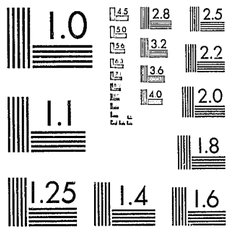

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Family Support Programs for Troubled Juveniles

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Contents

FAMILY SUPPORT PROGRAMS FOR TROUBLED JUVENILES

Ch. I. INTRODUCTION

Historically, the emphasis in child welfare has been on placement. The most highly developed services have been those that separate children from their families. Academic and training programs have taught placement. Resources have been invested in substitute care and programs which bypass or replace parents have prevailed. While early reformers affirmed the value of home and family as the basic institution of American society, programs did not reflect their convictions. Reform schools were built and institutions for children became a major industry. The first juvenile court (1899) and the Social Security Act (1935) legally and financially supported the removal of children from their homes and communities. Institutional commitment and foster home placement were the basic tenets of the child-saving philosophy. By 1970 the U.S. had become a leader among developed nations in the percentage of children in foster home and institutional care.[1]

In many localities placement has been the only developed alternative for agencies charged with the responsibility for the welfare of juveniles. Service programs for children and their families in the home have remained marginal; meantime, traditional methods of managing children and youth in trouble have been seriously challenged during the past three decades. Institutional and foster home care have not fulfilled either the modest or the grandiose hopes of their founders.

Prior to the age of accountability in child welfare (beginning about 1950) substitute care was utilized extensively without scrutiny. Since 1950 researchers have raised serious questions about the problems created by foster home care.[2] Similarly, numerous researchers have questioned the effectiveness of institutional care.[3] Very recent studies of the substitute care system have been well publicized and politicized.[4] Generally these studies point to the high psychological, social and economic costs of substitute care, its seemingly indiscriminate use, the absence of efforts to strengthen and maintain the child's family prior to placement, and the neglect of children in substitute care.

Spurred by these developments, we have witnessed the enactment of legislation during the past two decades which has permitted and encouraged the development and implementation of programs intended to serve as alternatives to institutional and foster home care for many children and youth.[5] Among these is Home Based Family Centered Services. But even with the support of recent legislation intended to deinstitutionalize noncriminal youth, progress in achieving effec-

tive alternatives has been exceedingly slow. New initiatives are invariably faced with the inertia of whatever is already in place. The energy generated by this process is sometimes misunderstood as an attack on the status quo. If there is a villain, it is the inertia. Indeed, more time and energy are probably expended in futile attempts to sustain old programs and failures, than in trying to create workable and effective alternatives. Planning, public education and staff training are necessary ingredients for change in any system. This has been no less the case in the evolution of Home Based Family Centered Care as a significant component in the child welfare system.

The Home Based Family Centered Service approach recognizes the family as the most powerful and primary social welfare institution. Professionals have long recognized the importance of the family to the development and amelioration of problems, but attempts to bring the family to the forefront in programming have not been widely established. Sigmund Freud emphasized the importance of the family relationship in regard to the general development of character and vital activity of the individual.[6] The power of family relationships and the primacy of human attachments is basic to the Home Based Family Centered model. Unfortunately, the practical application of what we know about the importance of keeping the parents in primary focus in planning and implementing treatment has been hampered by the emphasis of medicine and psychoanalysis on the one-to-one relationship. Patterned after its precursor, the religious confessional, psychoanalytic thought had a significant impact on the professional development of social work. But the Home Based Family Centered Service model places strong emphasis not upon cure, but on coping.

A. PRINCIPLES OF HOME BASED FAMILY CENTERED CARE

Home Based Family Centered care as discussed here began in 1950 with the St. Paul Family Centered Project.[7] Since then a number of similar programs have evolved throughout the nation. These programs have consistently reported relatively high success rates and costs significantly lower than the cost of substitute care. There are, however, significant variations among the programs, shaped by differences among communities, resources, targeted populations and program purposes.

The home based placement prevention programs generally tend to share the following principles:

1. A primary worker or case manager establishes and maintains a nurturing, supportive relationship with the family.

2. The programs offer small caseloads, staff availability and the utilization of a wide variety of helping options.

3. One or more associates who serve as team members or who provide back-up for the primary worker, and who usually meet regularly with the worker and the family.

4. Availability is assured twenty-four hours a day, seven days a week, with staff often serving as extended family.

5. The home is the service setting, and includes problem-solving efforts organized around the family's "system." This may involve the school, friends, relatives, police, employers, and so on.

6. Service is as complete, comprehensive, and intensive as is necessary to bring about problem resolution.

7. Maximum use is made of family resources, extended family, and community. Workers quickly discover and build on strengths in families, even in the most problematic families.

8. Provision of help with any problem presented. If the team does not have the expertise or resources needed, it arranges for or creates them in order to stabilize and improve family functioning.

9. The parents remain in charge of their family as educators, nurturers, and primary care providers. They are given renewed relevance and participate in setting program priorities, planning, and decision making.

In general, the Home Based Family Centered Care programs reflect the overarching principle that the first and greatest investment should be made in the care and treatment of children in their own homes.

B. A RATIONALE FOR HOME BASED FAMILY CENTERED SERVICE

While Home Based Family Centered Service is partly a reaction to the risks frequently associated with placement, the approach is more than a reaction. Its theoretical base is probably most strongly influenced by family systems theory and general systems theory. The activities of an in-house worker are based on the premise that there is no adequate substitution for the child's own family, particularly after the preschool years.

There are a number of advantages associated with Home Based Family Centered Care:

1. Of the children (families) who enter the service system, many are not amenable to more traditional in-office approaches; neither are the problems with which they are faced.

2. Home Based Family Center service is built upon a strong worker-family relationship; professional distance is avoided. The availability and consistency of the in-home worker tends to overcome the barriers of fear and mistrust so prevalent with families of children-at-risk or in severe conflict.

3. Those who will have the responsibility to maintain and sustain change are involved in the original program. This feature is best described by a former residential treatment staff member:

> Because the disturbing child had been selected as the one to enter the institution, the responsibility for change was really borne by him, rather than the problem causing environment: the family, the school, the neighborhood. With the child out of home, parents' motivation to change was sometimes abruptly diminished...It was not unusual for a child to be discharged after about eighteen months of treatment, to reappear three months later with the original problem. The final goal for these children was more adequate functioning within their own families and neighborhood schools. Training children to live in the institution was incongruent with this goal.[8]

4. In-home workers gain firsthand experience with the realities of the family's environment and struggles. Simply "being there" when the family experiences the greatest difficulties is often the catalyst for insight and programming ideas. Hidden problems related to basic needs, family relationships, or community relations can become quickly apparent to the worker.

5. Families' strengths are most obvious in their own homes. Acknowledgement of a family's strengths helps both worker and family to gain direction and hope.

6. Workers are able to utilize techniques that are appropriate to the needs of family members. The approach provides opportunity to correct the false assumption that clients should always be able to accommodate themselves to office interviews. Modeling, coaching, cueing, practicing—all are often necessary and can be encouraged within the home setting.

7. The approach provides judges, protective service workers, and families with an option which is more safe and comfortable for many families.

8. Focus is on the strengths of family units, not just the identification of problems.

9. Frequent contacts on the family's own turf can dramatically enhance the efficiency and coordination of services.

10. Home Based Family Centered care assures parents relevance and a role in the problem-solving task, conveys respect and responsibility, and helps avoid disenfranchisement.

11. The approach can help to facilitate planned, appropriate placement when necessary, placement based on sound, firsthand data and prognosis. Family members can be included in the decision-making, placement planning, and placement, as well as in the planning for return home, for permanent foster care, or for adoption.

12. Home Based Family Centered Service can often minimize the length of time spent in foster care, thus avoiding the problems of leaving children in limbo or losing them in the placement system.

Ch. II. APPLICATIONS OF HOME BASED FAMILY CENTERED SERVICE

The 1980 child welfare amendments to the Social Security Act (PI 96:272) modify the definition of child welfare services to emphasize preventive and reunification services. States are encouraged to plan and program for services designed to prevent placement. Agencies are faced with the necessity of identifying the most efficient and effective ways to utilize decreasing service dollars. Home Based Family Centered service challenges the public and private sectors to consider transition from a primary investment in substitute care, to investment of the available resources in strengthening troubled family units.

A. CHARACTERISTICS OF FAMILIES

It should be remembered that data on the characteristics of client families vary somewhat because of variation in agency criteria for service; thus, demographic data may vary among Home Based Family Centered service agencies. Home Based Family Centered programs serve a wide range of clientele in terms of income, type of problems, and family size and structure. Generally, however, the majority of families share the following characteristics:

1. Problems have been present for more than three years.

2. Problems are present in three or more areas of family life (e.g., school related, parent-child relationship, developmental).

