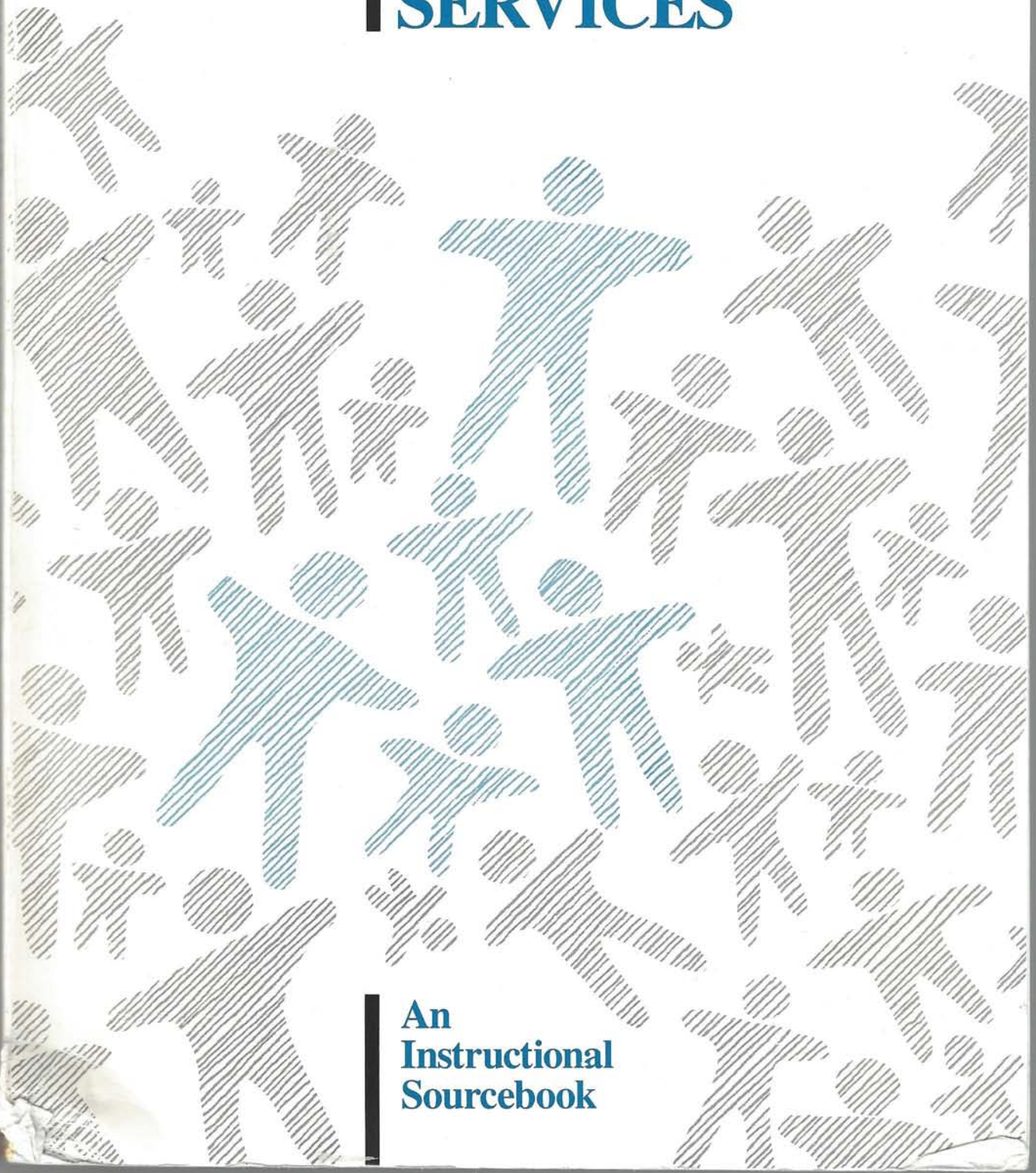
INTENSIVE FAMILY PRESERVATION SERVICES



An Instructional Sourcebook

INTENSIVE FAMILY PRESERVATION SERVICES: AN INSTRUCTIONAL SOURCEBOOK

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Intensive family preservation services (IFPS) are characterized by highly intensive services, generally delivered in the client's home over a brief period of time. The primary goals of intensive family preservation services are (1) to protect children, (2) to maintain and strengthen family bonds, (3) to stabilize the crisis situation, (4) to increase the family's skills and competencies, (5) to facilitate the family's use of a variety of formal and informal helping resources and (6) to prevent unnecessary out-of-home placement of children.[1]

The Edna McConnell Clark Foundation (1985, 1990), as well as other child welfare organizations, has promoted the use of the term "intensive family preservation services" to describe this particular form of professional help directed towards children and families. Recently, the Child Welfare League of America (CWLA) in its Standards for Services to Strengthen and Preserve Families with Children (1989) referred to this model as "intensive family-centered crisis services" (p. 46) in contrast to the other two types of programs described in the standards: "family resource, support and education services" (p. 13) and "family-centered services" (p. 29).

While intensive family preservation services are closely related to "family-centered services" and other "home-based services" in philosophy, rationale, and origin, they are different from a strategic standpoint and vary in service components (Hutchinson, 1983; Bryce & Lloyd, 1981; Lloyd & Bryce, 1984). The strategy for intensive family preservation services focuses on serving only children and families who are experiencing the most serious problems and, therefore, would be the most costly clients if they were utilizing conventional out-of-home treatments. Family-centered and home-based services are available to families experiencing a wide range of problems, some less likely than others to lead to placement. The approach of identifying families for whom less intensive services are not working, and then serving these families with a less costly

alternative to placement services is one crucial unique aspect of IFPS programs. IFPS programs also are distinguished by the intensity and brevity of services provided, as compared with other family-centered or home-based services. Unlike family-centered services, IFPS programs use the home or natural environment as the site for service delivery almost exclusively.

Nationally, family-centered and home-based service programs differ among themselves along a number of dimensions: staffing patterns, auspices (public/private), target population, client eligibility, caseload size, duration and intensity of service, and clinical methods (see Pecora, Haapala, & Fraser, this volume). The primary focus of this sourcebook is the HOMEBUILDERS model of intensive family preservation services, which is described more fully by Kinney, Haapala, Booth and Leavitt (this volume) and McKinney, Haapala, & Booth (1991). HOMEBUILDERS represents one end of the continuum of intensity and brevity of services. Notwithstanding the differences among various IFPS programs based upon the HOMEBUILDERS model, they share a number of key characteristics and features:

- Only families with children at risk of imminent placement are accepted.
- Services are crisis-oriented. Families are seen by HOMEBUILDERS therapists within 24 hours after referral.
- HOMEBUILDERS staff are readily accessible, in that they maintain flexible hours seven days a week.
- Intake and on-going assessment processes ensure that children are not left in dangerous situations.
- Although problems of individuals may be addressed, the focus is on the family and its context, rather than on parents or children as problematic individuals.
- Workers visit families in the families' homes, neighborhoods and communities. The frequency of visits depends upon the families' schedules.
- The service approach combines teaching skills to change behaviors, teaching the family how to obtain necessary resources and services,

and counseling based on an understanding of how to establish rapport and motivate clients.

- Services are generally based on identified family needs rather than strict eligibility categories.

- Each worker carries a small caseload. For example, HOMEBUILDERS staff work individually with two families at a time, but have access to team members for assistance, if needed.

- Programs limit the length of involvement with the family to a short period. For example, HOMEBUILDERS therapists work with a family on an average of four to six weeks.

- Most programs work from a family-and-strengths perspective and include use of extended family, community and neighborhood resources.

- A variety of worker tasks and roles are utilized, e.g., counselor, parent trainer, advocate, consultant, broker.

Developments within IFPS Programs

The development, expansion and future of intensive family preservation services programs assumes more meaning when viewed in the broader context and continuum of child and family service systems. Intensive family preservation services are congruent with a number of emerging trends in child welfare and other social service systems: the desire for permanent homes for children, the use of least restrictive settings, the ecological perspective, foster care reform and cost containment. In addition, the legal mandate for prevention services (P.L. 96-272) favors interest in and development of home-based services such as these in the years to come. In fact, The Family Preservation Act of 1990, a family preservation legislation, was recently proposed to Congress.

IFPS programs, among other family and home-based programs, have experienced rapid growth in the past decade. The National Resource Center on Family-Based Services at the University of Iowa currently lists over 300 family based programs; by comparison, the first directory in 1982 listed only 20 programs. A growing number of states have passed home-based service or IFPS legislation and are developing statewide programs.

The HOMEBUILDERS model has received increasing recognition and is perhaps the best known and most clearly articulated model of intensive family preservation services. The model is being implemented on a statewide basis in Tennessee, Missouri, New Mexico, Kentucky, Michigan, Iowa, New Jersey, Connecticut, New York and Washington. In these states, and others, intensive family preservation services are relying less on demonstration projects and moving toward institutionalized funding streams and higher levels of appropriation. There appears to be a trend toward state legislative IFPS mandates, as marked by Kentucky's and Tennessee's legislation (Family Preservation Clearinghouse, 1990). The result is that IFPS programs are available to many more children and families, and are becoming a regular part of child welfare services. Still, in many communities, the demand for these services far outweighs the availability of programs.

Another important development is the recognition that IFPS programs have applicability to other client groups. Following the lead of the HOMEBUILDERS program, many jurisdictions are now utilizing this service approach to help keep individuals in less restrictive settings and out of placements altogether in the program areas of mental health, juvenile delinquency, status offending youths, special needs adoptions and developmental disabilities. Various states and counties are attempting to merge funding streams across program areas to serve clients better with intensive family preservation services. In addition, special education students and drug-affected families are being targeted as groups who may benefit from the IFPS approach.

While a variety of factors have contributed to the rapid growth of IFPS programs (Cole & Duva, 1990), mounting research evidence has probably received the most attention, with a focus on the effectiveness of IFPS programs in preventing placement. Initial results of early projects, such as the St. Paul Family Centered Program in the 1950s, increased enthusiasm for home-based preventive intervention in the 1970s (Maybanks & Bryce, 1979; Bryce & Lloyd, 1981). Nationally, it has been estimated that between 70 to 90% of children who receive home-based care services are able to remain at home as measured at the termination of service (National Resource Center on Family-Based Services, 1983).

