EVALUATION OF THE LIVE-IN THERAPY PROGRAMME : A REPORT OF PRELIMINARY FINDINGS[1]

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By

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[1] Thanks are given Ms Juliana Toh and Mr Gerard Ee, the two family therapists of the Family Learning Centre, for their guidance, support and inputs throughout the study.

Abstract

The present study employs a pre- and post-treatment design to evaluate the effectiveness of the Live-in Therapy Programme of the Family Learning Centre. Dimensions for evaluation include family functioning, goal achievement, service acceptability and accessibility, and inter-agency collaboration. Both qualitative and quantitative data are collected from multiple sources, namely clients, therapists and staff of collaborating agencies. Instruments employed include the Family Adaptability and Cohesion Scale (FACES III) by Olson, Portner and Lavee (1985) and the Clinical Rating Scale (CRS) by Olson (1993) for family functioning, the Goal Attainment Scaling (GAS) by Kiresuk and Sherman (1968) for goal achievement, Client Satisfaction Scale - 8 (CSQ-8) by Larsen, Attkinsson, Hargreaves and Nguyen (1979) for service acceptability, and self-constructed items on clients' perceived accessibility and the quality of inter-agency collaboration. Two cases from the preliminary findings from March to November 1999 are presented. Due to the small number of subjects at the present stage, no statistical evidence of the effectiveness of the Programme can be shown. However, data from different sources indicated that the Programme is effective in improving the family functioning of the families, is acceptable and accessible to low-income multiple problem families. Also, it was found that the Programme is effective in complementing the work of professionals of collaborating agencies. Finally, suggestions on the completion of the study are introduced.

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Contents

1.0 Brief Description of the Family Learning Centre and the Live-in Therapy Programme

The Family Learning Centre (FLC) is dedicated to providing specialised therapeutic interventions, mainly through the Live-in Therapy Programme, for low-income community experiencing multiple problems. The Programme is conducted within a simulated home environment. It dispels the common belief that low-income community is unmotivated to participate in therapy.

The Programme operates on the principle that co-operative therapeutic relationships can be developed with low-income community if conditions such as having basic needs taken care of and met. They can be receptive to specialised therapeutic interventions.

Hence, the Programme views itself as a complementary part of an integrated family support service. It acknowledges that its target clientele would require both practical as well as specialised service. This specialised service also operates with generic front-line service providers.

The 3 broad phases of intervention are Preparation, Live-in Therapy, and System Evolvement.

The main task during the Preparation Phase is to identify and orientate potential families to the aims and working of FLC. When families express a clear desire to participate in the programme as a means to addressing their problems, mutually agreed goals for therapy are then established with the therapeutic team.

Since one objective of the Programme is for the FLC to share professional expertise and facilitate mutual learning experiences with other VWOs, effort is put into inviting staff of other VWOs to collaborate on cases.

The main task during the Live-in Therapy Phase is for the team to observe family interaction, identify patterns which disturb family functioning and highlight strengths in order

to meet the goals of therapy. Interventions are then introduced and reinforced over the period of stay.

The main task of the System Evolvement Phase involves the evaluation and reflection of the Live-in on the therapeutic system which includes therapy team, caseworkers from other VWO's and the family. Recommendations for future interventions and follow-up work with the family are subsequently made to caseworker.

Continued work with the family is crucial to reinforce learnt behaviours arising from the Live-in experience. This is will give time for family to stabilize and incorporate the behaviours or interactions into a more functional way of living. The possibility of a second Live-in might be discussed and offered to the family during this phase. Consultation by therapy team is provided to caseworker for a period of six months.

2.0 Evaluation Goals and Objectives

2.1 Evaluation Goals

a. To assess the effectiveness of the Programme as an intervention strategy for low-income families with multiple problems.

b. To assess the effectiveness of the services provided by the FLC in complementing the work of other VWOs.

The above goals can be broken down into the following objectives.

2.2 Evaluation Objectives

a. To assess the effectiveness of the Programme with regards to improvement to family's functioning.

b. To assess the effectiveness of the Programme with regards to acceptability for low income families with multiple problems.

c. To assess the effectiveness of the Programme with regards to accessibility for low income families with multiple problems.

d. To assess the effectiveness of services provided by FLC with regards to complementing work done by professionals from other VWOs.

e. To assess the quality of collaboration between FLC and other welfare organisations as perceived by their counsellors or social workers.

3.0 Methodology

A multi-trait, multi-method approach is used in the present study. An overview of the methods employed to measure the intended objectives are shown in Table 1 below.

Table 1 : Methodology of the Evaluation

	Qualitative	Quantitative	Objective
Clients	1. Goal Attainment Scaling 2. -- 3. --	1. FACES III 2. CSQ-8 3. Items on Perceived Accessibility	a b c
Therapists	---	CRS	a
Collaborating Agencies	Open-ended questions and follow-up discussions.	Likert scale items on the perceived improvement in clients' family functioning, acceptability and accessibility of the programme to families, usefulness of the Programme to caseworkers involved and other professionals of their agencies and quality of working relationship.	a b c d e

Since the evaluation is divided into three parts, namely the quantitative, qualitative and the inter-agency collaboration, the methods of each part will be discussed separately.

3.1 The Quantitative Analysis

3.1.1 The Family Adaptability and Cohesion Evaluation Scales (FACES III) and the Clinical Rating Scales

3.1.1.1 Theoretical Background

The Circumplex Model of Marital and Family System (Olson, Russell, & Sprenkle, 1989; Olson, Sprenkle, & Russell, 1979 was adopted as the theoretical background in this part.

The Circumplex Model was designed to bridge the gap between research, theory and practice (Olson et al., 1989). In their review of the fifty concepts commonly employed by family and marital systems theorists (Beavers & Hampson, 1990; Benjamin, 1977; Epstein, Bishop, & Levin, 1978), Olson (1993) concluded that most of the concepts, such as 'Affiliation', 'Affective Involvement', 'Interdependence' and 'Behaviour Control' can be grouped under the dimensions of ' Cohesion', 'Adaptability' and 'Communication'. These three concepts form the basis of their theoretical model.