3. Problems are severe.

4. Services have previously been extended by four or more community agencies.

5. Fifty percent of the families are single parent families.

6. For approximately half of the families, income is near or below the poverty level.

7. The community has known for several years of the family's dysfunction.

8. Fifty percent of the families have at least one member who has been involved with the juvenile court.

B. PROBLEM CATEGORIES

Often the event or presenting problem which stimulates referral is not the major issue for resolution or the primary focus of service. Specific behaviors which trigger referral for Home Based Family Centered care are legion. General problem categories are listed below:

1. Children at Risk of Abuse and Neglect

Existing child protective services have not been adequate, in either volume or quality, in their response to child abuse and neglect. The advantages of Home Based Family Centered service to families of children at risk of abuse and neglect include immediate and intensive crisis intervention services and monitoring. Treatment efforts begin with a comprehensive in-home assessment and then proceed with a flexible array of services designed to respond to families' needs.

Protective service staff often lack the time and training to undertake long-term intensive work with the family. Case management and service often involve coordinating and monitoring a variety of largely independent efforts. Thus, child protection workers may at times be unable to provide service which is realistically matched to the needs of the family facing placement. These circumstances too often lead to placement

when Home Based Family Centered care would be more appropriate if it were available:

Joan was a 20-year-old single parent of two children. When referred for Home Based Family Centered care her two-year-old son was already in foster care due to alleged neglect. Her four-year-old son was "unmanageable." Joan knew no methods other than physical discipline. She feared her four-year-old would also be taken from her.

Socially isolated, afraid of failing and unhappy, Joan's unsupported attempts to gain control of her son would have failed. A Home Based Family Centered program of training and support led to effective discipline. Initially the workers spent many hours with the family before the necessity for intensive support decreased.

Counseling, relocation, socialization, and a cooperative preschool were all part of Joan's program. Long-term foster care was avoided.

2. Developmental Disabilities

Some families, given the assistance and supporting services, prefer to care for their developmentally disabled member in the home. Institutional placement for children with developmental disabilities is sometimes sought because the resources at home have been exhausted. The development of in-home supports for these families can make it possible for the child to enjoy the benefits of living with his/her family. The parents can avoid emotional and physical exhaustion and at the same time learn to manage, teach and enjoy their developmentally disabled youngster.

3. Families with Disturbed Children

For disturbed children or adolescents and their families, Home Based Family Centered service avoids the problems inherent in leaving and re-entering the family and community. Treatment in the context of daily living integrates the important adults in the child's life into the treatment team as partners in the process.

John was a fifteen-year-old boy whose mother had recently died. He was being cared for by his father and grandmother. School personnel were increasingly concerned about his withdrawal from peers and teachers, and the bizarre fantasies he often shared, verbally and in writing. The worker's contacts with the boy and his father revealed that the fantasies were related to his strong desire to please his father.

The Home Based Family Centered worker developed and coordinated a service plan which included a class-by-class system of encouraging and recording appropriate in-school attention and interaction. The father was extremely threatened by Home Based Family Centered care and the Home Based Family Centered worker provided the school-home bridge. The father was helped to learn how to reinforce the appropriate in-school behavior and to provide age-appropriate expectations and attention.

The family's concept of "courage" had prevented the freedom to mourn the loss of mother. Mourning was facilitated during the in-house sessions. Residential placement probably would have precluded the involvement of John's father and grandmother. It was their intense participation, on the family's turf, which proved to be the key to the resolution of problems rooted firmly in the family system.

4. Implications for Minority Families

Minority children and youth make up a disproportionate percentage of the substitute care population. Black children constitute 22 percent of the youth in institutions and 36 percent of the children in substitute care, while blacks represent only 13.6 percent of the total youth population.[9] The cultural bias which has resulted in the placement of disproportionately large numbers of minority children and youth has been especially destructive for American Indian families.[10] Hispanic children are also over-represented in institutions for the neglected and dependent.[11] Indochinese families, now numbering almost 500,000 in the United States, bring cultural values and practices which are particularly well-suited to a Home Based Family Centered approach. Similarly, children from poor families are far more likely to be placed away from home.

Home Based Family Centered Service places a strong emphasis on the serving of basic needs, advocacy, and the development of self-advocacy skills. Housing, employment, transportation, adequate medical care, appropriate child care, and programs and experiences designed to enhance self-esteem are among the ways in which Home Based Family Centered Service programs combat the tendency of established institutions (medical, legal, educational, etc.) to sometimes disenfranchise minority, poor, and less educated families. These families should be of special concern to those who plan and implement Home Based Family Centered Service programs. Factors which render members of these families more vulnerable to being placed away from home include the following:

a. Cultural biases and misunderstandings often influence the decision to place. The Home Based Family Centered Service worker should be alert to the subjective nature of judgments and to the potential for over-reaction. What workers regard as neglect or abuse may really be unfamiliar customs, religious practices, beliefs, parenting practices, housekeeping and educational practices or standards, or eating patterns.

b. Parents often do not understand the documents, terminology, and proceedings of established institutions (courts, hospitals, and schools). In-home workers need to be prepared to represent the family in its negotiations with social service agencies.

5. Permanency Planning

As with much of our terminology, this phrase means different things to different people. For some, it has permeated practice for years. We first began to stress the importance of permanence[12] in the mid-sixties.

Permanency planning as a broad movement was prompted by the concern for children who were caught in the placement system. Thus, it began as an attempt to correct the system. This effort has involved an attempt to identify the characteristics of children served and their locations, to assess the barriers to the return of children to their own homes, and the establishment of a service program when appropriate. The purpose of the treatment program is to give the parents all the

support and service necessary for them to resume the care of their children. Such a program calls for the agency to extend itself in every respect to help parents. Home Based Family Centered Service stresses permanency planning and is designed to promote the following:

a. The accepting nurture which may make it possible for parents to gain the hope necessary to sustain effort in the face of threatening circumstances.

b. The time and resources to initiate and support a therapeutic partnership between foster parents and natural parents when possible and appropriate.

c. The opportunity for workers to do much more than merely tell parents what they must do in order to resume care of their children. The Home Based Family Centered worker provides a planned, sequenced program of service which may include didactic teaching, modeling, coaching, and encouraging. Integrating such teaching strategies with family counseling can provide service which is realistically matched to the needs of many families.

d. The time to facilitate, plan, and monitor increasingly frequent home visits by children who have been placed, leading up to reunification.

e. The monitoring of difficulties which may occur when a child returns home from having been in long-term care. Home Based Family Centered service can respond with immediate intervention, recognizing how important timing is to facilitating healthy readjustments.

A number of obstacles can stand in the way of attempts to reunify parents and children. Following is a list of the Parental Conditions and Parental Conduct which can be barriers to reuniting families, with notes as to the potential of Home Based Family Centered services for overcoming each barrier.

Parental Conditions--disabilities that are diagnosable and that incapacitate the parents so greatly that they cannot care for children.

a. Physical Illness--Homemakers or In-home Family Specialists may be able to assist the family to cope with even severe illness.

b. Low Intelligence--Although there are many special programs for children of low intelligence, there are virtually no programs for parents of low intelligence. Home Based Family Centered workers can adapt parenting materials so as to make them understandable for these parents and provide in-home programs of progressive teaching, training, and support in which many parents of low intelligence can learn to parent adequately.

c. Drug and Alcohol Addiction--A Home Based Family Centered treatment program may provide the best functional assessment of whether or not the drug dependency condition is treatable and/or whether the parent is willing to accept and utilize help. Coordination of all aspects of service by one worker helps to maintain gains from out-of-home treatment when the individual returns to the home and community.

d. Mental or Emotional Illness--If the parent wishes to care for the child/children; if gains made in hospitalization of a parent are not maintained in the home environment; or if no attempts have been made at treatment which included the entire family system of the parent, a Home Based Family Centered assessment would be in order. It may be more economical and less traumatic to place an adult caretaker in the home than to place the children.

Parental Conduct--this includes parental behavior that is detrimental to the child.

a. Poor housekeeping, lack of information about parenting skills, poor child supervision, and certain life styles.

b. Physical Abuse--Whether or not physical abuse is likely to occur or re-occur is often difficult to establish. Home Based Family Centered services provide the following advantages when family reunification is being considered:

(1) In-home assessment of the family's motivation and capacity to change.

(2) Daily (when appropriate) monitoring of a questionable family situation while the child is reintegrated into the family.