A number of recent research and evaluation studies have been conducted on the HOMEBUILDERS model (Haapala & Kinney, 1988; Fraser, Pecora & Haapala, 1991; Haapala, 1983), other intensive family preservation programs (Feldman, 1990), and other family-based service models or studies with a mix of samples (Hinckley & Ellis, 1985; Nelson, Emlen, Landsman, & Hutchinson, 1988; Yuan, McDonald, Wheeler, Struckman-Johnson, & Rivest, 1990). Although many studies have been limited by small samples, inadequate control groups and the expected difficulties of field-based research, evidence from the IFPS studies

generally supports the effectiveness of the IFPS programs in preventing placements, reducing family violence, and improving family functioning (see Kinney et al., this volume, and Fraser et al, 1991 for a more detailed description of recent HOMEBUILDERS program evaluations).

A number of lessons can be learned from IFPS programs that are relevant to child and family practice and, indeed, the social work profession itself. The HOMEBUILDERS program is a "whole cloth" model of service delivery that serves as a reference point for how practice, research, administration and policy come together in a practical way in the real world. Much can be learned simply by attending to IFPS service design and underlying values. The service delivery features of intensive preservation programs are organized to engage families in service (even families who have "failed" in other counseling attempts and are reluctant to try again), to keep them intensively involved in service for a limited period of time, and to increase the likelihood that they will benefit from service. IFPS workers provide a combination of services designed to deal with crisis situations, to enhance family functioning, to meet both concrete and clinical service needs, and to decrease the family's sense of isolation. The key features of this approach are accessibility, responsiveness and intensity of service. In their book, Within Our Reach (1988), Schorr and Schorr summarize some of the attributes of effective service programs, such as HOMEBUILDERS:

- A broad spectrum of services is offered.
- Traditional professional and bureaucratic boundaries are regularly crossed.
- Staff members and program structures are fundamentally flexible.
- The child is seen in the context of family and the family is seen in the context of its surroundings.
- Professionals are perceived as caring and trustworthy.
- Services are sought that meet the needs of families, crossing bureaucratic lines when needed.
- Professionals provide services in nontraditional settings, venturing beyond their own office surroundings.
- Professionals redefine their roles to respond to many more family needs.

Schorr and Schorr conclude that successful programs are "intensive, comprehensive and flexible" (p. 259). The service features of IFPS programs, and in particular the HOMEBUILDERS model, certainly reflect these attributes. What is even more important is that IFPS programs appear to be influencing and redefining child welfare services as well as the broader social work task with

children and families. These programs are dramatically and rapidly altering and, at the same time, challenging traditional forms of social service delivery because of their responsiveness, flexibility and accessibility. As more child welfare agencies and other child and family service systems adopt a family strengthening philosophy, the practice technology of IFPS programs is likely to be favored and adopted at many more points in the continuum of service.

Implications for Social Work Education

As IFPS technology is applied to other populations and to other points along the continuum, the need for skilled program practitioners, supervisors and administrators is growing at an alarming rate. Many IFPS administrators are confronted with difficulties in recruiting and hiring master's level social work staff. Some program administrators find it nearly impossible to find graduate level social workers with the motivation, commitment and skill levels necessary to provide intensive family preservation services with families. A frequent complaint is that newly hired social workers lack the skills, knowledge, values and attitudes for providing services and, thus, must be "re-trained." New IFPS workers bring many skills and attributes to the job but often have problems conceptualizing and applying what they know to the home-based, short-term setting. In certain states, BSWs and MSWs are being recruited, but working relationships between agencies and universities have not been established to facilitate staff recruitment and training.

The service components and service delivery features of intensive family preservation services hold a number of implications for the training and education of social work practitioners. The IFPS worker must be capable of applying a broad range of theoretical knowledge gained in the classroom into a field-based work setting. Much of this is or should be taught in schools of social work and related professional disciplines. The following knowledge base and competencies appear requisite to this form of practice:

- A knowledge of the person-in-environment perspective and an understanding of the family as a unit;
- An ability to combine concrete and clinical services and to assess and intervene with formal as well as informal helping resources;
- An ability to assess and utilize family strengths, to actively engage families in helping efforts, and to establish clear goals with families;

- An ability to communicate and cooperate with a variety of service providers;
- Knowledge of how and when to teach parenting skills, assertiveness skills, communication skills, etc., to families;
- An ability to offer services that are compatible with cultural traditions and established cultural help-seeking patterns;
- An understanding of the importance of evaluating clinical work, from single case studies to full scale rigorous program evaluation;
- Knowledge and skill in crisis intervention (Whittaker & Tracy, 1990, p. 7).

Knowledge of IFPS programs is equally important for social work students entering program development, policy and research positions. It is important that policy makers, program planners and program evaluators have an accurate understanding of program structure, administration and funding patterns. An ability to interpret current research findings, as well as contribute to the growing body of program evaluations also will facilitate the development and expansion of IFPS programs.

These opportunities and developments are occurring at a time when many schools of social work are taking a close look at ways in which to restructure their curricula so that students are taught practical clinical skills, effective management practices, and service delivery strategies that are responsive to the needs of poor and/or disenfranchised clients - the core mission of the social work profession. Intensive family preservation services represent an innovative approach to blending the best of what research and practice wisdom tell us can make a difference with families in crisis. It represents a technology that cuts across substantive areas and fields of practice (see Leavitt & McGowan, this volume). As such, this developing interventive technology, program development and service movement have much to offer higher education in terms of curricula and field placements.

Preview of this Volume

In the past four years, an issue-focused group of social work educators from a number of different graduate schools of social work met with administrators and practitioners from Behavioral Sciences Institute to discuss the

implications of intensive family preservation services to social work education. Each participant shared a common belief in the value of examining exemplary practice models as a guide to good professional education.

The work was supported by the Edna McConnell Clark Foundation and resulted in the production of Reaching High Risk Families: Intensive Family Preservation in Human Services. This volume, originally printed as Improving Practice Technology for Work with High Risk Families: Lessons from the HOMEBUILDERS Social Work Education Project, addressed critical questions for social work education.

- To what extent does the HOMEBUILDERS model of aiding families contain implications for the content of practice-methods curricula in graduate professional education?

- To what extent does the HOMEBUILDERS model present challenges to the teaching of research and, in particular, clinical practice evaluation?

- Are there organizational and administrative features inherent in the HOMEBUILDERS agency structure that might have implications for administration courses?

- What is the theoretical and empirical base for HOMEBUILDERS and other intensive family preservation services?

- What is the policy context for intensive family preservation services and what should we think of such family centered services - e.g., Where do they fit on the continuum? What are their limits and potential? (Whittaker, 1990)

The book Reaching High Risk Families received wide dissemination among schools of social work. It was viewed as a useful resource for schools modifying or adopting child-welfare sequences, primarily because it took the stance of studying a practice approach, as it is presently practiced, including its treatment technique, organizational design, underlying knowledge base and evaluation issues. All too often areas of practice and knowledge are compartmentalized in professional curricula in such a way that students learn about the individual "trees" but rarely glimpse the "forest." Through an examination of an entire program, students can become capable of integrating content that is frequently separated in focused teaching tracks.

Following this initial project, two new projects were implemented. One was the Family Preservation Practice Project, a specialized curriculum designed to provide background expertise for current and future practitioners, administrators, researchers, and educators in the IFPS field, implemented collaboratively between the University of Washington School of Social Work and Behavioral Sciences Institute. The other was a continuation of the social work educators group with a focus on the development of teaching materials for family preservation practice. This group also was responsible for planning and convening an invitational conference for social work educators. Fortunately, these two projects were able to join together to produce these volumes.

The first volume, Intensive Family Preservation Services: An Instructional Sourcebook, contains a number of background papers on IFPS programs and practice techniques, followed by a series of issues papers on current applications of IFPS technology. These papers represent the joint thinking of social work educators, IFPS practitioners and IFPS program administrators. Consequently, readers will find that the style and focus of each paper may differ, reflecting the unique partnership represented.

For readers who wish to gain more familiarity with the HOMEBUILDERS model, Kinney, Haapala, Booth, and Leavitt provide a description of the model. While most IFPS programs originated within the child welfare system, there are a number of new applications within different fields of practice. Leavitt & McGowan compare and contrast the delivery of IFPS within mental health and juvenile justice service systems and discuss implications for policy development in the IFPS field. In the chapter on evaluation, Rzepnicki, Schuerman and Littell discuss a number of issues and challenges for research on IFPS. Hodges addresses the critical importance of cultural sensitivity in the delivery of IFPS, concluding that key features of IFPS practice are highly relevant to work with ethnic minority families. Finally, Pecora, Haapala and Fraser outline key program components that should be considered when designing and comparing different models of family-based services.

The issues papers deal with current developments, challenges and applications of IFPS technology. A number of papers deal with program development, structure and organization. Whittaker describes the role of IFPS programs along the continuum of child and family services. Teather and Pecora discuss the issues and challenges inherent in developing and implementing new IFPS programs in existing family service agencies. Blythe's paper deals with the special tasks facing IFPS supervisors, particularly in newly developed programs. The remaining issues papers cover more specialized topics: Anderson's paper addresses important ethical issues that are emerging in this field; Frankel's paper discusses the role of child care as a IFPS intervention; Tracy and Whittaker's

paper describes the use of social network assessment and intervention; and Barth highlights the use of IFPS programs for drug-using families. The application of IFPS technology to family reunification services is described by Maluccio, Krieger, and Pine, and the application of IFPS technology in preventing adoption disruption is described by Barth. Johnston, Marckworth and Morgan, drawing from their experience in the Family Preservation Practice Project at the University of Washington, present the role of field practicum and the importance of agency/school partnerships.

The second volume, Intensive Family Preservation Services: Resource Materials, contains instructional materials and resources for teaching IFPS practice, which have been developed and used by the Family Preservation Practice Project at the University of Washington. Included in this volume are bibliographies, class outlines and exercises that can be put to immediate use in social work and child-and-family methods courses. The materials are designed to be used collectively in one course, or as individual modules in a variety of courses.

Conclusion

It is our hope that the teaching materials, in combination with the readings, will prove useful to faculty members teaching in schools of social work. While the materials are geared primarily for graduate-level courses, they also can be used in undergraduate courses. These volumes will join an expanding set of available resources to support students and practitioners in this field. As Schorr and Schorr (1988) noted, "effective programs require competent, caring and flexible professionals" (p. 273). The future leaders and shapers of IFPS programs deserve no less.

