



Consistency of outcomes of home-based family treatment in The Netherlands as an indicator of effectiveness



Jan W. Veerman^{a,*}, Ronald E. De Meyer^b

^a Behavioural Science Institute, Radboud University, PO Box 9104, 6500 HE Nijmegen, The Netherlands

^b Praktikon, Radboud University, PO Box 6909, 6503 GK Nijmegen, The Netherlands

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ABSTRACT

Most youth care interventions are not supported by evidence from experimental or quasi-experimental studies. Yet children and families have to be treated and financiers and policy makers are asking value for money. For these reasons, evidence from practice-based studies should not be overlooked. Particularly, strengthening the designs of these studies could yield useful indications of effectiveness. The present study shows how this can be done by analyzing consistency in group and individual outcomes over time and across locations. Pre- and post-measures of behavior problems were collected over nine consecutive years at three locations in The Netherlands from nearly 900 children whose families received Intensive Family Treatment (IFT), a home-based treatment for multi-problem families. Over the years, the overall effect size was 0.66 (range of 0.51–0.80). Further analysis showed that these effects were stable over time and across locations. The reliable change index showed that about 63% of the children improved significantly during treatment (range of 56–68%) and 9% deteriorated or relapsed (range of 6–13%). These changes were also stable over time and partially stable across locations. The consistency of these results serves as an empirical indication of the effectiveness of IFT. Due to the lack of studies using control groups, such consistency might help practitioners choose promising interventions that would support their clients and be accountable to financiers and policy makers.

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1. Introduction

Youth care interventions are increasingly required to be evidence based. Ideally, studies that include a control group and random assignment would support the efficacy of an intervention. The randomized controlled trial has become the gold standard for establishing evidence, as changes in the functioning of youth and their families could be ascribed to the intervention that was studied (APA Presidential Task Force on Evidence-Based Practice, 2005; Bower, 2003; Shadish, Cook, & Campbell, 2002). If these experimental designs are not feasible, evidence from quasi-experimental designs utilizing some form of control (e.g., untreated group, placebo group, and wait list group) would be accepted as an alternative. The growing number of internet databases that summarize effective treatments for youth consider the evidence only from these two kinds of studies as sound empirical support (see for instance Blueprints for Healthy Youth Development, www.blueprintsprograms.com; and The California Evidence-based Clearinghouse, www.cebc4cw.org). However, in practice, most youth care interventions do not have such evidence gathered on their behalf (Kazdin, 2003; Thoburn, 2010). It is estimated that not more

than 10% of youth prevention and intervention programs meet this requirement (Kumpfer & Alvarado, 2003; Veerman & Van Yperen, 2007). Furthermore, in the Dutch database of The Netherlands Youth Institute (NJI), which currently (October 2015) contains 220 interventions for youth and families with psychosocial problems, the same percentage (22 interventions) meets this requirement (www.jeugdinterventies.nl). Obviously, there are significant obstacles to the implementation of evidence-based interventions (Axford & Morpeth, 2013; Weisz, Ugueto, Cheron & Herren, 2013). In the meantime, children and their families who need care have the right to receive that care, and it is practically impossible and ethically unacceptable to withhold interventions and wait for the necessary evidence supporting these interventions.

Given this situation, it would be very informative to learn more about the effects of interventions from experiences in practice and to turn around the flow of evidence. Instead of taking the top-down route, in which evidence-based interventions are studied in a controlled situation and then implemented in practice, we might take a bottom-up route. This means we take the current state of youth care as a point of departure and encourage practitioners to conduct their treatment as usual. At the same time, we insist that they formulate an explicit theory that shows how and why an intervention is supposed to work and offer empirical data to show that an intervention does what it is supposed to do – bring beneficial changes to the lives of their clients. Veerman and

* Corresponding author.

E-mail addresses: jw.veerman@pwo.ru.nl (J.W. Veerman), r.demeyer@acs.w.ru.nl (R.E. De Meyer).

Van Yperen (2007) argued that explicating the theoretical foundation of an intervention and delivering empirical signs of beneficial change are two important steps on an effect ladder that ranges from knowing nothing about the effects of an intervention to establishing cause–effect relationships. By insisting too much on (quasi-)experiments as the gold standard for evidence and for the publication of studies, we have no idea about the effectiveness or ineffectiveness of most youth care interventions (Kazdin, 1997; Thoburn, 2010).

To establish this kind of knowledge, it is very important to conduct practice-based studies with at least two measurements, one at the start and one at the end of a theoretically well-founded intervention, with one or more standardized instruments aimed at measuring the expected outcomes. Methodologically, this is a pre–post design without a control group (Shadish et al., 2002). A major critique of such a design is that it does not tell us much about the cause–effect relationship. However, not looking at the results of such studies because they do not meet the gold standard, and therefore not publishing them, leaves practitioners and administrators with empty hands in front of their clients, policy makers, and insurance companies. Although the gold standard should not be abandoned, the reality is that in the practice of care, RCTs are difficult to conduct as intended, which undermines the strengths of this design: internal validity and statistical power to detect significant changes (James, Asscher, Dekovic, Van der Laan, & Stams, 2013). Jacobs (2003) maintained that experimental designs are not feasible to use with the vast majority of child and family programs, and therefore we should be satisfied with less rigorous research designs that are ‘good enough’. Moreover, as we discuss later in this introduction, it is possible to strengthen the evidence from this design (Axford, Little, Morpeth, & Weys, 2005; Reynolds, 2004).