(3) Documentation which can be invaluable in determining whether the child is likely ever to re-

turn home and in providing evidence which would support termination of parental rights when necessary.

(4) Appreciation of and potential for altering the impact of forces external to the family (e.g., housing, unemployment).

6. Families of Juvenile Offenders

Three major systems share in the processing, treatment, and care of children and youth who are in trouble. These include the juvenile justice system, the public/private child welfare system, and the public/private mental health system. For purposes of this discussion "juvenile offender" refers to those subcategories of children and youth who come before the court. As a practical matter, the court often delegates responsibility for juvenile offenders to social welfare and mental health agencies. These may include the traditional delinquency and neglect categories, plus those added more recently: (PINS) "Persons in Need of Supervision," (CHINS) "Children in Need of Supervision," and (FINA) "Families in Need of Assistance."

As society has increased its intervention in and control of family life, many common noncriminal behaviors have been labeled "abnormal." The label "status offender" has been given to those youths who engage in behavior such as running away, being ungovernable, or certain types of school problems (e.g., truancy). In many jurisdictions status offenders comprise the largest percentage of cases coming before the juvenile court.[13] For example, one study found that among the 85,000 youth committed each year to correctional facilities, 70 percent of the girls and 23 percent of the boys were adjudicated status offenders.[14] Nine out of ten of the girls came from poor families, most of which were receiving public assistance.[15] Except for the habitual runaway, the Home Based Family Centered Service model often offers important advantages for work with this group. These include flexibility of program, focus on the family system, availability of staff, advocacy, and frequent presence in the home.

Traditional methods for managing the status offender have been similar to those used for youth who commit more serious offenses. The Juvenile Justice and Delinquency Prevention Act of 1974 and its 1977 amendment (PL. 93-415) provided states financial incentives to

treat delinquent and status offenders separately. But the need for enactment of state legislation, issues of federal regulations, and the reluctance of state government personnel to divert funds to local programs, have delayed progress. Many would agree that the status offender and his/her family should be served through the public child welfare agency rather than the court. Again, issues of budget guarding, state government mistrust of local capacities, need for the authorization and development of local leadership, the need for staff training and community education, and the tendency for judges, court and institutional personnel to cling to and build on the established system have hampered progress.

Youth with school or behavior management problems are considered particularly good candidates for successful Home Based Family Centered service. This may be explained by three factors: 1) focus on the family; 2) the emphasis given by Home Based Family Centered service programs to the entire family system and 3) the daily coordinating role and availability of the Home Based Family Centered worker. As reported earlier, the chronic runaway presents sometimes insurmountable problems for the Home Based Family Centered program because of his/her unavailability.

For families of volatile youngsters the intensity and flexibility of Home Based Family Centered Service can increase the possibility that counseling and intervention will occur when the family is most willing and able to change and before emotions and positions have solidified. The family and community systems in which the problems have arisen can be deliberately included in the treatment process. Crucial keys to assessment and remediation are accessible because the worker is often with the family in the home during times of crisis. Community authorities, who often push for placement and removal from the community, are often more willing to support Home Based Family Centered serice because of the availability and intensity of the service.

Ch. III. DEVELOPING A HOME BASED FAMILY CENTERED SERVICE PROGRAM

Most Home Based Family Centered Service programs have been developed as components of existing multiservice agencies; others have begun as new pilot agencies offering only intensive, comprehensive Home Based Family Centered care as an alternative to placement.

In recent years, state governments have been relying to a greater extent on purchasing from the private sector in order to carry out its general welfare mission. However, there has been considerable disagreement about the extent to which social services ought to be purchased from private vendors as opposed to being provided by public agencies. In particular, the issue is debated as to whether Home Based Family Centered Service is better provided directly by the public agency or purchased with public funds from a voluntary agency. Advantages may be cited for both.

Advantages of HBFCS In a Voluntary Agency	Advantages of HBFCS In a Public Agency
1. Voluntary agencies invariably subsidize their programs to some extent.	1. Avoids negotiation of referral.
2. Voluntary agencies tend to be smaller and less bureaucratic in structure and therefore more flexible.	2. Monitoring of vendors not necessary.
3. Voluntary agency responsibility is not as comprehensive and therefore may allow greater attention to detail and creative initiative.	3. Greater number of resources and options available, especially if agency is integrated.
4. Voluntary agency personnel generally have smaller caseloads.	4. If agency is integrated, the continuity of worker-family relationship can be maintained.
5. Local initiative, voluntary effort, citizen direction.	5. More likely to serve families most in need of service.
6. Voluntary agency personnel generally have greater access to supervision.	6. HBFCS can become component of a total child welfare services plan.
7. Greater visibility of program.	7. Avoids complexities of creating a new agency.
8. Expansion can be more readily controlled.	
9. Supports the "decentralization of government" trend.	

The development and inititation of a new service involves a great deal more than can be detailed in this paper. Generally the steps include planning, public education, and staff selection and training. To be considered are program goals, geographic area and population to

be served and implications of the program for the agency and community. Documentation of need may include review of existing services. Is the purpose of the Home Based Family Centered Service program to reduce the incidence of unnecessary and inappropriate placements among severe to moderately dysfunctional, at-high-risk-for-placements families? If so, a more intensive, comprehensive program is indicated. If the program is intended to be more generally preventive in nature and applied at an earlier stage, then a Home Based Family Centered program of moderate intensity may be appropriate. The design, scope and "personality" of the program will emerge from the identified needs of the specific community.

Public Education

Just as planning is a precursor to program innovation and implementation, public education is a prerequisite to change. One way to gain public support for the program is to share the concept, need, and potential of Home Based Family Centered care with civic and religious organizations, other agencies and groups, and with legislators. A well-planned public education program will allow for dialogue, once the concept of Home Based Family Centered service is shared. An effective public education endeavor will:

1. Reach individuals who vote and contribute to political candidates' campaigns and those directly or indirectly involved in planning or delivering human services.
2. Encourage a review of traditional methods for managing troubled children, the rationale for those methods, and the current state of practice.
3. Present the advantages of Home Based Family Centered service, including cost- and service-effectiveness and social and psychological considerations.
4. Present clearly the principles and concepts of the Home Based Family Centered service approach to service delivery.
5. Present the appropriate applications of Home Based Family Centered service.
6. Provide written data and information which can be shared with legislators, policy makers, boards, friends, and other interested groups and individuals.
7. Identify and discuss implications for the community.
8. Challenge the public to view family and child welfare as a community responsibility.
9. Specify various ways in which individuals and/or groups can participate (in program design and implementation, e.g., as board members, volunteers, consultants).

Staff Recruitment

Working intensely with families in the home does not appeal to many professionals. While the type and level of formal education may vary with agency policy, funds available, and type of clientele, a general list of characteristics desirable in Home Based Family Centered workers are:

- A capacity to see the family as a system and the ability to coordinate.
- A commitment to the family as the basic social welfare institution.
- An interest in and knowledge of systems and family systems theory.
- A basic caring about others and the capacity to convey this in a constructive manner.
- The capacity to be assertive, and to nurture, support, and advocate.
- The capacity to teach and model behavior.
- The willingness to tolerate a flexible work day.
- The capacity ot listen and hear.
- The capacity to promptly analyze a situation and take action.
- The capacity to be pleased with small gains.
- The willingness to employ a variety of helping techniques and skills, and to seek and utilize consultation.
- A basic understanding of human behavior and development.
- Knowledge of the community and its service system and the ability to provide, secure, or create needed services.
- The ability to relate with and understand ethnic, minority, and value systems other than one's own.
- The ability to assume a variety of roles and perform an array of tasks with families and family members.
- The ability to work in teams and with groups.

Staff Training

The key to the success of a service program is the quality of

staff recruited and the initial and ongoing training provided. Unfortunately, staff training is often neglected. Family and child welfare workers will ordinarily be more comfortable and effective in working with family units on their own turf if they are deliberately trained to provide Home Based Family Centered service. Training is also good for staff morale. It can increase motivation, stimulate creativity, and decrease burnout.

Some theories and assumptions about people or families will need to be discarded as being either harmful, nonproductive, misleading, erroneous, or not applicable for Home Based Family Centered service. However, many can be adapted for home use. Existing Home Based Family Centered service programs have developed and tested training programs which include appropriate traditional skills, techniques, and values.

A training program for Home Based Family Centered staff should stress the following topic areas.