Reference Note

[1] This chapter is based, in part, on material adapted from Whittaker, J. K. & Tracy, E. M. (1990). Family preservation services and education for social work practice: Stimulus and response. In J. K. Whittaker, J. Kinney, E. M. Tracy, & C. Booth (Eds.), Reaching high risk families: Intensive family preservation in human services (pp. 1-11). Hawthorne, New York: Aldine de Gruyter.

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ETHICAL ISSUES IN INTENSIVE FAMILY PRESERVATION SERVICE

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Intensive Family Preservation Services (IFPS) have been analyzed and evaluated from a variety of perspectives. The clinical theory base and skills, to some degree, have been identified, defined and expounded. The financial cost, including the viability of delivering services intensively, family focused, in homes, for short time periods, have been quantified (see Kinney, Haapala, Booth & Leavitt, this volume). The purpose of this paper is to identify and explore some of the ethical issues raised and addressed by intensive family preservation services. The clinical effectiveness and the fiscal efficiency of intensive family preservation services have been suggested in a number of large non-experimental projects (Jones, 1985; Au Claire, & Schwartz, 1986; Fraser, Pecora, & Haapala, 1991; Kinney, Haapala, & Booth, 1991). Although it is not the purpose of this essay to prove the moral superiority of these services, ethical justifications will be presented, in addition to ethical dilemmas, potential dangers of intensive interventions, and the satisfaction of ethical standards by the responsible provision of intensive family preservation services.

The Justification for Family Preservation

There is no such thing as the provision of therapeutic services in a moral vacuum. Program planning and service delivery have an ethical component and do not take place in a value-neutral context. IFPS programs, in addition to a theoretical base, have a value base--respect for families--and a set of strategies that invite ethical review.

Respect for Families

Inherent in IFPS practice is the goal of keeping a family together, choosing to work for and prioritize the needs of a family in order to prevent family dissolution. Believing that parents have the right to raise their children and the right to assistance when lacking the resources to do so, therapists avoid negatively labeling parents, listen to and work with parental definitions of family problems, provide services in the environment of the family, engage in skill-building and limit the length of professional intervention into the functioning of the family.

Intensive family preservation services not only implies a respect for parental rights, but also is based on the conviction that it is in the best interests of children to be raised by their parent(s), or extended family support network. The quick removal of children into substitute family care may result from a social service worker's good intention to rescue the child. This separation, however, is often harmful to the child's overall and long-term well-being. It is right to work with families to preserve or create a level of safe and healthy functioning; often, it is wrong to separate children from their families without offering assistance that is appropriately intensive, timely and therapeutically focused on the family crisis.

Resource Allocation

Organizational decisions with regard to strategic budgeting and distribution of limited resources are ethical choices. Resource allocation reflects an organization's values, empowers or undermines its service delivery, and ultimately contributes to the success or failure of its service delivery. When the service delivered is therapeutic and the "product" is family health and safety, the allocation of resources potentially can minimize the possibility of detrimental outcomes and maximize family well-being or, alternatively, cause great harm.

Social service organizations have a variety of resources. These include worker talent, time and energy:

- Intensive family preservation services' prioritization of initial and ongoing worker education is an investment in worker skill for the benefit of families served. The neglect of worker education/ training ultimately hurts families.

- When there are multiple families requiring services, workers holding onto cases for long time periods results in families in acute need not being served. When families in crisis are not provided services there may be a greater likelihood of negative outcomes, including unnecessary child placement. When a family is in crisis, their needs may require more than a periodic interview with a therapist. The need for therapist involvement should not be restricted to daytime, traditional workplace hours. In IFPS programs, services are organized to provide intensive help, with flexibility and worker availability, for a short period of time--freeing the worker to effectively assist another family in crisis.

- Attempting to serve a high number of families who have multiple serious problems requires a conventional therapist to continually make suboptimal choices, including a triaging of families that neglects some who are in great need. This combination of high caseload and high demand for service discourages therapists and hurts families. IFPS programs are organized to limit caseload size. When there is a high need for services, in terms of number, complexity, and intensity, a limited caseload gives the worker the ability to devote her/his energy to meeting those needs.

IFPS advocates argue that an investment in prevention services--preventing further child abuse, neglect, and family conflict that lead to family dissolution and child placement--is clinically preferable to the higher demand for services posed by placement. In addition to psychological cost, there is a financial cost borne by a community when prevention is neglected and foster care, group home, residential and juvenile facilities are too quickly relied upon or prioritized. With limited financial resources to invest in mental health and family health, the spending of those dollars has an ethical implication as children and families are hurt by the failure to prevent or reduce harm.

The Potential Dangers of Intensive Family Preservation Services

A respect for the rights of parents and the best interests of children and an allocation of resources for effective prevention of harm and family dissolution are characteristics of IFPS. Such services, however, are not devoid of risks and potential harm for children and their families. The effort to preserve the family may be endangering the well-being of children while the service is being provided or if services fail or if parents satisfy workers by superficially complying with tasks. Troubling clinical, policy and moral questions may set the child's rights in conflict with the parent's rights or therapist's goals. These dilemmas include:

- Can all families be preserved, and if not, how can one distinguish?
- Should all families be preserved?
- Is the preservation of the family, i.e., keeping family members together under the same roof, in the child's best interest?
- Is the repertoire of intensive family preservation interventions sufficient for all problems and obstacles, i.e. drug-involved families (see Barth, this volume)?

Intensive, responsive, flexible services provided in the client's environment could become habit-forming. Well-intentioned workers may find themselves helping the client, even choosing for the client what is best for the family. Family members may be only too willing to trade a certain degree of autonomy for a secure therapist to lean upon. Such dependence in a crisis is easily developed; and the feeling of significance, even power, for the worker can be gratifying. Paternalism may be too easily justified when faced with the family's multiple needs, lack of skill and time constraints. The role of the therapist in intensive family preservation services work not only allows but encourages therapists to assist the family with concrete tasks. Therapists must test their actions; will they foster an unhealthy dependency or are they laying the foundation for family empowerment?

The social work Code of Ethics states that workers should cease providing services and end professional relationships with clients "...when such service and relationships are no longer required or no longer serve the clients needs or interests. The social worker should withdraw services precipitously only under unusual circumstances..." (NASW, 1980, p.5). The time limits that free the therapist to begin work with a new family in crisis may result in the dropping of a family before its service needs are met. In such a case, ending the service may not be harmful if an appropriate referral is made and another service provider is engaged with the family. But what if there is no service provider or, more likely, the referral service does not provide the same flexibility, intensity and in-home service provided by the family preservation therapist? Quick terminations and dubious transfers unbalance the family and heighten risk to children.

These dangers underscore: (1) the need for clear and valid intake criteria, close communication with referring sources to ensure accuracy and timeliness of referrals; (2) the importance of close supervision and therapist skill in negotiating family support and empowerment; and (3) the value of a clear contract with regard to time limits, the accurate identification of specific attainable goals, planning for termination from the onset of service delivery, and the identification or development of competent agencies as a referral network providing a continuum of services.

These issues highlight the tie between research and clinical practice. Ongoing evaluation of interventions and service provision are essential to ensure that what is believed to be helping actually helps. The failure to evaluate invites the acceptance, codification and distribution of impressions that may be self-deceptions. Integrating a research component, however, raises additional ethical concerns with regard to such issues as: (1) honesty and informed consent that is voluntary, without penalty for refusal to participate, and is communicated with regard for participants' dignity and privacy; (2) confidentiality, including

discussion of evaluation findings only for professional purposes and with those directly and professionally concerned with the services; and (3) participant protection from harmful consequences, i.e. unwarranted danger, deprivation, discontent and distress. (NASW, 1980)

The Responsible Provision of IFPS

Ethically, responsible service provision keeps the clients' interests as primary throughout intervention and respects clients' rights.

Primacy of client's interests

The Code of Ethics states that workers "should serve clients with devotion, loyalty, determination and the maximum application of professional skill and competence" (NASW 1980, p. 4). The IFPS therapist is empowered to do this through her/his education, skill and a strategy of providing service to a small number of clients, intensively. The client family's interests are served through the therapist's use of contracting, case management and consultation:

- Contracting explicitly requires the knowledge, agreement and commitment of the family to address their problems through development of a variety of skills. The Code of Ethics, in its requirement to appraise clients of their rights, opportunities, obligations and risks associated with services, underscores this open and informed approach to clients. IFPS practitioners depend on these explicit and clear agreements to provide the basis for their work with families.

- The case management role of the intensive family preservation worker affirms the primacy of the clients'needs by stating that the worker will refer and assist the client in gaining whatever resources the family needs. The needs of the family primarily define the services sought and provided. The therapist is committed to not only provide information about services but also enable the family to use and evaluate those services.

- Consultation with colleagues and supervisors is encouraged by the NASW Code of Ethics, as in the best interests of the family. In IFPS programs this professional consultation is enhanced by a

recognition of the family members as experts on their family. When family members are defined as family experts they have a consulting role to the worker that establishes an almost collegial quality to some therapist-family interactions. This collegiality with agency colleagues and family members suits the family preservation focus which reduces the distance, literally and figuratively, between therapist and client.

Respect for clients' rights

Intensive family preservation services maximize client self-determination by primarily following the clients' agenda, addressing the issues that clients' define as appropriate, and asking clients to specify their problems and how they should be resolved. This often is a balancing act involving the family's interests, priorities and goals that the therapist prioritizes as essential for the child to remain in the home. However, with a collegial view of the client, family members' involvement in decision-making and intervention is emphasized at all points. By attending to the concrete needs of clients, the therapist works on environmental conditions defined by the family as problematic. The use of educational instruction is respectful of the client's ability to learn and enables the client to acquire skills that are not dependent upon the presence of the worker. Even meeting with family members in their own home communicates a sense of control and autonomy for the family.

Intensive family preservation services therapists respect the confidentiality of clients and protect the privacy of what family members say during interviews and what therapists observe in the home. This respect for privacy is essential given the therapist's "intrusive" presence in the family home and frequent networking with community organizations (Levenstein, 1981). This respect for confidentiality and privacy can and should be overruled if the therapist learns of child abuse or neglect. All family members should be informed of the therapist's duty to report child maltreatment.

Lessening Harm and Maximizing Benefits for Families and Communities

Intensive family preservation services seek to respect family autonomy, privacy and rights. The intensive, timely services are focused on reducing harm to children, which would require more authoritative and intrusive state intervention. The therapist's role as supporter and teacher, and her/his

relationship with the family as positive and collegial, maximize family empowerment. Because it is in the best interests of children to intervene before crises worsen, so that separation is prevented, service delivery is structured to allow intensive, timely aid in a range of environments. Such efforts are less psychologically and financially expensive than unnecessary or lengthy out-of-home placements.