Family cohesion, according to Olson et al., (1983), is 'the emotional bonding that family members have toward one another' (p.70). The variables of emotional bonding, boundaries, coalitions, time, space, friends, decision making, and interests and recreation are used to measure and diagnose families in this aspect.

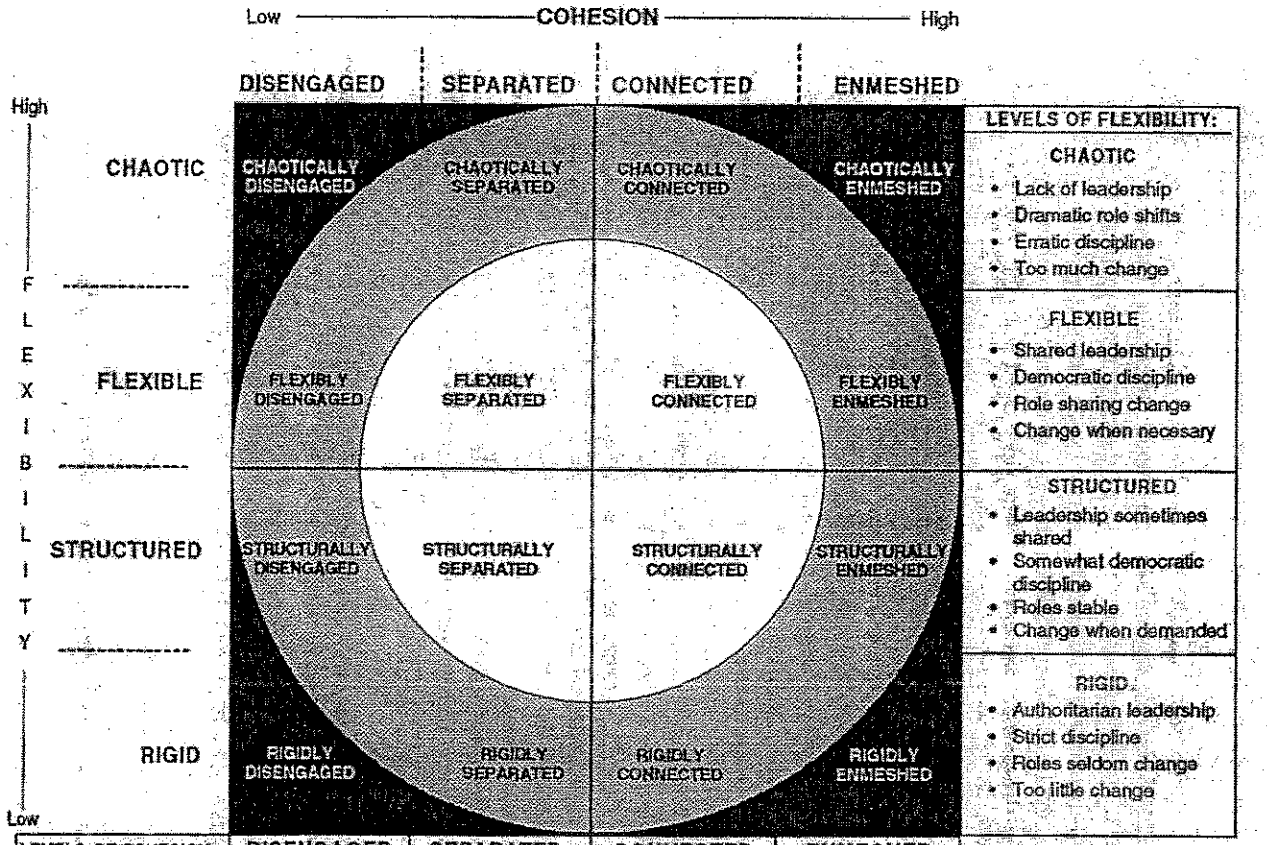
The four levels of family cohesion are 'Disengaged', 'Separated', 'Connected' and 'Enmeshed'. For optimal family functioning, the family has to be in the balanced or midrange regions ('Separated' and 'Connected' regions). Falling into either extreme ends is indicative of family having difficulty being emotionally connected with one another.

Family adaptability is 'the ability of a marital or family system to change its power structure, role relationships and relationship rules in response to a situational and developmental stress.' (Olson et al., 1983, p.70). The four levels of family adaptability are

'Rigid', 'Structured', 'Flexible' and 'Chaotic'. The family has to be in the 'Structured' or 'Flexible' regions to be functioning optimally. Being in 'Extreme' regions is indicative of family having difficulty adjusting the power structure, rules and role relationships in response to situational and developmental changes.

Based on the concepts of cohesion and adaptability, Olson et al., (1983) provided a framework for classifying families. This is shown in the following figure :

Figure 1



LEVELS OF COHESION:	DISENGAGED	SEPARATED	CONNECTED	ENMESHED
I - We Balance:	I	I-we	I-We	WE
Closeness:	Little closeness	Low-moderate	Moderate-high	Very high closeness
Loyalty:	Little loyalty	Some loyalty	High loyalty	Very High loyalty
Independence/ Dependence:	High independence	Interdependent (More independence than dependence)	Interdependent (More dependence than independence)	High dependency

(Source : Gorall & Olson, 1994)

Apart from 'Cohesion' and 'Adaptability', there is the third dimension of family 'Communication'. Olson et al., (1983) considered this to be a facilitative dimension having a

critical role in facilitating couples and families to move between the dimensions of 'Cohesion' and 'Adaptability'.

The Circumplex Model provides a very useful visual guide for both clinical and research purposes. Knowing the category from which the family is functioning at point of contact might facilitate therapists in designing and executing appropriate clinical interventions (Olson, 1993). This is with the intention of moving them from less functioning to more functioning way of living.

The model, which focuses on two dimensions of family functioning as opposed to some traditional research which focuses on one dimension, offers researchers and evaluators a more comphensive and systemic picture of families. It also allows researchers to detect changes in families more accurately.