- Discussion of participants' views of people, families, and family relationships.
- Acquaintance with the general scope, philosophy, nature and purpose of Home Based Family Centered service and the agency program in particular.
- How to do an in-home assessment.
- How to develop a service plan in collaboration with the family.
- How to contract with families and/or community agencies and how to monitor a service plan.
- How to respond to emergencies, calm people down, and provide structure.
- How to relate to and work with a variety of problematic situations.
- A variety of counseling and teaching skills and techniques, parenting and modeling skills, and when and how to utilize them.
- How and why to avoid negative and misleading labeling.
- Ways to motivate self and others.
- How to build trust and develop relationships.
- How to gather information, organize, and present it in a functional manner.

- How to recognize and utilize the family's agenda.

- Knowledge of variation in learning styles and capacities of people.

- Acquaintance with ways of responding to lack of problem resolution and absence of client progress.

- How to bring about case closure and plan follow-up.

- A working acquaintance with the community to be served.

- Acquaintance with, exposure to, and knowledge about minority and low socioeconomic families, values and cultural backgrounds.

- Acquaintance with, exposure to, and knowledge about the human services delivery system in the catchment area (e.g., health, education, welfare, housing, recreation, social, legal).

- Appropriate record-keeping and reporting skills.

(For more information on staff training, see June C. Lloyd and Marvin E. Bryce, Techniques of Placement Prevention and Family Reunification: A Practitioners Handbook, Iowa City, Iowa: The University of Iowa, 1980.)

Supervision

Supervisory models in Home Based Family Centered Service programs are shaped by the nature of the program and the philosophy and theoretical framework embraced by the staff. The type and extent of supervision varies. Variables among programs which influence the supervisory structure include:

1. Geographic Area Served: Workers who are more isolated tend to function more autonomously and with less frequent supervision. Phone conferences are commonly used between scheduled supervisory sessions. Generally, these workers are selected because of their maturity and experience.

2. Intensity of Service: The amount of supervision tends to increase with the intensity of service.

3. Agency Policy: Some agencies, as a matter of policy, allow for a relatively fixed amount of supervisory time. Others leave this to individuals involved.

4. Level and Type of Training and Experience: Home Based Family Centered Service agencies with professionally trained staff tend to devote less time to supervision. Agencies utilizing individuals from nonsocial work disciplines may not be familiar with traditional supervision procedures.

5. Characteristics of Clientele: Agencies serving the more severely dysfunctional and multiproblem families devote more time to supervision.

6. Team/nonteam: Where in-home workers work in teams, a peer consultation process occurs which tends to diminish the emphasis given to the traditional supervision model.

Where authority is assigned or structured more on a horizontal or parallel basis (in contrast to the vertical, bureaucratic pattern), communication is more easily facilitated and power more easily shared. This structure facilitates group peer supervision and is favorable to the casework approach. The worker must be aware that the provision of services to the family is an agency responsibility, not just the task of the worker. An available, supportive, nurturing, and helpful supervisory/consultative format is vital to the worker and to the integrity of the program. Preferably, the agency will make available to the staff both individual supervision and group peer consultation. In addition, provisions should be made for an ongoing staff development program and for job advancement, reward, and recognition opportunities.

Staff turnover in Home Based Family Centered Service programs has been relatively low. The following factors contribute to the low staff turnover:

- Provision for the worker to spontaneously have a "mental health day" off.

- Sharing of responsibility and work with team members.

- Recreation.

- Ample vacation time.

- Mutual recognition of creativity and performance under pressure.

- Appreciation of dedication.

- Administrative and supervisory personnel who provide a supportive, nurturing atmosphere.

- Open communication channels and opportunities that make the staff readily accessible to each other at every level.

- Teams that allow for the sharing of case responsibility.

- Staff training relevant to the work they do.

- Gratification that comes from the workers' frequent presence with the family in the home and community and the accompanying opportunities to help in problem areas most relevant to the family.

- Gratification realized by success with families who have often been discarded as hopeless by other agencies and by the community.

- The opportunity to maintain continuity of relationship with the same family unit for several months.

- A reduced caseload and agency structure that make it possible to provide the type and extent of help which matches the family's needs.

Supervision of family treatment thus addresses many different dimensions. It is concerned with structural elements within the family, its social history, and the agencies that are providing family services. Family hierarchy and communication patterns are objects of continual scrutiny; in fact, systematic interaction among family members can mirror problems or imbalance within a helping agency's own structure.

The worker's supervisor is part of the therapeutic system. To ignore this fact can disrupt any well-intentioned family treatment plan; therefore, supervision must address not just the skill of the worker, but, also, the ongoing operational development of the supervisory system. Supervisors should periodically join the in-home worker while the family is in the home. Live supervision is important in work with family systems and being in the home helps the supervisor maintain a realistic and informed perspective.

Ch. IV. SKILLS AND TECHNIQUES

Methods and procedures for in-home assessment vary considerably among Home Based Family Centered programs. The variables which seem to affect the choice of procedures include the following:

- Type and size of family.

- Nature of the presenting problems.

- Family priorities.

- Urgency of needs.

- Theoretical orientation of agency personnel.

- Program goals.

- Intensity of program and availability of staff.

Assessment is important as a means of providing the worker with information upon which to base the beginnings of a service program and identify important areas upon which to focus. With the active utilization of the family members as colleagues and consultants, problems can be clarified and confusion reduced. Options for solutions can be considered, goals established, and hope that things will get better can be generated.

Scientific methods and technological advances have permeated every aspect of our mechanistic society. Emphasis is increasingly given to measurable results and outcome which can be documented by the application of scientific principles that usually include tools or instruments thought to have a respectable degree of validity and reliability. This phenomenon, however, presents some problems for the social sciences, where work with complex human beings and an infinite number of variables frequently make precise measurement difficult. Attempts to apply the scientific method may at times come into conflict with the values and humane principles upon which social work is founded. But measurement, accountability and documentation of success are criteria upon which funding is often dependent. They also, on occasion, encourage us to wed ourselves to a single technique or procedure without paying close enough attention to the uniqueness of each situation. The tendency is sometimes to seek one "prescription" or formula which we can then apply with every family. This practice is often reassuring to staff. It is understandable that we would like to be able to say, "This is what I do, and this is how I do it" with every family. But to proceed in a fixed manner with every family is to ignore the existence of important differences, a problem common not only to families but to professionals as well. Engraved procedures are likely to render us useless to many families. Becoming locked into one theoretical orientation or procedure also closes doors to future learning.

The point to retain here is that common sense, intuition, and humane concerns must not be discarded in favor of a rigid "technique" or procedure. Techniques and procedures are not goals, but means and processes to be utilized to gain information, facilitate communication, stimulate thinking, and manifest feelings. Techniques are utilized to practice problem solving, increase coping skills, reduce stress, and promote therapeutic interaction. The purpose of the hundreds of treatment techniques, exercises and procedures are as myriad as family problems. Retention of that which is most personal, most human, authentic and natural about the worker lends credibility to the treatment techniques and procedures. The worker can then learn to utilize comfortably a variety of therapeutic interventions.

The Home Based Family Centered team should be prepared to assume a number of different roles and to apply the techniques and skills appropriate to each. Generally these functions include nurturing and re-parenting, teaching and training, counseling, coordination, and advocacy.

Ch. V. EXAMPLES OF HOME BASED FAMILY CENTERED SERVICE PROGRAMS

The programs below were selected to depict variations in geographical location, agency auspices, and staffing patterns.

Home and Community Treatment

This program is a component of the Wisconsin Department of Health and Social Services system. The program began in 1969 because gains made with children in residential treatment were not being sustained after discharge, resulting in a high recidivism rate. The residential staff essentially extended the skills and techniques utilized in the institution to the family, home and community. The program serves families and children who present excessive aggression or withdrawal, inordinate dependency or independence, or developmental dealy. The seven staff members, all experienced professionals, represent six disciplines.

Focus of the service is on parent-child interaction. Child management techniques based on social learning theory are basic to the program philosophy. Thirty-six percent of staff time is devoted to work with client families, and twenty-four percent of staff time is spent on training and consultation in other communities.

Homebuilders

Homebuilders, the Home Based Family Centered Service program sponsored by the Catholic Community Services of Tacoma, Washington, began in 1974. The service is as intense as necessary and is relatively short-term (6-8 weeks). The initial objective is to halt disintegration of the family, reduce stress, and avoid placement. Followup service is provided by a Mental Health Center or the Department of Social Services when indicated.

Clients of Homebuilders are viewed as colleagues who have important information about their situation. Family members become invaluable consultants to the staff. It is assumed that diagnoses, tests, and evaluations do not necessarily prove that a family's future is hopeless; indeed, the program's experience has been that very few families who say they want to stay together are, in fact, "hopeless." Labels are avoided because of their problems or limitations. For example, labels:

- Often refer only to one family member.
- Bear little correlation to behavior.
- Do not specify what needs to change.
- Tend to discourage and set a negative example.
- Are often so vague as to render them meaningless.
- Mean different things to different people.