A number of troubling questions persist. For example, how can family members be assisted to survive in an overwhelming and dangerous world? What is the proper role for intensive family preservation programs in community and environmental advocacy as families struggle to cope with external threats to their survival? Also difficult is determining the right balance between competing ethical values. Responding to ethical dilemmas in serving families will require case-by-case assessment and decision making guided by considering which courses of action maximize the best interests of the family, prevent or reduce harm to children, and respect the autonomy of the family.

The existence of continuing and new family and social challenges requires clarity about one's theory base, the ability to articulate how one works with families, and a commitment to ongoing evaluation. An awareness of the moral aspects of service provision results in a sensitivity to the helpfulness and harm of intervention and informs work on behalf of a child and family's best interests. The provision of services that are clinically competent and fiscally responsible enhance the ethical soundness of intensive family preservation services.

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THE ROLE OF CHILD CARE SERVICES IN INTENSIVE FAMILY PRESERVATION SERVICES

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In the myriad of services that intensive family preservation service (IFPS) workers provide or advocate for their client families, the need to develop child care services stands out for a number of reasons. First, there is sufficient evidence that inadequate or unstable child care puts a great deal of added stress on parents, particularly working mothers, and mothers or fathers in one-parent families (Hoffman, 1989; Clark-Stewart, 1989). In addition, unemployed mothers report increased stress levels when they do not have enough supportive child care in their routines (Ross & Mirowsky, 1988). There also is evidence that marital relationships improve when parents put their children into child care that is deemed adequate by the mother (Hoffman, 1989). Children, too, benefit from preschool experiences. These benefits include academic "headstarts" in test results in math, reading and IQ, at least for the first few years of schooling; less school dropout behavior; and less of a chance to be referred to special education classes. Moreover, when these children reach adulthood, they are less likely to be involved in welfare (Haskins, 1989). While there obviously are many factors that affect a mother or father's ability to appropriately parent abused or out of control children, the increased stress of inadequate child care is definitely one of the important variables in resolving family problems.

Second, there is increasing support that child care outside of the home is helpful to children who have been physically or sexually abused or are out of control. Research has suggested that structured settings, such as day-care centers, latchkey programs and schools, provide a social support system for abused children (Howes & Espinosa, 1985). Maltreated children exhibit different behaviors in group settings than children who have not been abused (George & Main, 1979; Cohn, 1979). There also is an indication that the parents of these children support their children's isolation (Parke & Collmer, 1975) and represent an atypical group as compared to other families who utilize child care services (Bradley, Caldwell, Fritzergald, Morgan, & Rock, 1986). Bradley et al. also found that when maltreated children were placed in child care, they and their parents, who were also under treatment, did better than when the children were enrolled in weekly children's groups. Thus, it may be possible that child care not only may be of help to children but may facilitate treatment with parents as well.

Third, the importance of providing concrete services in IFPS work along with clinical interventions is receiving more attention. A recent study of intensive

family preservation services in two states found that the number of hours workers spend in delivering concrete services to families is correlated with treatment successes and goal attainment (Fraser, Pecora, & Haapala, 1991). The delivery of concrete services by family preservation workers encompassing 453 families in two states indicated that in 12% of the families the workers provided babysitting, and in 8%, they helped the families find child care (Fraser et al., 1991). Of the 25 concrete services that were tracked, the two child care interventions together represented the third highest percent of concrete services delivered, surpassed only by providing transportation (54%) and recreation (20%). Thus, there is a basis for focusing on child care as one of the important concrete services that should be considered in the performance of family preservation work.

Fraser et al. (1991) reports that the most common type of child care IFPS workers deliver is to serve as babysitters. However, worker involvement in this type of child care is clearly temporary and helpful for reaching other goals during the short-term intensive family preservation service intervention period. Thus, more permanent child care arrangements were needed as well. In many cases, part of the IFPS treatment plan involved assisting parents with locating child care, as well as short-term babysitting arrangements.

Most of the care of children in this country, other than that of a parent or guardian, is provided by a relative of the family. This type of child care represents 80% of the children under care (Frankel, 1991a). While the stereotype of out-of-home child care is the day-care center, these centers actually represent only 3% to 15% of the children who are not in their homes, or about one million children (Floge, 1985). The great majority of children in structured child care are in an estimated 1.5 to 2.0 million family day-care homes with approximately 5.5 million children. Furthermore, 70% of all infants in out-of-home child care are in family day-care homes (Children's Foundation, 1988). In addition, school-age children are being cared for in a wide variety of latchkey programs before and after attending grade, middle and high schools. Yet, while there is no systematic data base to determine how many children are left at home after school with no parental supervision, a significant number of families, including those referred for IFPS, leave older children unsupervised in their homes.

There is evidence that families with abused children make use of all modes of child care. The Clearinghouse of Child Abuse and Neglect (1982) states that there is heavy use of child care for young maltreated children. There have been studies using therapeutic family day-care for abused children in conjunction with group sessions for parents and in-home treatment for the entire family (Irueste-Montes & Montes, 1988). There also have been comparisons of day-care centers especially designed for abused children with regular day-care centers and family day-care homes who also care for maltreated children (Bradley et al., 1986).

Nationally, there are strong indications that all types of structured child care are seriously considering the need to be part of the service delivery network for maltreated children and their families (Barber-Madden, 1983; Nightingale & Walker, 1986; Roscoe & Peterson, 1983; Gabor, 1988).

IFPS workers seeking appropriate child care alternatives for their client families need to consider at least three important factors: (1) availability (2) child care quality and (3) cost. Families served by IFPS workers are surprisingly like most of the families who use child care. Nationally, about 70% of women need child care to support their work schedules (Hoffman, 1989) and many parents served by IFPS have similar needs. According to Fraser, Pecora and Haapala, (in press), 66% of the primary caretakers being served by IFPS had jobs and many of the families (41%) were headed by single parents. These data suggests that families utilizing intensive family preservation services may be interested in exploring the availability of quality child care. In addition, according to Fraser et al., 25% receive public welfare assistance and 90% earn under $30,000 per year. Thus, the cost of child care is a factor for the majority of the families utilizing intensive family preservation services.

It is likely that preschool child care services are not needed as much as latchkey programs in intensive family preservation services. In the two states IFPS programs recently evaluated, the average age of the children in each family was between 13-14 years (Pecora, Fraser, & Haapala, 1991). Thus, even though the majority of IFPS families have older children, there always will be a significant number of families that need infant and preschool care. Other IFPS programs are focusing on a younger child population. Finally, it should be noted that the age of children in typical IFPS families in any given area could easily be a function of referral sources.

In seeking child care, IFPS workers and families should assess the availability of relatives. The social support network analysis described by Tracy and Whittaker (1990) is one approach that can help families systematically identify potential resources. Relatives are not only the most common form of child care, but they are the least expensive as well. Neighborhood babysitters might be another possibility, costing more than a relative but possibly less than out-of-home care. However, relatives and babysitters are not the best alternatives if they are not competent enough to perform certain tasks, e.g., following a consistent schedule, or if transportation becomes an insoluble issue. Assuming the relative-baby-sitting option is not possible, the next alternative is the day-care center or family day-care home. There is no data base at this time to suggest whether centers or family day-care homes offer higher quality services to maltreated children (Bradley et al., 1986). Therefore, other factors will need to be considered.

IFPS workers who deal with families with older children need to examine the possibility of latchkey programs for child care support. These programs can be found in family day-care homes, day-care centers, YMCA's that are sponsored by a number of community centers or social service agencies, and public school systems. Most states do not currently regulate latchkey programs, so the quality of these programs will have to be judged on a case-by-case basis. However, when looking for quality latchkey programs, parents or IFPS workers should look for the same characteristics that are found in quality day-care programs--a safe environment with competent, caring child care workers.

For infant and preschool child care programs, the regulations are more organized. All day-care centers in this country are required to be licensed. There also are regulations for family day-care homes in 47 states. Obviously, IFPS staff should not refer children to infant or preschool programs that are not licensed or regulated. However, since there are no national standards for child care programs, each state sets its own regulations, and they vary widely in quality. Young and Ziegler (1986), in their review of these state standards, suggest that quality child care is a rare event. Therefore, workers should first acquaint themselves with state regulations and, then, inspect prospective programs to see if child care ratios are reasonable, physical plants are safe, group sizes are kept small, and most importantly, caregivers are competent and caring. According to the results of recent longitudinal studies, whether a child care program offers academic learning, such as pre-reading and pre-math training, is not as important as whether there are caregivers present who can form warm, affective relationships with children and will be in their jobs long enough to provide the stability these children need (Haskins, 1989; Frankel, 1991b). Frequent staff turnover is a serious problem in the child care industry, and this instability might be an even more serious problem for children coming from unstable homes (Jones & Prescott, 1982). Since many parents may not have the skills to discriminate higher quality child care, with many using location as their main criterion (Endsley, Bradbard, & Readdick, 1984), IFPS workers can serve an important function in educating families about the importance of child care and helping parents find quality child care options. In addition, since a number of children who receive IFPS may need special supervision, IFPS workers need to pursue those child care services that have staff competent to handle children who have a history of emotional, behavioral and/or physical problems. Local social service agencies, such as mental health centers and family services might be able to help in this regard.

Considering that the cost of child care is a factor in the majority of families referred for intensive family preservation services, IFPS workers should become aware of how child care is funded in their communities and states. Headstart programs are funded by a combination of state and federal monies and

are available at low to no cost for preschool children, ages 3-5, whose families meet local means tests. While Headstart has traditionally been available only half a day, more and more programs are offering full-day programs for preschoolers. In some states, the legacy of what was known as the federal Title XX programs is now state funded and offered to preschool children at subsidized rates. Many state welfare programs have funds to support child care for needy families available through local child welfare offices. This support is either in the form of vouchers that parents give to child care programs or special reserved "slots" at reduced or no cost in identified family day-care homes or day-care centers.

The newest federal-state child care initiative is commonly called "workfare." It is presently available in many states and will likely be available in all states in the near future. Families on welfare are eligible for funds to support parents who are in job training and funds to put their preschool children in family day-care homes or day-care centers. Since a good percentage of families referred for IFPS are on welfare, "workfare" programs should be explored to support child care.