Another strength of the Circumplex Model is its applicability to a wide diversity of therapeutic goals (Olson, 1993). The summary of goals found suitable for family therapy using the model are: goals which focus on reducing presenting problems and symptoms; goals regarding marital and family systems which focus on changing the system from less functioning to more functioning; and metagoal which focuses on increasing family's ability to negotiate system change over time. This goal is preventive in nature.

As evident from the above goals, the model is in line with the goals and objectives of the Programme and FLC in improving the family functioning of low-income multiple problem families.

The Circumplex Model also takes into consideration the culturally diverse ethnicity of families (Gorall & Olson, 1996) as well as families in different stages of their family life cycle (Olson, 1993). These are in line with the families participating in the Programme as they are of different ethnicity (i.e., Indian, Chinese, Malay) having different family structure

Changes made by families are measured using the linear scoring scale (Olson et al., 1985). This is shown in Table 2.

Table 2 : Linear Scoring : Family Type

Cohesion			Adaptability			Family Type	
8	50 48	Very Connected	8	50 41	Very Flexible	8	Balanced
7	47 46		7	40 30		7	
6	45 43	Connected	6	29 27	Flexible	6	Moderately Balanced
5	42 41		5	26 25		5	
4	40 38	Separated	4	24 23	Structured	4	Mid-Range
3	37 35		3	22 20		3	
2	34 25	Disengaged	2	19 15	Rigid	2	Extreme
1	24 10		1	14 10		1	
____ Cohesion +			____ Adaptability			___/2	= Type

The scale is well-established with more than 400 studies utilising it. The scale had been validated and re-validated and used on different subject groups, including single parent families, families of drug abusers and runaway youths (Olson et al., 1985).

Clinical Rating Scale (CRS)

As mentioned in 3.0, a multi-trait, multi-method approach of data collection was used in the present study to obtain a comprehensive picture. The Clinical Rating Scale (CRS) is a tool used to gather information on family's functioning on the 'Cohesion', 'Adaptability' and 'Communication' dimensions from therapists' perspective.

and relational dynamics, presenting problems, and are at different stages in their family life cycle.

3.1.1.2 Subjects

Subjects are families receiving services from Bukit Ho Swee Family Service Centre or from other VWOs working in collaboration with FLC. On average, one family per month participated in the Programme since March 1999.

3.1.1.3 Instruments

The Family Adaptability and Cohesion Scale III (FACES III)[2]

Olson, Portner and Lavee's (1985) Family Adaptability and Cohesion Evaluation Scales III (FACES III) was employed to measure the family functioning of subjects, both before and after Live-in. The instrument was translated and back translated into both Chinese and Malay by two social workers, native speakers of the language and proficient in English respectively.

FACES III contains 20 perceived and 20 ideal items, with each item responding to a 5-point Likert scale, ranging from 1 = "almost never" to 5 = "almost always". The 20 questions measure two areas of family functioning, adaptability and cohesion, with 10 questions for each dimension. The discrepancy between the ideal and perceived family functioning provides an inverse measurement of family satisfaction. Greater difference is indicative of less satisfaction on family life.

[2] Thanks are given to Professor David Olson for his kind permission for employing both the FACES III and CRS in the present study.

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Therapists are invaluable source of information on the family and therapy process. Olson (1977) and Gurman and Kniskern (1981) emphasised the importance of having both 'insider's' and 'outsider's' perspectives of relationships in family therapy. Whereas FACES III provides information from 'insider's' perspective, CRS provides information from 'outsider's' perspective. As with FACES III, the theoretical basis of CRS is the Circumplex Model. It was suggested that the tool be used together with FACES III.

In the present study, the therapy team utilised the CRS to rate the family separately at the end of the first day of the Live-in and at the Follow-up stage (System Evolvement Phase).

3.1.1.4 Statistics

Scores on perceived family functioning and the discrepancy between the perceived and ideal family functioning obtained from FACES III are calculated. Linear scoring procedures are also performed (Olson & Tiesel, 1991). After the pre- and post-treatment scores are obtained, paired t-test for correlated groups will be performed using SPSSV9.0. A series of chi-square statistics as suggested by Olson et al., (1985) will also be carried out in light of the salient findings.

With regards to the CRS, after the scores of all the families (about 24) were collected, t-test was used to determine the changes within the families after the Programme. Scores of the CRS will also be compared with the scores of the FACES III, using appropriate statistics.

3.1.2 The Client Satisfaction Scale (CSQ - 8)

Attkisson's Client Satisfaction Scale (CSQ-8) (Larsen, Attkisson, Hargreaves, and Nguyen, 1979) is another well-established instrument for measuring clients' perception of the value of therapy received as well as treatment outcomes (Attkisson and Greenfield, 1994).

The scale contains 8 items with each item responding to a 4 point Likert scale, ranging from 4 = "Excellent" to 1 = "Poor".

The purpose of using this instrument in the post-treatment stage is to measure the acceptability of the Programme by low income families experiencing multiple problems. Higher scores on the instrument means greater perceived satisfaction.

The tool is one of the most widely used instrument in evaluative studies. It was used for patients with panic disorders (Aubry, Wilson, & Bilash, 1992), adolescents, children and families who received mental health services (Garland & Besinger, 1996; Plante, Couchman, & Diaz, 1995) and psychotherapy (Deane, 1993).

Scores of the CSQ-8 are added to obtain scores on clients' satisfaction.

3.1.3 Perceived Service Accessibility

Items on the accessibility of the Programme were constructed. As Quah (1998) had pointed out, five requirements should be met in order for a service to be accessible. The five requirements are quantitative adequacy, geographical distribution, cost affordability, information or education, and perceived accessibility. After considering their respective suitability for the present study, only the criteria of quantitative adequacy is selected. Items on this dimension are included in the Inter-Agency Collaboration Feedback Form for staff of collaborating agencies and a separate form on Perceived Accessibility for participating families.

3.2 The Qualitative Analysis

3.2.1 The Goal Attainment Scaling (GAS)

The GAS (Kiresuk & Sherman, 1968) is included in the present study to measure the effectiveness of therapy. This is evaluated on the basis of the alleviation of the presenting problem (Haley, 1976) or on meeting the goals set for therapy.