Traditional evaluations, which take several days or weeks and can delay service, are not considered appropriate for families in crisis. Motivating clients is included in the worker's job description. This helps avoid the mind-set that clients who do not meet worker expectations are unmotivated for change. Staff attitude, orientation, philosophy, and respect for clientele are part of the helping process.

Youth Services, Inc.

Located in Philadelphia, this voluntary multiservice child care agency implemented its Home Based Family Centered Service program in 1974. Funded by the William Penn Foundation, the agency transferred the resources and skills of the child care and social work staff to the homes of very needy families. Generally, families facing placement of one or more children are referred by the city public welfare department. The families tend to be neglectful and meet the criteria for abusing parents, with a long history of connections with other service agencies, physical or mental abuse, or gross physical and emotional deprivation. Most are minority families living with a great deal of environmental stress. The purposes of the Home Based Family Centered program are to help families set individual and family goals, learn more effective coping and parenting skills, and improve their physical and emotional environment.

Certain philosophical assumptions and standards, traditionally held as absolutely essential, were restrained or diluted to allow for the Home Based Family Centered program component. This Home Based Family Centered Service program is based on the following convictions:

- Some children entering placement could be better served if the appropriate quality and quantity of concrete and psychological services provided to the child in placement could be provided the youngster at home.
- The provision of concrete and casework services to family members must be agreed to by the parents.
- Disorganized family life, while a function of psychological stress, is also a function of lack of goods, services, and experience in implementing the routines which contribute to family organization.
- Parenting and family management skills can be taught and learned. The teaching and learning, however, will be most effective when taking place within the current reality of family life.
- The costs of the service will not be inexpensive. However, the cost of serving an entire family will approximate the cost of placing one child outside the home.

The Youth Services program is based on the traditional residential treatment model which assumes that the role of the social worker-therapist and that of the Family care worker should be separated.

Parents and Children Together

The Parents and Children Together demonstration project in Detroit is funded by the Wayne County Department of Social Services. The program, begun in 1977, is housed at the Department of Family and Consumer Resources at Wayne State University. University faculty are used as consultants, and students in the Human Development and Relationships program serve as counselors.

Referrals come from the Wayne County Department of Social Services and must meet a series of intake screening criteria established by the agency. The program emphasis is on developing home management skills.

Each student counselor serves six to eight families. The home support services include: child care, parent workshops, surrogate parent program, surrogate siblings program, moving services, and home repair services.

FAMILIES

FAMILIES began in 1974 in West Branch, Iowa, and provides exclusively Home Based Family Centered Service. The agency was created in response to the closing of one of the large state institutions for disturbed children. The program was funded for the first two years by a Title XX contract with the State Department of Social Services. The program was expanded in 1976 and has since been supported with state mental health funds by an annually negotiated purchase-of-service contract.

During the first two years, the agency served families in a six-county area with at least one member who had already been destined for placement in an institution. In 1976 the program expanded to serve nine counties and families with a member destined for any type of out-of-home placement, e.g., foster home care, shelter care.

Half of the nine-county population of 500,000 resides in two cities. In addition to the central administration office, branch offices are also maintained in the two largest cities. Workers live in the communities they serve and, generally, work out of their homes. All referrals are determined and made by the county departments of social services or the juvenile courts. FAMILIES does not screen referrals except when staff time is available.

Iowa Children's and Family Service In-Home Support Program

This voluntary multiservice agency added an in-home support unit in 1976. Each worker serves four to five families. Funding is primarily from purchase of service contracts. The program is based on a "systems" approach to understanding and intervening in family systems. In-home support service is provided to families with one or more children at high risk of placement, and to families with children returning from placement. Intervention aids the family in restructuring interactions between family members and in improving how the family interacts with members of other systems. Homemakers are utilized, as are the professional services of other service units within the agency.

Champaign County Mental Health Center, Child Adolescent Program, Champaign, Illinois

This program serves adolescents who are destined for institutionalization as a result of acts of violence and severe psychosocial dysfunction. The service program recognizes the youth's needs for a pragmatic and structured plan with consistent attention from an interested adult and opportunities to make personal decisions. Intervention ordinarily occurs in the home environment and is comprehensive, multifaceted, organized and persistent. Goals are organized around seven "life domains" which include the following: family life, social interpersonal relationships, thought processes and emotions, education, employment, leisure activities, and personal care/physical health.

Over 90 percent of the adolescents served have remained in the community and 85 percent have continued to live in their own homes.[19]

The Washington Program

The State of Washington recently revised its juvenile code in an effort to prevent placement and promote deinstitutionalization. In 1969, various groups began encouraging the state legislature in Washington to adopt a new juvenile code. Group-home beds had doubled in ten years. Referrals were being made for placement on a somewhat indiscriminate basis with little regard for the potential for reuniting the family. A pattern emerged where one resource after another was being "burned up" as a result of the "automatic placement response" to family crises. Obviously, the foster care budget reflected the increasing rate of placement. Between 1969 and 1975, the six bills introduced failed to gain enough support to pass both Houses. Court directors and judges, in general, wanted minimal reform, limited to procedural safeguards. Prosecutors and civil libertarians wanted to change the basic concept of the juvenile court. The issue did not have high priority within the legislature or with the public at large. Faced with this continuing stalemate, the senate judiciary committee decided to put aside comprehensive bills for the time being and concentrate on what it considered to be the most pressing need: reform of laws relating to incorrigibles.

Senate Bill 3116. Alternatives for Incorrigibles, was actively lobbied by Legal Services and the American Civil Liberties Union.

Both Houses passed the bill in the special session of 1976. It provided that "incorrigible" children--those who are found by the court to be "beyond the control and power" of parents--could not be sent to institutions after July 1, 1977.

One of the significant points of the bill was that for the first time responsibility for providing services to these children was placed with an agency other than the courts and the correctional institutions. The Department of Social and Health Services was directed to develop a plan for providing alternatives for incorrigible children along the lines of services it already provided, through its child welfare programs to homeless, neglected, and dependent children.

The most obvious effect of the passage of S.B. 3116 was a reduction in population at the state's juvenile institutions. By July 1, 1977, the effective date of the Act, all of these "incorrigible" children were released from the institutions and moved back into their own communities.

S.B. 3116 contains within it one exception which allows up to thirty days of diagnostic treatment in a state facility as a last resort for hard-core incorrigibles. The exception was part of a compromise struck to secure passage of the bill. Furthermore, the status offenders who are routinely held in county detention were not covered in the bill. These two remaining areas of potential incarceration for noncriminal youth meant that compliance with federal standards was still incomplete. This added to the pressure for further change.

House Bill 371. During the 1975 legislative session, a subcommittee of the House Social and Health Services Committee was appointed to look closely at the state correctional system, both adult and juvenile. The subcommittee viewed its task as developing policy. This meant that instead of starting out with bills drafted by outside groups, it proceeded first to achieve an internal consensus about what direction to take. The subcommittee put the House on record as supporting a number of conclusions and recommendations which helped lay the groundwork for House Bill 371. The resolution criticized "the constant increase in appropriations for treatment without a significant increase in the rate of effectiveness." It stated that "maintaining the family unit should be the first consideration in all cases of state intervention into children's lives." It proposed that a pilot project in the juvenile system be fashioned whereby the strictness of the sentence would be related to the severity and frequency of the child's criminal behavior. The resolution also placed a high priority on the development of crisis intervention programs to work directly with families, "keeping children out of the court and institutional system."

Based upon the committee's direction, a research report was prepared, and presented to the committee. It documented three major criticisms of the existing system:

1. The system was not accountable to the citizens. No way had been found to measure its performance. The ends were unclear, the means inconsistent.

2. The system did not hold youthful offenders accountable. Violent offenders often had their cases "informally adjusted," while misdemeanors and nonviolent felonies were formally adjudicated by the court.

3. The system was unable to help offenders. The conflict between the punishment and rehabilitative roles of the probation workers and institutional officers had undermined their ability to help; and juvenile crime was increasing, demonstrating the system's ineffectiveness.

The report recommended a model for change based on the assumption that "any hope for success in the area of delinquency prevention and treatment rests in the community and except for reasons of public safety, no juvenile offender should be removed from the community." Diversion, restitution for property offenses, and removal of court jurisdiction over status offenses were several concepts emphasized in the report.

The first draft of a bill based upon this model was completed. In August, 1976, the draft was presented to a joint meeting of the House and Senate Judiciary Committees. Throughout the rest of the year, staff members worked closely with interested persons and groups, explaining the bill and making technical revisions.