Unfortunately, the organization of latchkey programs in this country is in its infancy. This not only makes it potentially difficult to find quality programs; but the pattern of federal, state or local subsidies for low income families has not yet emerged. Yet, many of these programs emanate from social service or community agencies and the cost is very low. In addition, child care support for maltreated children often is connected with private or public social service agencies on sliding scales, thus giving low-income families better access to child care.

In general, when assessing the potential costs for non-subsidized child care, relatives are usually the least expensive, followed by babysitters. Family day-care homes and day-care centers are the most expensive. However, it should be remembered that cost is not necessarily related to child care quality.

Another alternative that should be explored by the IFPS worker is potential child care support in the parent's workplace; it is relatively rare to find on-site day-care centers for employees. Employer subsidies are becoming increasingly common, such as a child care reduction in wages before taxes are deducted, which is then sent directly to a child care program; guaranteed slots at reduced rates at a family day-care home or day-care center; and employer sponsored referral systems to search for the least expensive quality child care in the area where the employee lives.

There also is an existing tax incentive that allows families to write off a portion of their child care expenses, thus reducing their federal tax bill or allowing more of a refund. While this tax relief may be of no consequence to some families, a family with working parents who pay federal taxes could use

that tax money to pay for child care. Workers need to know how to assess this possibility as part of the search for affordable opportunities for child care.

In the coming decade there is every likelihood that the federal government will pass a child care bill that will increase the opportunities for child care in low income families. This federal support will take the form of either an improved tax incentive or a voucher system distributed to families to use for any type of child care the family deems necessary. IFPS workers need to keep abreast of these potential supports for their families. In addition, since each community and state has different regulations and funding options for low-income families and for families with maltreated or out-of-control children, IFPS workers should become knowledgeable about such issues as part of their ongoing Intensive Family Preservation Services continuing professional education.

While there are many concrete services that family preservation workers need to concentrate on in the relatively short time they have with their families, permanent child care is one service that can be successfully developed within the context of a four-to-six week period. Based on what is known about the positive effects that child care has on children, mothers and families, permanent child care can have profoundly positive social and economic consequences for the families with maltreated or out-of-control children. Thus, it is a concrete service that should be assessed for every family preservation referral. IFPS workers should consider making contacts with local agencies and associations that focus on child care issues, such as local chapters of the National Association for Young Children, the National Association For Family Day-Care, Headstart programs, and the agencies that are responsible for licensing child care. In many cases, quality and affordable child care are found to be an available option, supporting the values of family preservation and the goal of keeping families together.

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SOCIAL NETWORK ASSESSMENT AND GOAL SETTING IN INTENSIVE FAMILY PRESERVATION SERVICES PRACTICE

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Friends, neighbors, and relatives typically help parents cope with the demands of child rearing. Such informal helping networks provide emotional and material support, serve as role models for parenting, and frequently link parents with outside sources of help and advice (Powell, 1979). A number of studies have documented the beneficial impact that this type of social network can have on parenting behaviors, attitudes toward parenting and parent-child interactions (Tracy & Whittaker, 1987).

Many of the families served by intensive family preservation services (IFPS) may lack or be isolated from supportive resources, even the most basic social resources such as someone to talk to when things get tense, someone to help with chores and errands, and someone to give a break from child care. In some instances, the IFPS worker becomes the sole source of support to the family. Other families may lack the skills needed to mobilize support for themselves and their children. Still other families may be surrounded by a social network that is beset with problems and is not able to provide positive support and role modeling. The social network may in fact support self-defeating behaviors, such as substance abuse.

Consequently, enhancing social network and social support resources may be an important goal of intensive family preservation services. These services are typically based on the premise that many more children can be enabled to remain at home if intensive services are provided to support parents in their parenting efforts (Norman, 1985). One means of supporting parents is by mobilizing a skilled informal support system that will continue to be available to the family after formal services have been terminated. This issue paper reviews (1) key concepts related to social networks and social support, (2) the rationale for incorporating a social network perspective in intensive family preservation services practice, (3) guidelines for network assessment and goal setting, and (4) major intervention issues.

Definitions of Key Terms and Concepts

Social support has been conceptualized in a number of different ways; therefore, it is important to establish a common definitional language at the outset. Social support refers to the many different ways in which people render assistance to one another: emotional encouragement, advice and concrete assistance or tangible aid. Social support occurs spontaneously through natural helping networks of family, friends, neighbors, etc. It also can be provided through professionally designed or mobilized networks, such as support groups or helplines.

The term social network refers to the structure and quantity of a set of interconnected relationships, while a social support network is that subset of the network which provides support on a regular basis (Whittaker & Garbarino, 1983). Not all networks are socially supportive, nor do they always reinforce prosocial behaviors (Stack, 1974). More social network resources do not necessarily imply more social support for an individual. In addition, the perception that others would be available for support is a key factor in mediating stress. Because of these complexities, social support is increasingly conceptualized as a multi-dimensional construct, consisting of network resources, types of support, perceptions of support, and skills in accessing and maintaining supportive relationships (Heller & Swindle, 1983).

Rationale For a Social Network Perspective

There are a number of reasons why social support is an important area of assessment and intervention in IFPS practice. First of all, even though IFPS workers devote a great amount of time in direct contact with families, the time they spend with clients is small compared to the time the family spends with informal helping resources. Most people turn to informal helping resources before utilizing formal services; a large number of helping exchanges occur within informal helping networks regardless of the availability of formal services (Birkel & Reppucci, 1983). The task for IFPS practitioners is to work with, and not against, an informal helping network that is operating in positive ways on behalf of a family. All too often, important social resources are not identified at all or identified too late to be of help in implementing a case plan. Early involvement of these people with available resources might pave the way for more successful treatment outcomes.

A second reason is that a social network perspective helps the IFPS worker provide more culturally relevant services. By identifying informal helping

resources, the IFPS worker may gain a better understanding of and sensitivity to culturally specific patterns of help giving. In that way, the IFPS worker is better able to include all relevant people and to draw upon the strengths of the community and extended family.

Third, a great deal of research evidence has accumulated indicating that people with more social and environmental resources are in better physical and mental health, and are better able to adapt to change (Cohen & Wills, 1985). Social network resources can mediate the negative impact of stressful events and help people cope with life changes. For example, mothers living in highly stressful conditions are less likely to resort to child abuse when they report strong supportive networks (Gaudin & Pollane, 1983). A frequent correlate of child maltreatment, particularly neglect, is social isolation and lack of social support (Seagull, 1987).

Finally, there is some evidence that without social support people are less likely to maintain the changes achieved during intervention. Insularity, a pattern of social contacts characterized by high levels of coercive interchanges with family and social service agents, has been related to lack of maintenance of treatment gains. Insular families benefit less from parent training and have more difficulty maintaining treatment gains (Dumas & Wahler, 1983).

Other studies have examined the manner in which social network attributes and the degree of community interaction might distinguish families requiring placement of their children. One study of HOMEBUILDERS families examined the extent to which social support resources distinguished treatment failures from treatment successes (failure being defined as child placement with a non-relative or continuous runaway behavior for two weeks or more). While social support did not distinguish failure from success, successful families made more changes in social support during treatment, indicating significant reductions in aversive relationships for parents. Specifically, mothers found their spouses and extended network contacts less negative. Fathers also indicated that they perceived their spouses as less aversive (Fraser, Pecora, & Haapala, in press).

In summary, a social network perspective aids in gaining an appreciation of the family's preferred patterns of help seeking, in pinpointing sources of strength available to the family, in encouraging efforts at self-help, and in identifying potential sources of support to facilitate the maintenance of treatment gains. The assessment and mobilization of social network resources is one component of overall service to the family.

Guidelines For Social Network Assessment And Goal Setting

Since IFPS workers provide services to children and families in their homes, they are often in a unique position to identify and work with the family's social network and to make use of the social environment as a target and resource for change. IFPS programs provide an opportunity to access and enhance a wide variety of formal and informal supportive services. The IFPS worker is in a good position to understand the support needs and resources of the family and to appreciate how the family copes with its environment. More family members may be engaged, even those members who are initially reluctant to participate. In addition, IFPS workers may be more likely to make contact with the family's natural helping network, such as relatives, friends, and neighbors in the course of their visits to the family.

Social network assessment information can be gathered through interviews with family members, observations of interactions and activities in the home, as well as through a variety of paper and pencil measures. Tools that visually display network composition and membership can be extremely helpful and clinically useful to the family and worker in generating appropriate change goals (Tracy & Whittaker, 1990).

Whatever method is chosen, social network assessment must consider structural and functional elements. Structural elements include the number and types of social network relationships, for example, the composition of a mother's personal social network or the variety of community resources available to a family. Functional elements include the quality of help provided, the perception of being supported, the functioning of relationships with the network, and the manner in which supports are accessed.

There is some evidence that structural measures alone, such as network size, are poor indicators of perceived social support. In one study of social network resources of HOMEBUILDERS families, most respondents did perceive a number of supportive resources within their networks (Tracy, 1990). At the same time, some network relationships created additional stress and strain. Many families, particularly single parents, had a high proportion of network members who were critical of them. Reciprocity or mutual exchange among helping relationships was also found to play a prominent role in the delivery of social support; the most supportive relationships were those characterized by more reciprocity.

An assessment of social network resources then must consider both strengths and weaknesses in order to yield the most comprehensive information for intervention. A consideration of strengths and weaknesses also gives the

family a more complete picture of the resources available to them. Among the strengths that can be examined are:

Number of supportive relationships. While network size alone is not a good indicator of support, the presence of supportive relationships is always an important area to assess. These relationships may offer support and assistance, such as child care or encouragement for behavior management efforts, which may reinforce intervention efforts or otherwise enable the child to remain at home. Look for network members who are identified as responsive to requests for help, effective in their helping, accessible, and dependable.

Variety of supportive relationships. The composition of the network may be an important factor since different types of support may be more or less available from different network domains. Consider whether the network is primarily kin dominated or if other network domains, such as friends or neighbors, are represented.

Types of support available. It is important that there be a fit between the types of supports available from the network and the types of support the parent needs or desires. Determine which network members provide concrete support, emotional support, and information and advice. Then examine who in the network is willing and capable of providing different types of support. Some network members may provide more than one form of support, but the family may prefer or not prefer to utilize certain helpers.

Reciprocity among helping relationships. Relationships based on mutual exchange are typically perceived as more supportive. Giving to others without receiving help in return is stressful and draining. On the other hand, always being the recipient of help may lower self-confidence and result in feeling obligated to others.

Among the weakness or problems in networks that need to be examined are:

Lack of or insufficient social resources. The family may have few members in their social network or be lacking in one or more important categories of help, such as friends. The parent may be extremely isolated with no one to rely on in times of need.