In the present study, the scale is also used to connect the quantitative and qualitative aspects of this research. Whilst FACES III and CRS focused on specific concepts of

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Adaptability, Cohesiveness and Communication, GAS provides information on the extent to which therapeutic goals set by the family have been achieved.

GAS is a systematic and objective tool that serves the purpose of evaluating goal attainment as established by families. Meeting the goals of families is a critical step in assessing the efficacy of family therapy (Gurman, Kniskern & Pinsof, 1986) and evaluation (Smith, 1976).

GAS was administered during the intake of the Live-in where therapeutic goals and other related issues were discussed and clarified. A maximum of 5 goals are identified. The team and family then prioritise and agree on the weightage of each goal to be addressed during the Live-in.

At follow-up, the team and family discuss the extent to which the therapeutic goals are attained. Scores were calculated using the formula suggested by Kireusk and Sherman (1968). A single standard score will be calculated for all families. A series of statistical comparisons of this standard score among the group will be made.

3.3 Analysis of the Quality of Inter-Agency Collaboration

A self-constructed questionnaire is distributed to the caseworkers collaborating on the Programme. The questions are divided into five areas: Programme's ability to help other agencies' existing services, meeting the therapeutic needs of low-income families with multiple problems, quality of inter-agency working relationship, the future utilisation of services provided by FLC and perceived demand for the Programme by the community.

Both open-ended questions and those responding on Likert scale ranged from 1 = "Strongly Disagree" to 5 = "Strongly Agree" are included in order to obtain qualitative and quantitative data. Items responding to Likert scale format are added to obtain scores on perceived accessibility.

3.4 Limitations of Methodology

The major limitation of the present evaluative study is the small number of subjects available, affecting both the statistical power and external validity of the quantitative findings. The lack of control group and groups in other treatment modes also poses problems to the validity of the findings.

Another limitation of the quantitative segment concerns the validity and reliability of the instruments employed. The two instruments chosen (FACES III and CSQ-8) were originally in English and translated into Chinese and Malay for the present study. Although back translation increased the validity of the instruments, no validation can be made in the present study because of the small number of subjects and lack of resources to conduct test-retest reliability.

Although Gorall and Olson (1996) have provided strong evidence to support the applicability of the Circumplex Model and FACES III to a wide diversity of ethnic groups, past validation was done using Anglo Saxon subjects. Therefore, the norm and cutting scores obtained may not be applicable to Chinese, Malay and Indian families presented here.

4.0 Preliminary Results

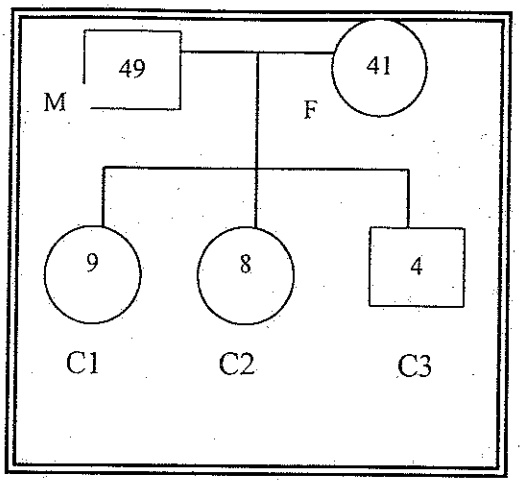
This research is currently in the preliminary data collection stage. Findings from detailed and extensive statistical analyses using t-test and chi-square are not yet available.

Therefore, only results gathered from two families (out of the six families) using FACES III, CRS, CSQ-8 and GAS will be presented along with a summary of the feedback by collaborating agencies.

4.1 Case One : The Ong Family[3]

[3] To ensure confidentiality, pseudonyms are used for the two families.

The family was referred to the Programme by CFSC to address their second daughter's stealing behaviour and parenting issues.