Lobbying was heavy, but the bill had a well organized and broad base of support. Research had revealed that out of the 47,464 children referred to the state's 39 juvenile courts in 1975, thirty-nine percent (18,569) of the referrals were for status offenses: curfew or alcohol violations, running away, truancy, incorrigibility, and "inability to adjust." Juvenile court directors, probation workers, and judges who opposed the bill found themselves in a distinct minority. H.B. 371 was signed into law in 1977.

The bill was intended to limit the courts to their judicial function, to request them to deal more consistently with youngsters who commit offenses, and to identify social resources outside the court for handling noncriminal behavior. The bill moved away from the parens patriae doctrine of benevolent coercion, and closer to an emphasis on justice. Offenders would be dealt with according to the nature and frequency of their criminal acts, not on the basis of social background or "need for treatment." Serious offenders could be incarcerated in order to ensure public safety.

The bill declared the family to be a fundamental resource of American life and that it should remain intact in the absence of compelling evidence to the contrary. In Washington, as in many states,

prior to the implementation of the new juvenile code in July, 1978, any child without a parent or guardian "willing to exercise or capable of exercising proper parental control" or "whose home" for any reason was considered "unfit for such child" could be removed from home by the court. The broad definition of dependency was resulting in excessive and unnecessary intrusion into families. Decisions to place were subjective and therefore inconsistent.

H.B. 371, Part C., limits unnecessary intrusion into family life by restricting the definition of dependency. Part D states that, unless a very serious crime or several crimes have been committed, a child will not be removed from the parents for an extended period of time and that the authority of the court to place a juvenile offender in foster care shall be limited. The law reduces the chances that a family will be broken up inappropriately. H.B. 371 limited dependency to circumstances in which a child was abused, neglected, or abandoned. The 1978 revisions to the bill (Engrossed Substitute Senate Bill 2768) broadened the definition of dependency to include those situations where, although the potential is high, actual harm has not occurred. It also allows for a prompt termination of parental rights proceeding when the likelihood of reconciliation between parent and child is remote (H.B. 371 called for a six month waiting period).

The new Washington Code, by narrowing the definition of dependency and by introducing the notion of accountability into the handling of juvenile offenders, supports family autonomy. Prior to H.B. 371, families in conflict were often left with little option but to abdicate their child-rearing responsibilities to the court, who could in turn opt for placement. Following placement, reunification was often slow, difficult, or nonexistent. Police are now given authority to pick up runaway children and either take them home or to a service care facility (known as a crisis residential center). When a parent and child are unable to resolve a serious conflict and the court has approved an out-of-home placement, the law requires the DSHS to present a case plan for appropriate and temporary placement, and for services selected to resolve the conflict and reunite the family as soon as possible. There is no implicit blame attached either to parent or child; the focus is on the family unit.

An LEAA grant of nearly two million dollars was obtained to assist interim funding of the Washington program, thus avoiding the familiar pitting of one program against another and minimizing competitive sabotage. A number of programs designed to strengthen families have resulted.

Crisis Intervention Service. Crisis Intervention Service is provided during a family crisis to maintain and strengthen the family unit and to avoid unnecessary out-of-home placement. Available to every community twenty-four hours a day, seven-days-a-week, CIS is intended to alleviate personal or family situations that present a serious and imminent threat to the health and stability of the family.

Intake/assessment is completed within four hours and includes the following:

1. Immediate intervention and diffusion of potential for violence.
2. Assessment.
3. Exploration of options.
4. Assessment of the need for--and referrals to--appropriate service resources and/or the provision of short-term counseling as indicated. Referral may be indicated for:

   - Medical services.
   - Legal services.
   - Child protective services.
   - Educational services.
   - Ongoing counseling.
   - Alcoholism and drug abuse services.
   - Homemaker services.
   - Day care.
   - Mental health services.

Crisis intervention services are provided at three levels of intensity:

Level I

This is a short-term service (usually three to five hours) available twenty-four-hours-a-day and seven-days-a-week. The objectives are as follows:

- To resolve the problems when possible.
- To relieve the immediate stress.
- To clarify options if indicated.
- To refer to an appropriate resource if necessary.
- To structure the situation, and refer to Level II if indicated. (Level II service is available within sixteen hours.)

The experience suggests that about fifty-five percent of the cases are likely to be resolved at this level, or referred to the appropriate resources outside the crisis service.

Level II

This is a more intensive crisis intervention service. Up to fifteen hours of direct service is provided within the first thirty days, with appropriate authorization. This level of service may be extended for selected families. Objectives at this level include:

- Keeping explosive situations structured.
- Working toward resolution when possible.
- Clarification of feelings, and review of options when indicated.
- Reuniting family.
- Assistance in implementing chosen options when needed.

Level III

This is the most intensive level of the crisis intervention service program. Six to eight weeks of extremely intensive and comprehensive services, similar to the most intensive Home Based Family Centered Service programs, are provided. These families are the most serious and problematic and are in crises which are not readily resolved. Objectives at this level of service include problem resolution, improved family functioning, and avoidance of placement. Post-crisis, follow-up, family support service of about five-hours-per-month may be provided by the Delinquency Prevention Services or Community Services office staff.

Objectives at the followup level are to:

- Continue problem resolution when needed.
- Provide supportive services.
- Maintain previous progress.
- Monitor progress when indicated.

The crisis intervention services program was begun before the general public became familiar with the new code. A significant number of requests were received from parents seeking immediate placement of a youngster, rather than crisis intervention. A massive public education program, including fifteen public forums across the state, was subsequently conducted. Statewide staff training for crisis intervention and Home Based Family Centered Service is provided by a voluntary Home Based Family Centered Service agency. To date, less than half of the service is provided in the home. A major concern has been the apprehension evidenced by untrained staff at the prospect of working in the homes of families in crisis. It is expected that the fear will diminish with training and experience in Home Based Family Centered Service and crisis intervention, and that more of the work will eventually take place in the home.

Crisis Residential Care. In 1978, amendments to H.B. 371 authorized and appropriated funds for the provision of crisis residential care. Crisis Residential Care is utilized as a last resort after every attempt has been made, through the crisis intervention phases already described, to prevent removal of a child from home. Service goals are to return the child home within seventy-two hours, or arrange for an appropriate plan when return home is not possible. Crisis residential care provides emergency and temporary residence not to exceed seventy-two hours, available on a twenty-four-hour-a-day, seven-day-a-week basis for dependent, runaway children, and children absent from

home pending their return home or to an alternative residential placement. These short-term residences include:

1. Family crisis residential centers or family foster homes, not to exceed two placements (beds) at one time, and not to exceed ten days without regional office approval.

2. Group crisis residential care for children aged thirteen or older who are not suitable for receiving care or family crisis residential care due to the nature or degree of their problems and/or behavior, yet who do not need maximum security. A maximum of two beds are generally provided within a larger program licensed as a group care facility. Care does not exceed seventy-two hours without an alternative residential placement petition being filed.

3. Regional crisis residential care. These highly structured facilities provide direct treatment and close supervision to the most difficult youth who cannot be managed in family or group crisis residential care. This is the most secure care short of total confinement.

The Washington experience since the new law has shown that building a family-oriented service concept into the law can significantly reduce the number of children who go into foster care. This program coupled with permanency planning, appears to effectively address the need for placement prevention and family reunification programming.[20]

Ch. VI. SUMMARY OF RESEARCH ON HOME BASED FAMILY CENTERED SERVICE

Research is one way of answering questions about the nature of programs and their impact on the individuals who receive their services. Most of the Home Based Family Centered Service research has been "formative" in nature. The purpose of formative research (as opposed to "summative" research) is to provide prompt information for feedback on program operations and results while the program is still in progress. Such process evaluation can alert staff to incipient weaknesses or unintended failures of a program and can insure proper operation by those responsible for its administration.

The St. Paul Project

Prior to 1952, there was almost no research concerning multiproblem families; that was the year in which Buell's initial St. Paul Family Centered study was published. Research, not unlike service programs, had been primarily concerned with the child, often at the exclusion of family. Prevalent was research on person-centered psycho-

logical theories, the effect of newly discovered internal organisms in medicine, and self-actualization. The St. Paul project initiated a renewed focus on the family as the service unit.