Lack of or inadequate types of support. There may be a gap in the types of support needed as compared with the types available. For example, the parent may not have back-up child care resources or may not have needed forms of concrete support.

Lack of or inadequate social and communication skills. The parent (or youth) may lack the skills needed in accessing, developing, and mobilizing a social support network. This includes the ability to reach out to others, to offer feedback, to make requests for help, to say thank you when appropriate, and to reciprocate to others.

Negative network influences. The parent (or youth) may be in the midst of a network that does not support prosocial behaviors or reinforce change efforts. The network may not understand or be aware of other options and therefore not be available for needed support. Without support from others, the parent (or youth) may find it even more difficult to maintain changes over time.

Network overload or burnout. Network members may already have provided support in the past and may be unwilling or unable to continue to do so. Overwhelming family stressors, such as homelessness, may be present which interfere with the provision of support. In other situations, the same stress factors that result in a need for more support may also deplete the resources of those available to provide support. Network members, themselves, may be drained by the long term "cost of caring."

In summary, a social network assessment yields important information about the strengths and limitations of the family's social network and identifies relevant others who may participate in the helping process. Taken together with other available information about the family, a social network assessment helps both the worker and family identify network structure, types of support, sources of conflict, degree of reciprocity, and the overall adequacy of the network. Asking the family to visualize an "ideal" network is sometimes useful in generating change goals.

Intervention Issues

Depending on the family situation, social support interventions may be directed toward any of the following goals:

- To increase or mobilize types of support, e.g., concrete, emotional, informational, as in enlisting volunteer transportation services for a family;

- To change the structure or the composition of an individual's or family's social network, as in helping a client develop new friendships;

- To increase skills in developing and maintaining supportive relationships, as in teaching social and interpersonal communication skills;

- To improve or enhance the functioning of social relationships, as in helping a family learn to reduce arguments among themselves.

Social network interventions may take a variety of forms depending on the family's needs and circumstances. For some families, interventions to decrease isolation and create opportunities for supportive interactions may be needed. Volunteer matching, parent-to-parent peer counseling programs, and parent support groups and organizations may be helpful. Neighborhood approaches with natural helpers and informal helping networks may also be employed. Network facilitation, in which the worker meets and plans interventions with network members, is another option. Some families will need help handling critical network members or improving relationships within their network.

Social network interventions should be congruent with intensive family preservation program objectives such as:

- Maintaining the child safely in the home, as in arranging for a neighbor or older relative to provide child care and supervision;

- Defusing the precipitating crisis, as in involving a network member in running errands or helping with household chores;

- Preventing future crises by developing a plan and a means to reach out to others for support when needed;

- Fostering maintenance of change over time, through, for example, helping a parent join a support group or self-help program.

Implementation of social network interventions requires skill and flexibility in executing a number of worker roles familiar to IFPS staff, including broker, advocate, organizer, counselor, and teacher. The empowerment philosophy and strengths-oriented perspective of these interventions is highly consistent with IFPS practice. Most importantly, the focus and use of the helping resources found in the existing natural environment is respectful of cultural and ethnic differences.

There are, however, several emerging issues relating to social network interventions with at-risk families. For example, families with substance-abuse problems create special concerns for social network interventions. Often the network has abandoned the family and is no longer willing to provide support; or the network itself supports and reinforces substance abuse. Rebuilding or the establishment of new networks may be necessary following intervention. In addition, work with Alcoholic Anonymous and Alanon may be essential in creating a non-using support system.

Even though IFPS workers provide intensive services, social network goals may not initially be seen as high a priority as other family needs, such as substance abuse or family violence. There may be a tendency to delay work in the area of social supports and social networks or to consider it part of community follow-up services after case closing. At this point, more studies are needed to determine the best timing for social support interventions and the relationship between success in achieving social support goals and other outcomes relevant to intensive family preservation services programs, such as reducing child placement and improving family functioning.

As was mentioned earlier, social network interventions also seem to be particularly appropriate for use with ethnic minority families, particularly for those families who need interventions that involve and make use of extended family resources. It is important, then, that social network interventions be informed by culturally sensitive practice techniques. This means that workers must understand culturally determined helping patterns, the definition and structure of extended families, and the roles of fictive and geographically distant kin (see Hodges, this volume). Only in this way can interventions support but not supplant these important naturally occurring helping resources.

Finally, two frequently mentioned barriers to linking formal and informal helping networks are the issues of accountability and confidentiality. If a worker arranges for a neighbor to provide some supportive service to a family, how does the worker ensure that the service is of high quality? Who is accountable if the service is not helpful or poses a risk to the child or family? How much information must be conveyed to network members about the family and under what circumstances do network interventions pose a threat to the client's right to confidentiality?

Summary

Systematic assessments of client's social networks have been found to be helpful in better understanding the needs of families referred to intensive family preservation services. Social support resources can often play a direct role in preventing the need for placement and in maintaining changes achieved through IFPS programs. However, it is important not to make assumptions about the social networks of at-risk families. The variety of ways in which social support is experienced by different families must be recognized and interventions must be tailored to meet individual family needs. While the presenting problems of the target population and the time-limited nature of IFPS programs make network based interventions challenging, the assessment and mobilization of social network resources is an important service component to help children and parents who are at risk of family dissolution.

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INTENSIVE FAMILY PRESERVATION SERVICES TO DRUG-USING FAMILIES

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Child welfare agencies in major metropolitan areas across the nation report that drug use is increasing among women and their children. The most widely cited estimate is that 375,000 children (11% of births) were born exposed to illicit drugs in 1988 (Chasnoff, 1988). This is certainly a high figure since it is based on research in large city hospitals. In such settings, universal toxicology screening of newborns yielded peak estimates as high as 25%, although recent evidence suggests a decline (Fulroth, personal communication, June 8, 1990). The vast majority of babies born prenatally exposed to drugs are exposed to more than one drug and are exposed to drugs other than crack. Crack cocaine probably is involved in no more than 1 to 4% of births (Besharov, 1989; Pettite & Coleman, 1990). This accounts for upwards of 30,000 drug-affected newborns per year, many of whom will require the attention of child welfare services. In New York City, between 1986 and 1988, 73% of child abuse deaths were the children of drug addicts (Feig, 1990). Estimates of the proportion of new child welfare cases involving drug abuse in particular cities or states range from 50% in Illinois to 80% in Washington, DC (Feig, 1990). According to case records of black children who entered foster care in 1986 in Detroit, Houston, Miami, New York, and Seattle (five major cities), parental drug abuse was a contributing factor in 36% of the placements and 54% of the children were still in foster care at the end of the study period, 18 to 40 months later. This figure varies widely, however, with only 12% remaining in foster care in Houston and 86% in New York. The majority of children taken into foster care as a result of parental drug exposure are one year old or younger, although their siblings are often brought into foster care as well (Feig, 1990).

The attention that drug-affected newborns receive from child welfare services varies greatly. Oregon and Minnesota use positive toxicology screens as prima facie evidence of child abuse. On the other hand, Iowa has new legislation prohibiting criminal action against the mother for drug use and requires more than a positive toxicology screen as evidence of child abuse. In various states and municipalities, children who are born with drugs in their systems are routinely made dependents of the court. In addition, certain agencies are changing their policies as their foster homes fill with drug-affected children; e.g., San Francisco county, before recently revising its policy, made all children identified with a positive toxicology screen dependents of the court for two years. A few jurisdictions have begun prosecuting drug-abusing pregnant and post-partum

women by using new definitions of child abuse or neglect that include drug exposure or by stretching existing laws to fit these cases. Drug czar William Bennett suggested that we may need to reopen orphanages on a massive scale to care for the children of drug-using women. The need for an informed approach to intensive family preservation services is great.

Are Drug-Affected Families Categorically Different from Other Families?

Not a word on intensive family preservation services for drug-affected families would need to be written if "drug-affected" were not considered synonymous with "crack-affected" or if these families were not considered significantly different from other families. The popular and professional assumption is that drug-affected families, especially crack, have rendered conventional child welfare services impotent. Yet, child welfare has successfully provided in-home services to substance-abusing families for more than a century (Gordon, 1988). Earlier discussions of family-based services are available to help alcoholic families change (Allen, 1986) and it is assumed that "most of the same principles apply to chemical dependency." Yet "crack" is thought to be instantaneously addictive, cause violence, hypersexuality, and rejection of the maternal instinct and role. Whereas recent evidence from interviews with crack-using women indicate that all of these conditions have been widely exaggerated in the popular press (Rosenbaum, Murphy, Irwin, & Watson, 1990), women who use crack can quickly become destitute, distracted and duplicitous; and their children suffer from lack of supervision during maternal crack use. They also may suffer from witnessing the humiliation of their mothers and from assaults on themselves by strangers and paramours. The fundamental questions addressing providers of family-based services to crack-using families are: Can we do anything and, if yes, for whom and how?

Risk Assessment

Risk-assessment protocols have not been validated for working with drug-affected families. Los Angeles County's protocol contains many of the issues that must be considered in any thorough assessment. It is not particularly useful, however, in making decisions pertaining to the removal of a child. There is little research regarding the course of crack use or to predict a family's ability to recover in order to provide a minimum, sufficient level of care. Empirically, as we shall see later, we do know that drug-using families can provide such care.

The diversity of crack use is minimally understood. Exposure to crack was initially touted as tantamount to addiction. Crack addiction was thought to be all consuming. The media found no place for experimentation, occasional use or recovery. Yet, Williams' (1989) ethnography of a crack ring indicates that there are many ways to participate in the crack culture and multiple outcomes exits other than death or desperation. The same is true for drug-affected children. The effects of prenatal drug-exposure on children have been described by a leading researcher at UCLA "as if a part of the brain that makes us human beings capable of discussion or reflection is wiped out" (The Crack Children, 1990; p. 63). Yet drug-exposed and crack-exposed children greatly vary from one another. Educators from the same city report, "there is no typical profile of a drug exposed child, and as such each child must be educated as an individual with particular strengths and vulnerabilities. The continuum of impairment can range from minimal symptomatology to severe impairment in all areas of the child's development" (Los Angeles Unified School District, 1989; p. 1).

