth National Symposium on Doctoral Research in Social Work, Columbus, OH, May 8, 1998.