The project's sample included only severely malfunctioning families, each with at least one child in "clear and present danger" as a result of delinquency or verified neglect, or both. A Guttman-type rating scale covering nine dimensions of family functioning was used to measure change between intake and closing: 65.3 percent of the families showed a positive change, 18.7 percent showed no change, and 16 percent showed negative change.[21]

Association for Jewish Children of Philadelphia

Goldstein reported on the Association for Jewish Children of Philadelphia service program to children in their own homes. These high risk* families had more than one child in need of intensive service. Most had incomes below $5,000 annually. Sixty-one percent were single parents and most had received service from one to thirteen other agencies. Long-term service was found to be inevitable (2 to 6 years) and was considered preferable to long-term placement. Less than five percent of the families served over a three-year period required placement of a family member.[22]

The Rutgers Study

Wolock and colleagues have compared the relative effectiveness of a foster, residential, and own-home programs. Comparisons were made among the three groups in nine major areas of family life at the beginning and end of a twenty-four-month-period of service. They found basically similar profiles among the families at the time of intake, except that the in-home group of children was somewhat more poorly adjusted than those in placement. A more favorable outcome was found in a greater number of areas for children served in their own homes and foster homes, than with the children in institutions. Residential care was found to be two and one-half times more costly than foster care, and thirteen times more expensive than the own-home service. The researchers concluded:

> The own-home program not only constitutes as viable and as effective a program as foster or residence placement programs, but a much less costly one as well.[23]

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*"High risk" refers to families possessing a configuration of characteristics that have been strongly associated with out-of-home placement and at least one member who is judged to be at imminent risk for placement.

Comprehensive Emergency Services

Burt, reporting on the final results of the Nashville Comprehensive Emergency Services Project, has demonstrated how out-of-home placement can be reduced by the integration of services and by the provision of comprehensive services to family units. This is precisely what the coordinating role of the Home Based Family Centered worker can provide. The CES model provided twenty-four-hour, seven-day-a-week intake, emergency caretaker services, twenty-four-hour emergency homemaker service, emergency foster homes for temporary care, emergency family shelter care, and standby shelter care for older abused and neglected children. In addition, the Juvenile Court and Department of Social Services coordinated decision-making on placement. Included in the findings was a 51 percent decrease in the number of children removed from home and an 85 percent decrease in the number of children institutionalized. The program totally eliminated the institutionalization of children under six and appeared to bring about a significant decline in recidivism of cases. Compared to the system it supplanted, the program brought a net savings of $68,000 annually to the Nashville community. Followup efforts on those children who were placed and intensive work with their parents reduced long-term foster care (two years or more) from 94 percent to 34 percent in that community.[24] This appears to be an excellent example of how administrative design may account for effectiveness.

The New York Study

Jones has reported on a demonstration study which was administered by the New York State Department of Social Services to 549 families. The project was evaluated by staff of the Child Welfare League of America. The families had relatively few resources and a myriad of environmental and functional problems. All the families had children who had been dispositioned for placement. They were poor, had female heads of family, more children than the average American family, and the parents had an average of ten years of formal education. The findings indicate that a program of intensive counseling and concrete services made readily available to the families when placement is imminent can be effective in preventing placement and reducing the length of placement. The program also enhanced the functioning of parents and children, improved the environmental conditions of the family, and achieved considerable savings. The worth of the availability of strong, supportive, and supplemental services to families was validated.[25]

Homebuilders

In 1975 Homebuilders, in Tacoma, Washington, began an intensive family-centered service program. Components of the design include twenty-four-hour availability and no screening of referrals. Clientele consists of families with severe and long-term problems. Techniques utilized include modeling, advocacy, facilitating utilization of community resources, contracting, and teaching communication skills. Of

the 119 families seen during the first two years of operation, 188 family members were judged as having high potential for placement. Institutional placement was prevented in over 85 percent of the cases through the third year of operation, and almost all of the cases reported continuing satisfaction with the crisis resolution which prompted referral.

A study of families served by Homebuilders during 1977 included a control group and one-year followup. Of the families treated, 73 percent avoided placement, and the cost of service was $3,346 per family. For the control group 72 percent were placed and per client cost was $4,991.[26]

FAMILIES of Iowa

A study of the first three years of the FAMILIES program in Eastern Iowa included 140 families, 66 percent of whom had at least one child who had already been dispositioned for institutional placement. The remainder had at least one child at risk of imminent placement. Most of the families were single parent, poor, and identified as having severe to moderately severe problems in three or more areas which had been present for three or more years.

Over the three-year service period covered by the study, 70 percent of those children identified as the reason for referral were still living at home. It is assumed that the Home Based Family Centered Service was effective for those families, half of which had at least one child who had been before the juvenile court.[27]

Ch. VII. ETHICAL CONSIDERATIONS AND POLICY ISSUES

Essentially, the parent(s) make the final decision to accept or reject Home Based Family Centered Service for the family. Most do so without outside coercive influence. However, at times the decision may be influenced by a court order or by the awareness that rejection of Home Based Family Centered Service may mean placement of a family member. The very idea of intervening into family difficulty implies intrusiveness; therefore, respect for the individuals and their choices must prevail.

Some maintain that the Home Based Family Centered Service method of intervention is less intrusive than placement away from home, particularly involuntary placement. The approach invests resources in the child's own family and community in the least restrictive manner. The relevance of the parents in the young person's life is retained and encouraged. Some professionals maintain that adolescents are best served separate from family; however, while adolescents may experience a period when the family seems unnecessary and even burdensome, almost all will return to a family lifestyle.

Treatment and rehabilitation have been the cornerstone of the entire juvenile justice system. The child's right to treatment has been widely assumed. Why has it not been established that families have a similar legal right to treatment?

Society's right to remove children from their homes, without a major effort to provide services to their families without removal, will likely continue to be tested in the courts. Government policy and some legislation have discouraged the provision of services to intact families. Perhaps this can be attributed in part to the absence of a family policy in America. The U.S. is the only industrialized nation without a family policy. A 1977 statement made by the Vanderbilt Institute for Public Policy summarized the problem.

> In the United States, the family has never been a major concern in the formation of public policy. In contrast, most other developed countries of the world have worked toward the family to take congnizance of its central role in the social structure. Nonetheless, families in the United States are affected by many public policies. What we have, then, is a family policy by default. We lack criteria and procedures for assessing the influence of policies on families, and until recently we have lacked even the conviction that such assessment should be undertaken. As a result, the nation has numerous policies that work against family solidarity and effectiveness and few policies that are designed explicitly to strengthen families. National programs have been launched that have had harmful effects on family life and child development; systems necessary for the support of families and children have not been carefully worked out; and, on many indices, America's children fare less well than do the children of other nations.

In regard to juvenile offenders, the broadly defined categories generated by juvenile court legislation seem unrelated to what actually occurs with respect to treatment or service. Decisions to place and where to place are subjective and therefore inconsistent and often have little to do with need. If the reduction of unnecessary and inappropriate placement is an objective, then Home Based Family Centered Service might be extended to all families of children who come to the attention of the service system, except perhaps for very serious and habitual criminal offenders. Intensity of service would vary with need. (It is estimated that the most intensive model provided as an alternative to placement is indicated for ten percent of the youth who enter the service system.) Parents could be given a choice and the choice based on informed consent. This would require a major shift in policy.

It remains to be seen if states will take advantage of the flexibility provided by block grants. Almost all the states chose to utilize the Title XX Public Child Welfare Block Grant funds to expand existing services. Categorical legislation for individuals, addressing specific problems, denies the development of an integrated network of services. Separate delivery systems with independent guidelines, regulations and eligibility requirements essentially discourage the development of a unified community plan for human services. The New York State Child Welfare Reform Act of 1979, for example, potentially strengthens that state's capacity to provide families and children with preventive services. Numerous states have moved decidely toward reprogramming of supportive services for families at risk, rather than toward substitute care. Variations among states in the service systems require differential planning which may include legislation, as in the states of New York and Washington. Some additional areas to be addressed include the following:

1. Standards for preventive programs. Extent of need for a given family must be realistically matched with extent of service. The absence of this match has been a major problem in the past. Levels of intensity and comprehensiveness of service will need to be developed.

2. Development of a stage and/or situation-specific plan to include strategies for reassignment of resources.

3. Assessment of existing child and family welfare resource allocations.

4. Strategies for obtaining training and transition funds.

5. A training program for staff at every level designed to deemphasize placement and to enhance home-based treatment skills in work with families in the home and community. Shifts of guidelines, authority and resources alone will not provide options. Local personnel may need assistance to discover, develop and install appropriate alternative practices.

6. An education-information program directed at key committees and councils, administraters, planners, referral resources, legislators, judges and the general public. It is essential that there be greater local community understanding of its role and responsibility and that local leadership be developed.