Crack-using mothers can parent children, but not when the crack use consumes their time and resources. A long quote from the results of interviews with crack users is edifying:

> As mothers, crack users share basic American parenting values. They express a great deal of concern for their children, even if they cannot always demonstrate techniques commonly agreed upon as exhibiting good mothering.... They cannot simultaneously support a crack habit and children. Yet, they often try, for a period to do both. The problem is not always simply financial. The crack scene is all consuming and women become inundated in it.... Non-deliberate neglect is a more appropriate term for the mother-child relationship than abuse. We have not found evidence of exceptional physical abuse.... These women are aware that they are hurting their children, as evidenced by the fact that many in our population voluntarily gave their children to relatives because they doubted their ability to care for them. (Rosenbaum et al., 1990, p. 2-3)

We do not fully understand the range of the crack experience for mother and child, but several programs have begun to articulate the possibilities for family-based services for these families.

During routine risk assessments, social workers assess the capacity to parent. Part of this assessment depends on the availability of concomitant and future services that will support the parents, protect the child and preserve the

family. Services for drug-using parents, especially crack, are exceptionally rare. The familiar continuum of alcohol treatment programs from 28-day rehabilitation programs, to residential facilities, to long-term residential treatment programs, to halfway houses, to outpatient services, to self-help groups is not available for most drug-using women. In the communities most affected by crack, the few programs that are emerging include: (1) residential treatment programs that care for mother and child together (e.g., Mabon House in New York, Phoenix House in San Francisco, and Mandela House in Oakland); (2) day treatment programs that provide child care and early intervention services for children and education, training and recovery activities for mothers; (3) outpatient drug treatment and mental health programs; and (4) self-help (e.g., Narcotics Anonymous). As expected, the less intense the service the more available it is. Yet, the latter two programs are considerably less useful for women caught between the responsibilities of participating in drug treatment and parenting simultaneously.

Mothers of drug-affected newborns may have other young children who were prenatally exposed to drugs. A critical asset for drug-using mothers who have pre-school and school-aged children who were perinatally substance exposed and are experiencing behavioral effects is a specialized school program or enrollment in early intervention services (P.L. 99-457). Such programs often have social workers or public health nurses on staff who work with parents on caregiving issues and provide a safety net for the families. (As a policy issue, IFPS program staff need to work with their local early-intervention programs to guarantee the eligibility of drug-affected children.)

Home-Based Services Programs

Home-Based Services programs are now testing their mettle with drug-using families. The Families First program in Detroit, a IFPS program, has concentrated on families involved with crack cocaine (Sudia, 1990). Families of children who have experienced severe abuse are not often referred. Specially trained workers make contact with the mother and family, evaluate the level of drug use, and work with the mother to encourage participation in drug treatment and develop a plan for the continued care of her children. Families First has developed a continuum of substance use to determine which families qualify for these services. The continuum ranges from "occasional/recreational use" to "weekly/continuous use" to "daily use." The latter group involves families most often described in the press: families who sell belongings and behaviors for drugs, families who are unable to plan for treatment, and families who are not ready for change. The agency rarely receives referrals on these cases. The majority of cases fall at the other end of the spectrum, a picture that is consistent with the growing

understanding that crack is not inevitably an all-consuming drug. In a review of the first 97 cases, only 15 children were placed in foster care (15%) and 9 of the 15 were placed with family members (i.e., there was a 3% nonrelative placement rate). As of December 1989, about 50% of the cases were closed by the state shortly following Family First intervention; the remainder were kept under supervision.

Most home-based and intensive family preservation services programs have a broad focus that includes drug-using families. Eighty-six percent of all children served in Metro-Dade County's home-based services programs were with parents or relatives at discharge and remained out of foster care at the three-month follow-up (Metro-Dade, 1989). Of all families served, 58% were involved with cocaine and 76% demonstrated improvement in family functioning at the three-month follow-up. Thus, some cocaine-using families apparently made gains.

About 12% of the families served by the Children's Home Society's Emergency Family Care Program were identified as having substance abuse problems (Berry, 1990). The placement rate among these families was 19%, which is higher than average for the program (for all families the placement rate was 12%). The Healthy Infant Project (HIP) at Highland Hospital (Oakland's public hospital) provides in-hospital assessment and post-discharge home-based services to women who are identified as having had a positive toxicology screen. HIP receives all referrals of positive toxicology babies and provides home-based social work and public health services. They ultimately refer only 10% of referrals to child protective services.

Intensive family preservation services typically have been limited to placement prevention programs. Yet, especially with drug-affected families in which a range of harms including placement are likely, intensive family preservation services are warranted for child abuse prevention. The developmental impact of intensive placement programs with drug-using families has not been determined. Intensive family preservation services are intended to be activated at a moment of crisis. This is a narrow conception of their use; families can also benefit from their use during a time of opportunity. Pregnancy and the birth of a newborn, with all the attending aspirations and hopes, offers such an opportunity for many mothers. Numerous studies have shown that services that begin during pregnancy or, at the latest, during lying-in are particularly effective if they employ professionals, who visit frequently and for a long enough time to develop relationships (Olds & Kitxman, 1990).

Many questions and answers face the providers of intensive family preservation services to drug-using families. In addition, if these services are not lasting and supportive, they probably do not adequately serve the purpose. Heavy drug-using parents who participate in drug treatment programs, need

PRESERVING FAMILIES THROUGH REUNIFICATION

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Each year in the United States many children in foster family care, group homes, or residential treatment centers are reunited with their families. In 1983, for example, over 100,000 (56%) of the 178,000 children who left care were discharged to their biological families (Tatara, 1989). A substantial proportion of these children, however, sooner or later return into some form of out-of-home placement or enter another helping system, such as juvenile justice or mental health (Fein, Maluccio, Hamilton, & Ward, 1983; Rzepnicki, 1987). In addition, many others await reunification (Fein, Maluccio, & Kluger, 1990). In response to the needs and experiences of these children and their families, in recent years there have been increasing efforts to apply principles and strategies of intensive family preservation services (IFPS) to case situations involving family reunification.

Intensive efforts to reconnect families separated by foster care placement and keep them together are similar in many ways to efforts designed to prevent placement. Foremost among their similarities is a shared purpose: strengthening and enhancing families. Other similarities include the provision of concrete as well as intangible services and supports in the family's home by accessible staff who work flexible hours. Attention is paid to the family as a system to strengthen family bonds, help families use formal and informal resources, and help parents improve their child care skills (Whittaker, Kinney, Tracy, & Booth, 1990).

However, intensive family preservation services aimed at reunifying families differ from those designed to prevent placement in significant ways. Chief among them is the work with a family whose members are separated by the placement. For some families, this means first, that contact between children and parents may need to be re-established before family bonds can be strengthened. Second, the practitioner and the family face different challenges in teaching and learning parenting skills when children are out of the home, as there may be fewer opportunities to observe parent-child interactions. Third, family reunification does not necessarily involve a crisis as when a family is threatened by the imminent removal of a child. Fourth, a family whose child has been placed may be perceived by themselves and others as a "failed" family; therefore, fostering hope and a belief in competence and the potential for success presents a greater challenge in work with families who have experienced placement than those who have not. And fifth, during placement a child may have formed a

relationship with a caregiver, such as a foster parent, that will need to be recognized and dealt with by parent and child.

In addition, efforts to prevent placement presume that parents have the willingness and ability to be daily caregivers for their children. An essential aspect of reunification practice is the assessment of the optimal degree to which parents (or other family members) and children can be reconnected. The results of the assessment may show that it may not be possible for children to live full-time with their birth parents or relatives, but family bonds can be preserved through less extensive forms of contact.

Finally, another significant difference is the length of service provision. While reunification services may be intensive at times, services designed to help families reconnect and stay together may need to be provided on a much longer term basis than is true in most IFPS models. It is possible that some families need services indefinitely in order to stay together (Maluccio, Krieger, & Pine, in press).

Against the backdrop of these similarities and differences, this paper presents a conceptual framework for family reunification practice, delineates major program components of effective family reunification and their relationship to IFPS, and indicates various practice and service delivery issues that need to be considered in the education and training of social workers involved in this area of practice. Differences requiring modifications when IFPS programs are applied to family reunification are noted.[1]

Conceptual Framework[2]

Definition

It is essential that we think broadly and flexibly about family reunification in response to the unique qualities, needs, and situations of each child and family. For this reason, we define it as follows:

> Family reunification is the planned process of reconnecting children in out-of-home care with their families through a variety of services and supports to the children, their families, and their foster parents or other service providers. The aim is to help each child and family to achieve and maintain, at any given time, their optimal level of reconnection -- from full re-entry into the family system to other forms of contact and affirmation of the child's membership in that family, such as visiting (Maluccio, Krieger, & Pine, in press).

This expanded view of family reunification underscores the value of maintaining and enhancing connectedness or reconnectedness between children in foster care and their families. At the same time, it recognizes that not every parent can be a daily caregiver and that some families, though not able to live together, can still maintain kinship bonds.

Underlying Principles

As suggested by the earlier definition, family reunification practice is guided by a number of underlying principles, including the following:

1. Family reunification is an integral part of the philosophy and practice of family preservation and permanency planning, with an emphasis on ensuring continuity of care for children. Family reunification should be systematically considered and planned as early as possible in a child's out-of-home placement.

2. Family reunification is a dynamic process based on the child's and family's changing qualities, needs and potentialities. It should be viewed as a continuum, with levels or outcomes ranging from full re-entry into the family system to partial re-entry to less extensive contact such as visiting, phoning, writing and other affirmations of the child's membership in the family. At any given point during the child's out-of-home placement, the most appropriate or optimal level of reconnection should be identified and actively pursued. At the same time, it should be recognized that reconnection is not possible or desirable in some situations, which may require termination of parental rights.

3. Reunification, as an expression of family preservation, embodies convictions about the role of the biological family as the preferred child-rearing unit; the potential of most families to care for their children, if properly assisted; and involvement of all members of the child's family, including the extended family members or others who, while not legally related, are considered by the child and themselves to be "family."

4. Reunification practice is guided by an ecologically-oriented, competence-centered perspective that emphasizes such aspects as improving the interaction between people and their environments;

promoting family empowerment; engaging in advocacy and social action so as to achieve societal conditions and structures that promote family preservation; reaching for, and building on, the strengths and potentialities of parents and other family members; involving parents as partners in the helping process; and providing, as needed, family-based, home-based or intensive family preservation services.

5. There should be an ongoing partnership among children in care, their biological families, foster families and other caregivers, social workers, and other service providers. Partnership is promoted through effective teamwork, in which the differential roles of all parties are clearly spelled out and understood.