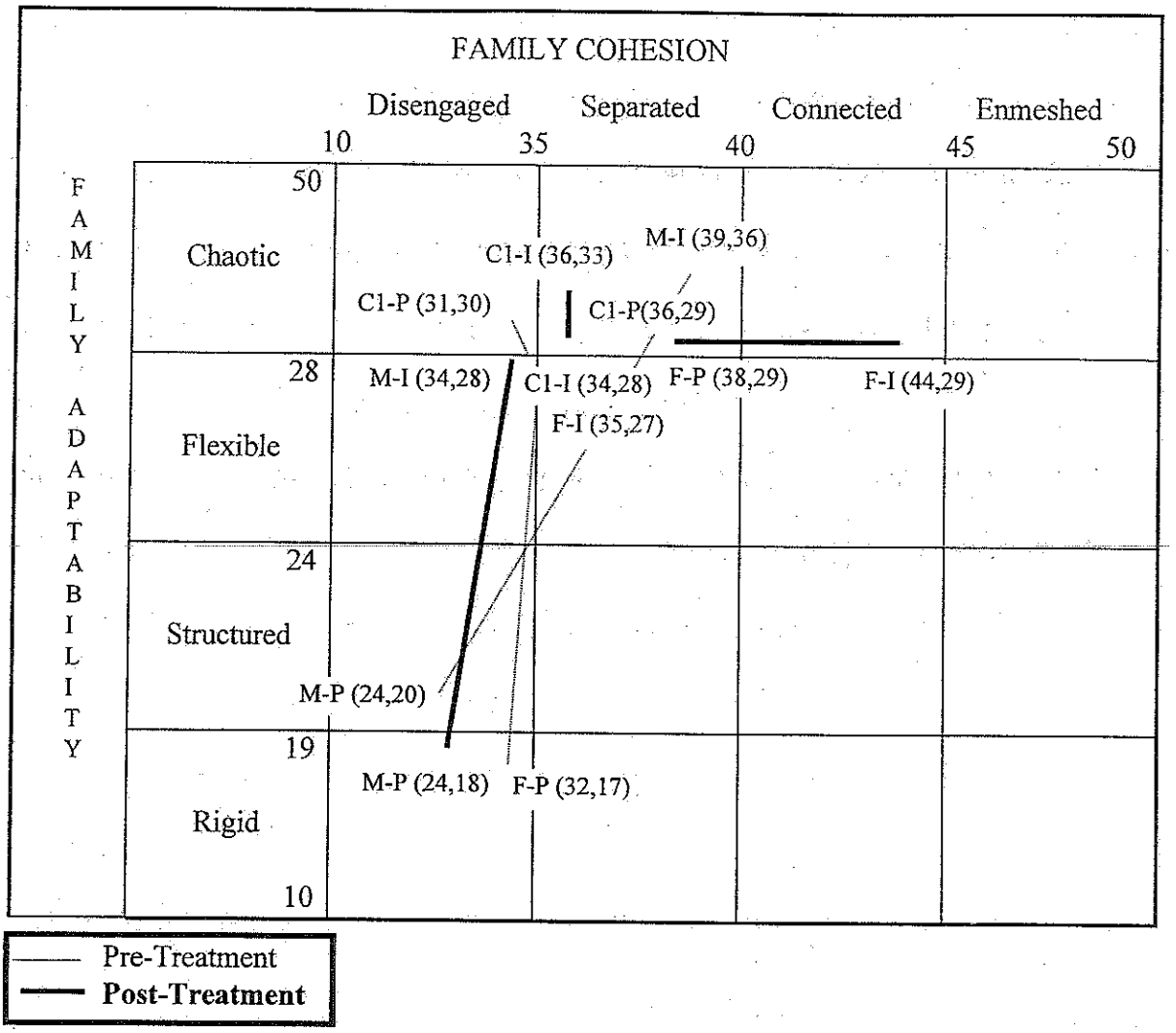


Father, the breadwinner of the family, had been imprisoned for outrage of modesty and released recently. Mother is a housewife.

Their children are of ages 9, 8 and 4.

Findings from FACES III both at intake and follow-up are shown in Figure 2.

Figure 2 : Findings of FACES III for the Ong Family



Using linear scaling (Table 3), mean linear scores obtained from perceived cohesion and adaptability scores of family members are presented below:

Table 3 : Linear Scores of the Ong Family

	Cohesion		Adaptability		Overall
	Score	Family Type	Score	Family Type	Family Type
Pre-Treatment	29	Disengaged	22	Structured	Mid-Range / Extreme
Post-Treatment	33	Disengaged	25	Flexible	Mid-Range

Findings from CRS are shown below:

Table 4 : Findings of CRS of the Ong Family

	Cohesion (1-8)		Flexibility (1-8)		Communication (1-6)	
	T1	T2	T1	T2	T1	T2
Pre-Treatment	2	2	3	8	4	1
Type	Disengaged	Disengaged	Structured	Chaotic	--	--
Post-Treatment	3	4	3	7	3	2
Type	Separated	Separated	Structured	Chaotic	--	--

Findings of GAS are shown in Table 5.

Table 5 : GAS of the Ong Family

Client : Ong

Level at Intake : _I__ | Level at Follow-up : _F__ | Guide Developed : 20/8//99 | Date of follow-up : 23/9/99

Check whether scale has been mutually negotiated between patient and FLC

Scale Headings and Scale Weightages

Scale Attainment Level	**Score**	Yes _√__ No ___ Scale 1 : C2's Stealing Behaviour W : 2	Yes _√__ No ___ Scale 2 : Parenting W : 2
a. Most unfavourable tx outcome thought likely	-2	C2 Continues to steal & frequency increases	F & M continue to fail to pay enough attention to C2, make her sad (contribute to her stealing behaviour) [I]
b. Less that expected success with tx	-1	C2 continues to steal without acknowledging stealing is wrong [I]	F & M recognise inadequate attention is given to C2 [F]
c. Expected level of tx success	0	C2 knows stealing is wrong and promises to stop	F & M decide to change their ways of parenting by giving more attention to C2.
d. More than expected success with tx	+1	C2's stealing behaviour stops for 1 month [F]	F & M show continuous actions in paying more attention and affection towards C2.
e. Best anticipated success with tx	+2	C2's stealing behaviour stops for an extended period of	Couple & C2 show consistent closeness.

		time (6 months)	

Table 6 below shows the scores of as well as the weightages of the different goals.

Table 6 : Findings of GAS of the Ong Family

Scale	Score	Weightage
1	2	2
2	1	2

According to Kiresuk and Sherman (1968), the following formula is used to calculate a single T-score with a mean of 50 and a standard deviation of 10 :

$$T = 50 + \frac{10\Sigma\omega_i x_i}{\sqrt{(1-\rho)\Sigma\omega_i^2 + \rho(\Sigma\omega_i)^2}}$$

where ω_i = weightages for each of the i (=2) in Table 6;
x_i = scores 'gained' in Table 6;
ρ = 'average correlation' among the i scales, usually given the value 0.3

$$\text{The score is } 50 + \frac{10 \boxtimes 6}{\sqrt{0.7(8)+0.3(16))}} = 68.6$$

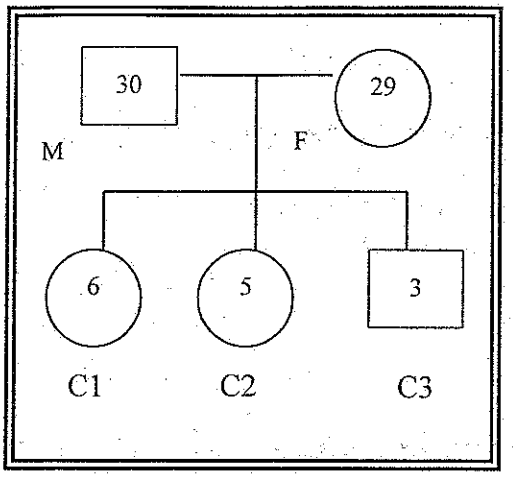
Findings of CSQ-8 and self-constructed items on service accessibility are as follows