The present study focuses on showing empirical indications of the effectiveness of an intervention that possesses a solid theoretical base. The treatment at stake is Intensive Family Treatment (IFT) (known in Dutch as IOG) carried out in The Netherlands. IFT is a home-based family preservation program developed in the 1990s. The general aim is to prevent out-of-home placement of children at risk of such placement. The next section presents the content of this intervention in more detail. The Dutch database of effective interventions in youth care classifies IFT as ‘theoretically well founded’ (www.jeugdinterventies.nl). IFT is also one of 17 Dutch family preservation services in a meta-analysis that showed a medium overall pre–post effect size of 0.52 for externalizing behaviors and 0.55 for parenting stress (Veerman, Janssens, & Delicat, 2005). IFT had an effect size of 0.60 and 0.58, respectively. A later Dutch study on IFT confirmed this result (Veerman, De Meyer, & Roosma, 2007).

In the present study, we will report outcome data of IFT from subsequent years collected in different locations and analyzed in different ways. This fulfills the ‘consistency principle’ Reynolds (2004) introduced. According to Reynolds, consistency of association between treatment exposure and outcome ‘indicates whether the estimated program effect is similar across sample populations, at different times and places, under different types of analyses and model specifications, and for similar intervention theories. The greater the consistency of findings favoring positive effects, the more likely the observed effects are real’ (Reynolds, 2004, p. 20). To conduct different analyses, we used group statistics as well as individual statistics to look for changes in children’s behavior problems. Group analyses are used in almost all change studies. Such analyses usually compare the group means of an outcome measure before and after treatment and use a statistical test to decide whether improvement has occurred. An effect size is calculated to determine the magnitude of the observed changes (mostly Cohen’s *d*). However, as Hiller, Schindler, and Lambert (2012) maintained, group analysis has a limitation in that it does not provide information about changes that have taken place in individual clients, and hence it provides no information about the relative proportions of clients who respond to the treatment. Group statistics also provide no information on who improved after the treatment and who did not. Hence, there is

growing consensus among treatment researchers that individual treatment outcomes should be evaluated and reported in addition to group analysis (Barkham et al., 2008; Nelson, Warren, Gleave, & Burlingame, 2013). We used the reliable change index (RCI) to analyze individual treatment outcomes (Jacobson & Truax, 1991). Briefly, the RCI indicates change that is very likely to be greater than chance. Moreover, by including a criterion for normal and problematic functioning, several patterns of change can be identified. This is further outlined in the *Analyses* section. Based on the earlier Dutch studies, we expected positive outcomes from the group analysis as well as from the individual analyses. Furthermore, we expected these outcomes to be stable across years and locations, thereby fulfilling Reynolds’ principle of consistency.

2. Method

2.1. Participants and treatment

Participants were Dutch youths aged between four and 18 years, who had been referred to Intensive Family Treatment (IFT) at three youth care agencies in three provinces in the north and east of The Netherlands and completed their treatment between 1999 and 2008. IFT is a home-based family-preservation service for families with several severe psychosocial problems (often characterized as multi-problem families), such as parenting problems, marital problems, behavior problems of the child(ren), parent–child interaction problems, financial problems and housing problems. Out-of-home placement of a child is often perceived as imminent; however, the families are not always in crisis, as is the case with Families First (FF), on which IFT is modeled. FF is a four-to-six-week Dutch program offered to families facing an acute crisis (Veerman, De Kemp, Ten Brink, Slot, & Scholte, 2003). This program is based on the American Homebuilders model (Kinney, Haapala, & Booth, 1991). Services encompass a range of treatment techniques rooted in learning theory, systems theory, and communication theory. These techniques include behavioral instruction, behavioral exercise, modeling, motivating, and setting daily routines. Family workers are thoroughly trained in these techniques and receive continuous supervision on the job. The techniques are outlined in a treatment manual and recorded during the course of the treatment (Ten Brink et al., 1997; Ten Brink, Veerman, De Kemp, & Berger, 2004). In a review of the Washington State Institute for Public Policy programs, the Homebuilders programs were judged effective in preventing out-of-home-placement (Lee, Aos, & Miller, 2008). Although the reasons for referral and the content of the treatment are similar to those of FF, in the absence of an acute crisis IFT is allowed to last longer (up to nine months, with a mean of about five months), and a family worker visits families in their homes twice a week. Most treatment goals are related to out-of-home placement, mostly to prevent placement, but also to shorten placement or to facilitate reunification.

A part of the treatment in Dutch family preservation services involved the use of standardized instruments to rate the nature and severity of child behavior problems and parenting stress. The results of individual checklists were discussed with the primary caretakers (mostly the natural parents), and they were used to set goals and to evaluate treatment progress. In the present study, the data of the checklist assessing child problem behaviors gathered between 1999 and 2008 were used to evaluate IFT. Every family that completed a checklist twice, at the beginning and at the end of treatment, was included in the present study. To guarantee the independence of the data, one pair of checklists per first admitted child of a referred family was allowed, and we collected each one at the start and end of treatment after the parents of the referred family had completed them. The checklists completed by mothers were preferred to those completed by fathers in the event that both parents completed the checklists during treatment. The rationale here was that the mother is usually the primary caretaker, and therefore plays a more active role in dealing with the child’s behavior problems.

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