7. Legislation mandating Home Based Family Centered Service and establishing priorities and staffing patterns providing for integrated and coordinated service programming which allows for flexible efforts to address the entire life-system of the child and his/her family, and which fits individual family needs.

8. Criteria and allowance for decision making at the intake level which include a primary emphasis on the extension of preventive services.

When planners in either private or public systems become enthusiastic about and committed to the potential of preventive services, they are often able to develop excellent options to substitute care. The impetus can receive a dramatic boost once key administrators and planners have developed in-depth understanding of how and why Home Based Family Centered service can prevent out-of-home placement.

NOTES

1. Bulletin of the National Clearinghouse Project on Home-Based Services for Children. 1 (2), Spring, 1978. (These statistics were compiled from a variety of sources as documented in the Bulletin.)

2. For early examples of research which raised profound issues about foster home care, see Henry S. Maas and Richard Engler, Children in Need of Parents (New York: Columbia University Press, 1959); Betty M. Rickets, "Child Placement and Its Effects on the Child and His Family." Master's thesis, Smith College School of Social Work, Northampton, Mass., 1959; David Fanshel, "The Exit of Children from Foster Care: An Interim Research Report," Child Welfare 50(2) (February 1971): 65-81. These sources are offered as a point of departure. A full listing would be extensive.

3. See for example, Melvin E. Allerhand, Adaptation and Adaptability: The Bellefaire Followup Study (New York: Child Welfare League of America, 1966). Allerhand and Associates found that adjustment at discharge was not predictive of adaptation one year or two years after discharge. The presence of constructive or destructive factors in the boys' environment after discharge had greater influence on later adjustments. See also Alfred Kadushin, "Institutions for Dependent and Neglected Children," in D.M. Pappenfort et al., Child Caring: Social Policy and the Institution (Chicago: Aldine, 1973). U.S. Department of Health, Education and Welfare. OCD: Statement of Priorities for Research and Demonstration Activities in the Area of Children at Risk and the Child Welfare System. Washington: Government Printing Office, 1976. (The latter document noted that a major criterion for determining the quality or effectiveness of the institutional experience has been the incidence of discharge from the institution. If a child is released and returns to the community, it is generally assumed that the institutional experience was effective. Thus, meeting of standards and discharge from the institution have comprised the major research thrusts.)

4. These studies include: Shirley M. Vasaly, Foster Care in Five States: A Synthesis and Analysis of Studies from Arizona, California, Iowa, Massachusetts, and Vermont (Washington: Social Research Group, George Washington University, DHEW Pub. No. (OH) 76-30097); Kenneth Keniston, All Our Children: The American Family Under Pressure (New York: Harcourt Brace Jovanovich, 1977); Alan Gruber, Children in Foster Care: Destitute, Neglected, Betrayed (New York: Human Sciences Press, 1978); Children's Defense Fund, Children Without Homes (Washington: Children's Defense Fund, 1978).

5. Major legislation providing incentives to the development of home and community based programs for children, youth and families include the following:

1968 Juvenile Delinquency Prevention and Control Act. This Act assigned HEW responsibility for developing a national approach to the problems of juvenile delinquency. Upon approval of a state's plan federal funding was provided to implement prevention, rehabilitation, training, and research programs.

1968 Omnibus Crime Control and Safety Streets Act. This Act made available to states, block grants which could be used to fund delinquency control and prevention programs.

1971 Revision of the 1968 OCCSSA. Authorized community-based juvenile delinquency prevention programming.

1974 Juvenile Justice and Delinquency Prevention Act. Provided for a national program to deal with juvenile delinquency within the context of the total law enforcement and criminal justice effort. The Act was amended in 1977 to extend the time period within which states must complete the deinstitutionalization of status offenders.

1975 Title XX. Emphasized community or home-based care rather than inappropriate or unnecessary institutional care.

1975 Education for All Handicapped Children Act. Encouraged the development of local education programs for many who were formerly institutionalized for education purposes.

1980 Child Welfare Reform Act. Includes the fiscal incentives for states to develop placement prevention and family reunification programs.

6. For treatment of this phenomenon, see John Spiegel and Norman Bell, "The Family of the Psychiatric Patient," in Silvano Arieti, ed., American Handbook of Psychiatry I (New York: Basic Books, 1959): 114-49; and J.C. Flugel, The Psychoanalytic Study of the Family (London: Hogarth Press, 1931): 32ff.

7. For a review of the St. Paul Family Centered Project, see Charles Horejsi, "The St. Paul Family-Centered Project Revisited: Exploring an Old Gold Mine," in Treating Families in the Home: An Alternative to Placement, eds., Marvin Bryce and June Lloyd (Springfield: Charles C. Thomas, 1980): 12-23.

8. Mary Ann Fahl and Donna Morrissey, "The Mendota Model: Home Community Treatment," in Home Based Services for Children and Families: Policy, Practice, and Research, eds., Maybanks and Bryce (Springfield: Charles C. Thomas, 1979): 226.

9. Sheila Kammerman and Alfred Kahn, Social Services in the United States (Philadelphia: Temple University Press, 1976): 217-20.

10. See Steven Unger, ed., The Destruction of American Indian Families (New York: Association on American Indian Affairs, 1977).

11. Sheila Kammerman and Alfred Kahn (1976): 217-20.

12. Bryce, Marvin E., "The Significance of Parental Force in Psychotherapy with Disturbed Children in an Open Residential Setting," Child Welfare, 46 (November 1967): 514-521; Bryce, Marvin E. and Ehlert, Roger, "Foster Children," Child Welfare, 50 (November 1971): 499-503.

13. National Council on Crime and Delinquency, Jurisdiction Over Status Offenders Should Be Removed from the Juvenile Court, Policy Statement, Hackensack, New Jersey, 1975,p. 207.

14. Ibid., p. 27.

15. Thomas, William I., The Unadjusted Girl (New York: Harper Row, 1977).

16. For a more detailed discussion of the planning of a Home Based Family Centered Service program, see Marvin Bryce and June Lloyd, Placement Prevention and Supervising the Home Based Family Centered Program, National Clearinghouse for Home Based Services to Children, The University of Iowa, 1980, p. 24-61.

17. For discussion of a supervisory model, see Marvin Bryce and June Lloyd, Placement Prevention and Family Unification: Planning and Supervising the Home Based Family Centered Service Program, National Clearinghouse for Home Based Services to Children, The University of Iowa, 1980, pp.102-118.

18. For a detailed discussion of Home Based Family Centered assessment and the various treatment roles, see June Lloyd and Marvin Bryce, Placement Prevention and Family Unification: A Practitioner's Handbook, National Clearinghouse for Home Based Services to Children, The University of Iowa, 1980, pp. 54-154.

19. For a more thorough description of the Champaign program, see Katheryn Clayton-Fechtmann and Janis Seibold, "Community and Home-based Treatment Planning for Adolescents and Their Families," in Treating Families in the Home: An Alternative to Placement, eds., Bryce and Lloyd (Springfield: Charles C. Thomas, 1980): 273-85.

20. Information on the Washington State legislation and program was obtained from the Office of Program Research, House of Representatives, State of Washington; "House Bill 371: An Introduction," by Mary Becker; Revisions 17 and 18 to Manual G (2/80), Washington State Department of Social and Health Services; and W. Darby Brown, Washington DSHS, Bureau of Children's Services.

21. Project reports were issued by the Greater St. Paul Community Chest and Councils, St. Paul, Minnesota. For a summary report on this project, see Charles Horejsi, "The St. Paul Family Centered Project Revisited: Exploring an Old Gold Mine," in Treating Families in the Home: An Alternative to Treatment, eds., Bryce and Lloyd (Springfield: Charles C. Thomas, 1980): 12-23.

22. Harriet Goldstein, "Providing Services to Children in Their Own Homes: An Approach That Can Reduce Foster Placement," Children Today 2 (July-August 1973): 2-7.

23. Isabel Wolock et al., "Three Child Care Programs: Comparative Study," unpublished paper, New Brunswick: Rutgers University, Graduate School of Social Work, 1977.

24. Marvin R. Burt, "Final Results of the Nashville Comprehensive Emergency Service Project," Child Welfare 55 (November 1976): 661-664.

25. Mary A. Jones, "Reducing Foster Care Through Services to Families," Children Today 5 (November-December 1976): 7-10.

26. Jill Kinney et al., "Home Builders: Keeping Families Together," Journal of Consulting and Clinical Psychology 45 (August 1977).

27. Marvin Bryce, "Client and Worker Comparison of Agency Organizational Design and Treatment Techniques in an Intensive Home-based Social Service Program for Families," unpublished Doctoral thesis, The University of Iowa, 1978.