:Table 7 : Findings of CSQ-8 and Items on Service Accessibility of the Ong Family

	Score	
	F	M
How would you rate the quality of service you have received ? 4 Excellent 3 Good 2 Fair 1 Poor	3	4
2. Did you get the kind of service you wanted ? 1 No, definitely 2 No, not really 3 Yes, generally 4 Yes, definitely	4	3
3. To what extent has our programme met your needs ? 4 Almost all of my needs have been met 3 Most of my needs have been met 2 Only a few needs have been met 1 None of my need have been met	4	3
4. If a friend were in need of similar help, would you recommend our programme to him or her ? 1 No, definitely not 2 No, I don't think so 3 Yes, I think so 4 Yes, definitely	4	3
5. How satisfied are you with the amount of help you have received ? 1 Quite Dissatisfied 2 Indifferent or mildly dissatisfied 3 Mostly satisfied 4 Very satisfied	3	4
6. Have the services you received helped you to deal more effectively with your problems ? 4 Yes, they helped a great deal 3 Yes, they helped 2 No, they really didn't help 1 No, they seemed to make things worse	4	4
7. In an overall, general sense, how satisfied are you with the service you have received ? 4 Very satisfied 3 Mostly satisfied 2 Indifferent or mildly dissatisfied 1 Quite Dissatisfied	4	3
8. If you were to seek help again, would you come back to our programme ? 1 No, definitely not 2 No, I don't think so 3 Yes, I think so 4 Yes, definitely	4	4
Services Accessibility		
1. Did you find it convenient to join the Live-in Therapy Programme ? 1 Yes 2 No	1	1
2. Based on your own experience, do you think it will be easy for other families to join the programme ? 1 Yes 2 No	1	1

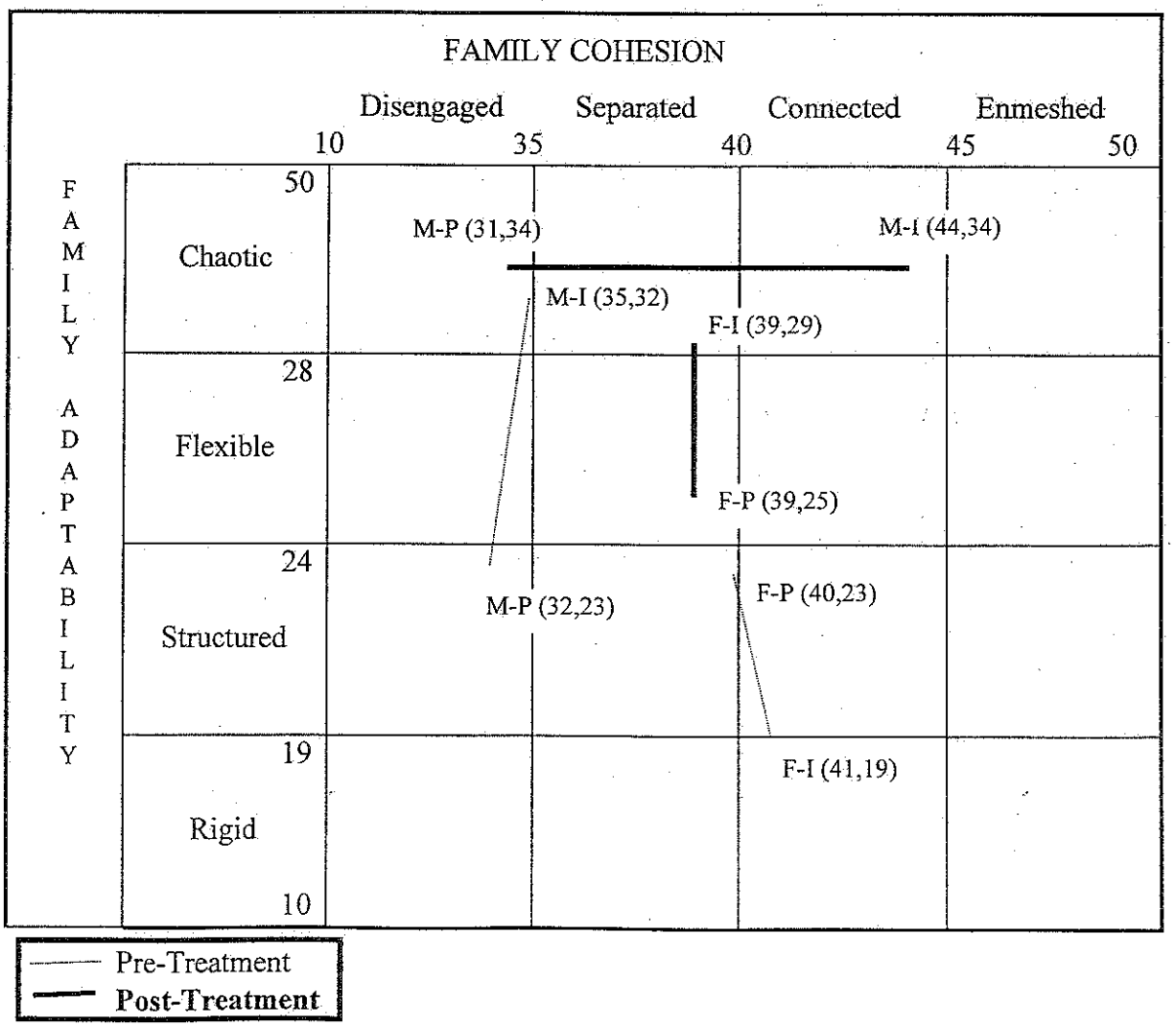
4.2 Case Two : The Gopal Family

The family was referred by BHSSSC to the Programme for marital and parenting issues. Wife had left the matrimonial home, with the children, following a quarrel with her husband. The couple also had different views about parenting. Husband was mandated for counselling at CFSC. At intake, husband was unemployed and pleading for wife's return.



Findings from FACES III both at intake and follow-up are shown in Figure 3.

Figure 3 : Findings of FACES III for the Gopal Family



Using linear scaling (Table 3), mean linear scores obtained from perceived cohesion and adaptability scores of family members are presented below:

Table 8 : Linear Scores of the Gopal Family

	Cohesion		Adaptability		Overall
	Score	Family Type	Score	Family Type	Family Type
Pre-Treatment	36	Separated	23	Structured	Mid-Range
Post-Treatment	35	Separated	30	Very Flexible	Moderately Balanced

Findings of CRS (based on the global ratings) are shown as follows :

Table 9 : Findings of CRS of the Gopal Family

	Cohesion (1-8)		Flexibility (1-8)		Communication (1-6)	
	T1	T2	T1	T2	T1	T2
Pre-Treatment	3	2	3	2	2	2
Type	Separated	Disengaged	Structured	Rigid	--	--
Post-Treatment	6	6	3	2	3	2
Type	Connected	Connected	Structured	Rigid	--	--

Findings of GAS are shown in Table 10.

Table 10 : GAS of the Gopal Family

Client : Gopal

Level at Intake : _I__ Level at Follow-up : _F__ Guide Developed : 21/6/99 Date of follow-up : 27/7/99

Check whether scale has been mutually negotiated between patient and FLC

Scale Headings and Scale Weightages

		Yes _√__ No ___ Scale 1 : Marriage W : 2	Yes _√__ No ___ Scale 2 : Parenting W :3
Scale Attainment Levels	**Score**		
a. Most unfavourable tx outcome thought likely	-2	Couple separates and father drinks	Couple quarrels a lot over parenting methods [I]
b. Less that expected success with tx	-1	Couple provokes each other by mentioning ex-boy/girl friends. Frequent quarrelling [I]	When there is a disagreement on parenting issues, couple argues with intermittent heated exchanges.
c. Expected level of tx success	0	Couple stay in the marriage for children	When there is a disagreement, couple separates & does not talk to each other for a while
d. More than expected success with tx	+1	Couple can still stay at home (without running away) after quarrels; quarrels can be settled quickly and couple is patient in listening to each other [F]	One person takes care of the children without being asked by the other
e. Best anticipated success with tx	+2	Couple shows a lot of trust to each other and can co-operate on house matters	Couple can discuss what to do with children [F]

Findings of the GAS are shown in Table 11 below.

Table 11 : Findings of GAS of Gopal Family

Scale	Score	Weightage
1	2	2
2	4	3

Similarly, by using the same formula as we used in Case One, the single T-score is

$$50 + \frac{10 \boxtimes 16}{\sqrt{0.7(13)+0.3(25)}} = 89.3$$

Results from CSQ-8 for the Gopal family are shown in Table 12 below.

Table 12 : Scores of CSQ-8 of the Gopal Family

	Score	
	F	M
1. How would you rate the quality of service you have received ? **4** Excellent **3** Good **2** Fair **1** Poor	4	3
2. Did you get the kind of service you wanted ? **1** No, definitely **2** No, not really **3** Yes, generally **4** Yes, definitely	4	3
3. To what extent has our programme met your needs ? **4** Almost all of my needs have been met **3** Most of my needs have been met **2** Only a few needs have been met **1** None of my needs have been met	3	2
4. If a friend were in need of similar help, would you recommend our programme to him or her ? **1** No, definitely not **2** No, I don't think so **3** Yes, I think so **4** Yes, definitely	4	3
5. How satisfied are you with the amount of help you have received ? **1** Quite Dissatisfied **2** Indifferent or mildly dissatisfied **3** Mostly satisfied **4** Very satisfied	3	2
6. Have the services you received helped you to deal more effectively with your problems ? **4** Yes, they helped a great deal **3** Yes, they helped **2** No, they really didn't help **1** No, they seemed to make things worse	3	3
7. In an overall, general sense, how satisfied are you with the service you have received ? **4** Very satisfied **3** Mostly satisfied **2** Indifferent or mildly dissatisfied **1** Quite Dissatisfied	3	3
8. If you were to seek help again, would you come back to our programme ? **1** No, definitely not **2** No, I don't think so **3** Yes, I think so **4** Yes, definitely	3	3

Service Accessibility

1. Did you find it convenient to join the Live-in Therapy Programme ?		
1 Yes 2 No	1	1
2. Based on your own experience, do you think it will be easy for other families to join the programme ?		
1 Yes 2 No	1	1

4.3 Findings of the Quality of Inter-Agency Collaboration

Caseworkers from the 3 collaborative agencies expressed that the Programme had positive impact on the families and themselves.

The Programme provided caseworker with new information, insights and a different experience of the family. They experienced the working relationship between themselves and FLC team to be facilitative in promoting mutual learning, in sharpening of clinical skills and clarifying of professional values. It was a valuable experience, which they would recommend to fellow professionals from other VWOs.

It was further mentioned that the time frame provided by the Programme created time and space for problem solving, helping families demonstrate commitment towards problem resolution, addressing unresolved and connected issues and facilitating positive experiences of family interactions. Undoubtedly, the Programme improved the family functioning of the participating families and can meet their needs.

They all expressed that the quality of collaboration they had with staff of FLC has been good and allowed a lot of mutual sharing of professional expertise. They would continue to utilise the services provided by the FLC.

There was a consensus that the Programme is an acceptable and accessible intervention for low-income families experiencing multiple problems. They all agreed that there is a need for the Programme in the community and the Programme is serving the function of filling in a service gap. It should be promoted to other VWOs.

5.0 Discussion

Figures 2 and 3 illustrate pre- & post- Live-in changes to family functioning as perceived by both families. The changes differ in magnitudes and directions.

For the Ong family, before participated in the Programme, Father perceived family functioning to be 'Rigidly-Disengaged' and a month later, to be 'Chaotically-Separated'. This implied that Father's perception of family functioning moved from the 'Extreme' to 'Mid-Range' region.

On the other hand, Mother perceived family functioning to be 'Structurally-Disengaged' at the time of intake and moved to 'Rigidly-Disengaged' at point of follow-up. Although there was a change in the family type, her perception moved from the 'Mid-Range' to the 'Extreme' region.

At intake, C1 perceived family functioning to be 'Chaotically-Disengaged'. At follow-up, perceived family functioning moved to 'Chaotically-Separated' in the mid-range region, indicative of a shift towards a more balanced family functioning.

For the Gopal family, similar results were also indicated. Husband's perceived family functioning before participated in the Programme was 'Structurally-Separated'. At the time of follow-up, it was 'Flexibly-Separated'. Both types of family functioning are under the 'Balanced' category. This implied that Husband's perception of family functioning had been balanced and remained so after the Programme.

However, Wife's perception of family functioning changed from 'Structurally-Disengaged' to 'Chaotically-Disengaged' after participated in the Programme. This was a shift from the 'Mid-Range' to the 'Extreme' region.

The data represented in Tables 3 and 8 indicated a one level shift in family types as perceived family functioning changed in the two families. Family type for the Ong's shifted

from 'Extreme'/'Mid-Range' to 'Mid-Range', whilst the Gopal family shifted from 'Mid-Range' to 'Moderately Balanced' family type.

The overall shift in family type implied an overall change in family functioning in the positive direction for both families. It would seem that the interventions introduced during the Live-in phase brought forth systemic changes. More importantly, the families experienced some mastery over the skills introduced and continued to use them, thus affecting family interaction and functioning.

Although goal attainment in therapy does not necessarily translate into a more functional family type, in the case of the Ong's and Gopal's, it did. Results from GAS (Tables 5 & 10) show positive changes and support the shifts made by the families. Both families reached their therapeutic goals in different magnitudes.

The two goals of the Ong family were 'C2's stealing behaviour' and 'parenting'. The baseline level of the first goal was 'C2 continues to steal without acknowledging stealing is wrong'. At follow-up, the family reached the level 'C2's stealing behaviour had stopped for 1 month'. For the goal of parenting, changes were also observed from 'couple failed to pay enough attention to C2' to 'they recognised inadequate attention was given to C2'.

GAS scores of the Gopal family also showed similar positive results. The couple changed from the level of 'provoking each other by mentioning ex-boy/girl friends' to the level of 'they can stay at home after quarrels, quarrels can be settled easily and they are patient in listening to each other' after participating in the Programme. As for their parenting issue, the couple moved from 'quarrelling a lot over parenting methods' to 'they can discuss what to do with children'.

However, scores obtained from CRS were contrary to findings from FACES III. For the Ong family, members were perceived by therapists to have shifted along the 'Cohesion'

dimension whereas family members perceived themselves to have moved along the 'Adaptability/Flexibility' dimension.

For the Gopal family, therapists assessed them to have moved along the 'Cohesion' dimensions with the same degree of flexibility, whereas they perceived themselves to have been otherwise.

A possible explanation for the difference in perceptions of what have changed in the respective family functioning is that families can describe changes which are observable and concrete. They can see themselves and other members making behavioural changes, doing something different that brought about a more acceptable way of functioning. Emotional closeness might be too abstract a concept to be identified by family members at this point of change. Perhaps with passage of time, the cohesiveness or lack of it, could be experienced emotionally by the members. In addition, family members maybe more open to future interventions towards more balanced levels of functioning.

It might also be therapists' inclination to attend to emotional connections. Nevertheless, as therapists adopt a systemic view to change, a change along any dimension would affect relationships and family interaction. In a study by Fristad (1989), discrepancy in findings between the FACES III and CRS were found. In his study, he found that there was no significant correlation on 'Cohesion' and a negative correlation in 'Adaptability' ($p<.05$) between the two instruments. This implies that while clinicians rated families to be more chaotic, families rated themselves to be rigid. Kolevzon, Green, Fortune, and Vosler (1988) in their study of the comparison on different perspectives, found little agreement between families' and therapists' assessment of family functioning. Fiske (1975) and Gurman et al. (1986) advocate the importance of understanding the value of data collected from different sources rather than attempting to induce agreement among sources.

Our data show that there have been small changes in family type in Adaptability of FACES III and in Cohesion of CRS only. Being a latent dimension, we can expect there would not be any substantial changes in Communication of the CRS. Data from the two therapists confirm this view. For the two families, according to therapists' assessment there have only been small changes, and the families remained at more or less the same states of communication.

Findings from CSQ-8 clearly showed the acceptance and accessibility of the Live-in Therapy Programme to the two low-income multiple problem families. As observed in Tables 7 and 12, both families expressed that the Programme had met their needs they received. They were satisfied with the help rendered, and would seek the help from the Programme if future need arises. They found the Programme convenient and accessible. They also thought that it would also be convenient for other families to participate in the Programme.

6.0 Conclusion

In conclusion, although results from the quantitative part (FACES III and CRS) were contradictory in terms of which dimension the change took place; nevertheless, it indicated some positive changes in the direction of family functioning and family type. Qualitative findings from GAS and CSQ-8 were both encouraging and positive, with therapeutic goals being met and collaborating caseworkers benefitting from the Programme.

As far as the evaluation goals and objectives are concerned, results from the two families so far has indicated that the Programme is effective as an intervention strategy for low-income multiple problem families because it can improve their family functioning (Objective 2.2 a, p.2) and is acceptable and accessible to them (objectives 2.2 b, c, p.2). Besides, the Programme is effective in complementing the work of other welfare organisations. This is reflected from the feedback given by staff of collaborating agencies on

the usefulness of the Programme both to themselves and to their fellow professionals (Objective 2.2 d, p.3) and the good quality of working relationship they had with the FLC staff (Objective 2.2 e, p.3).

7.0 Future Directions

The collection of data and calculation of statistics as mentioned in the methodology segment will be continued. The following suggestions are made to enhance the continuation of the project and to overcome some of the difficulties involved.

1. Provide more intensive counselling during the 6 month follow-up period to help families sustain changes made during the Programme.
2. Further promote the Programme to VWOs in order that more families and fellow workers can benefit from the service.
3. Extend the Live-in Stage from 3 and a half days to 5 days to allow for more time to reinforce interventions and stabilize changes.

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