6. There should be respect for human diversity -- cultural, racial, ethnic, etc. -- and acceptance of lifestyles and child-rearing methods that might be considered different or unusual, so long as they promote a child's health and safety. This principle is especially crucial, since a disproportionate number of children in care come from minority families, whereas most practitioners are from a white, middle-class group.

7. There should be a commitment to early and consistent contact between the child and family as an essential ingredient in preparing and maintaining a successful reunification.

8. Family reunification services should be offered for as long as they are needed to maintain the reconnection. For many families, an intensive family reunification service may need to be followed by a less intensive service. For a few families, some level of service may be necessary until the children reach young adulthood.

Program Components

Various exemplary or special projects throughout the country seek to operationalize the principles discussed in the previous section. These projects vary in terms of agency auspices (public, voluntary or a combination); primary service context (e.g., foster family care, residential treatment center or community mental health setting); target population (e.g., families with young children); and duration of service (e.g., three months to two years). A review of these projects

indicates that they share some or all of the following program components (Pine, Krieger, & Maluccio, in press).

Family-Centered Orientation

The first and foremost component is a "family-centered orientation" to service delivery. This basically refers to the idea that the family should be the central unit or focus of attention and that decisions be made in the best interest of the family. The assumption is that human beings can be best understood and helped within their significant environment, and the family is the most intimate environment of all (Hartman & Laird, 1983; Maluccio & Whittaker, 1988).

As in all IFPS efforts, intervention is directed as much as possible toward strengthening the family. The family's own environment can be employed as the arena in which practitioners intervene to help strengthen tangible resources, such as those related to housing and employment, as well as communication, parenting skills and parent-child relationships.

Partnership with Parents and Other Family Members

A second component, which flows from the first one, is an ongoing partnership among practitioners, foster parents and parents, as well as other family members. The intensive family preservation services and family reunification programs that are most effective are those that involve family members as partners, especially parents, as much as possible in the helping process. This is an idea that is widely accepted in theory but that is most difficult to implement in the area of family reunification, once a child has been removed from the home. A variety of organizational and service impediments exist, including inflexible work schedules, poor client transportation services, limited fiscal resources, and insufficient worker time to visit families in their homes. Practitioners need to work hard to involve parents and children as decision makers in a continuing partnership with foster families, child care workers, social workers and other providers. IFPS programs have demonstrated how partnerships can and should be developed. (See Kinney et al., this volume and Kinney, Haapala, & Booth, 1991).

There are different tools and strategies for implementing the concept of partnership, such as use of the contract or service agreement. But, above all, this involves major attitudinal changes toward parents on the part of social workers and others; in particular, shifting from the view of parents as carriers of pathology to the belief that they can change and grow, if given adequate supports

and opportunities to realize their potentialities and demonstrate their strengths. As in IFPS programs, parents can be viewed as colleagues in the change process (Kinney, Haapala, Booth, & Leavitt, 1990).

In this connection, it also should be stressed how important it is to view foster parents and child care workers as partners in the provision of services as members of the service team. Such a view underscores the importance of clarifying their respective roles, offering varied opportunities for professional development, and providing adequate supports and financial rewards.

Empowerment of Social Workers

Social workers need to be trained, supervised and given the authority to make decisions in family reunification practice. Specifically, agencies need to empower staff by creating a climate and structure that promotes professional skill attainment, permits the exercise of needed decision making and authority, and recognizes that the staff's ability to empower families is linked to the degree to which they feel empowered.

It stands to reason that social workers who are helping children and families to take charge of themselves must practice within an environment that recognizes, sustains and enhances their professional identity. Above all, if family reunification is to occur, social workers need to be supported in the difficult decisions they are required to make. As demonstrated by IFPS programs, this can be accomplished through flexible schedules, opportunities to work in teams, creative and flexible supervision or consultation, and other organizational supports (Kinney, Haapala, Booth, & Leavitt, 1990).

Comprehensive Services and Supports

Given the multiple and complex needs of families in basic life areas, another major component in both IFPS and family reunification is the provision of a variety of supports and services. Although more extensive research needs to be undertaken, studies suggest that the best way to successfully reunite children and families is to provide a combination of soft" services, such as counseling and parent training, as well as "hard" services, such as income assistance, housing, and day care. Informal supports, such as parent aides, volunteers, or recreational opportunities for parents, have been found to be especially useful (Haapala, 1983; Levine, 1964; Pine, Krieger, & Maluccio, in press; Polansky, Chalmers, Buttenweiser, & Williams, 1981).

At the same time, it is important to avoid providing rehabilitative or therapeutic services in a way that says to parents that they are defective; we should avoid the typical tendency to "blame the victim." The range of societal or systemic problems that lead to out-of-home care in the first place, such as racism, poverty and homelessness, call for advocacy and social action in addition to direct practice with families (Pelton, 1989).

Collaboration and Case Management

Successful programs recognize that family reunification practice requires the services of numerous systems, such as legal, health and mental health and education, and they regularly convene inter-agency, inter-disciplinary teams for service planning, implementation and training.

Providing the kinds of services that are required is no simple task, even when services are adequate and accessible. As in the human service field, in general, there needs to be someone to orchestrate the entire plan and its implementation with and on behalf of the family. Given the many difficulties involved in formulating as well as implementing a service plan in complex situations that come to the attention of agencies, the case manager has a crucial role to play in any family reunification program. In addition to negotiating with service providers, such as those noted above, on behalf of families, the case manager helps parents to attain skills in working with these systems on their own behalf.

Therapeutic Use of Out-of-Home Placement

Another component is the therapeutic use of out-of-home placement. With the exception of a few children, care away from home can no longer be viewed as an end in itself, as a full substitute for the biological family or as the provision of custodial care. Out-of-home placement is a vehicle or a means to an end, namely, rehabilitation of the family or child, and reconnection of the child with the family as much as possible. This means, for example, that parent-child visiting is used therapeutically for a number of purposes, including maintaining or enhancing the parent-child relationship, assessing the parent's functioning as a parent, and teaching parents and children to relate to each effectively (Hess & Proch, 1988).

Even in cases where it is not possible for the family to totally care for a child, efforts should be made to teach parents skills to relate at least partially to their child. This is especially important for adolescents who move into

independent living situations. Research shows that many of these young people resume contacts with their parents upon discharge from care and start of independent living (Fanshel, Finch, & Grundy, 1990; Jones & Moses, 1984). Often, the adolescents and their parents are unprepared for such a relationship, even though they may want it. Both need help to develop the necessary skills for living together, whether permanently or on a temporary basis (Maluccio, Krieger, & Pine, 1990).

Specialized Training

There should be specialized training of social workers, foster parents and others for family reunification practice, with emphasis on the values of family preservation and the specific knowledge, attitudes and skills required when working to reunite a family that has experienced the trauma of separation and placement, and to help the family remain reunited.[3]

As delineated in detail elsewhere (Maluccio, Krieger, & Pine, 1990), practice in this area requires that social workers not only have generic or core competencies in child welfare but also possess specialized family reunification competencies in relation to:

- Values and attitudes, such as conviction about the importance of preserving family ties;
- Assessing readiness of child and family for reunification;
- Goal planning that actively involves parents in decision making on behalf of their placed children;
- Implementing the family reunification plan;
- Maintaining the reunification; and
- Ending the service.

Special Themes In Social Work Education And Training

The principles and program components delineated thus far in regard to family reunification clearly have much in common with IFPS practice. In addition, the unique aspects of family reunification practice noted earlier suggest that practitioners be required to have specialized education and training. As discussed more extensively elsewhere (Pine, Krieger, & Maluccio, in press), following are some of the practice and service delivery themes requiring emphasis in

appropriate courses in schools of social work and in staff development programs in agencies.

Continuum of Reunification Outcomes

Families as well as service providers need help to recognize that reunification represents a continuum of outcomes, from returning home to other, more appropriate forms of contact. IFPS strategies and principles can contribute to the efforts to support connectedness of children with their families, whether birth, extended, foster or adoptive.

In particular, ambivalent parents can be helped to maintain relationships with their children by deciding on the degree of reconnection that they and the children can and wish to have, and to prepare for it through such means as trial visits. In identifying each child's and family's optimal degree of reconnection, consideration should be given to helping the child rejoin with family members, including not only parents and siblings, but also relatives and significant others who constitute a family for a particular child. It also should be recognized that occasionally no contact is appropriate or desirable.

Mobilizing Motivation

Various approaches may be employed to take advantage of the motivation that family members often have to become reconnected. If a threat of termination of parental rights exists, clarification of this possibility can help parents to become more focused and involved in reunification activities. In most cases, however, a great deal of outreach is required on the part of the worker, so as to support and encourage family members' concern for and interest in the child. Unless contraindicated, there should be aggressive efforts to maximize the family's involvement with the child during the placement process as well as the placement itself.

As noted earlier, placement can thus be used as a therapeutic tool not only to promote changes in child and family but also to maintain and improve their sense of connectedness with each other. One especially pertinent strategy is to encourage the use of claiming behaviors by both parents and children, such as sharing photographs, use of child nicknames, celebration of birthdays, and re-initiation of healthy family rituals practiced in the past (Fahlberg, 1979; Hartman & Laird, 1983).

Perhaps an even more important element in bringing about lasting reconnections is the social worker's attitude toward the family. Social workers are

apt to be helpful when they fully believe that almost all families can be growth-promoting units with powerful tendencies to survive. The maxim, "what we expect, we will find," is particularly relevant to reunification practice. When social workers assume that the family with which they work is motivated, caring and interested in finding ways to care for themselves better, they can encourage family members to change in positive ways (Zamosky, Sparks, Sharman, & Hatt, in press).

In this regard, family reunification practitioners can learn much from related IFPS values, concepts and strategies. For example, in the HOMEBUILDERS model there is emphasis on the belief that "people are doing the best they can"; the conviction that, "even in the worst of presenting situations, family members care a great deal about one another"; and the need for "a more compassionate view of the problems of families" (Kinney et al. 1990, p. 37).

Readiness for Reunification

One of the major challenges in family reunification practice is working with family members to assess whether and when they are ready to be reunited. Family members and service providers need to balance the risks of returning home with those of prolonging the child's stay in foster care. Just as in IFPS programs, there is the need to ensure the child's safety while respecting family integrity and autonomy. Also, workers and family members must assess whether the conditions that initially necessitated placement have been addressed satisfactorily.

Therefore, in family reunification as in IFPS programs, practitioners need to be versed in assessment of risk factors associated with various forms of child maltreatment. Especially pertinent in this regard is an ecological framework for assessment that considers the following aspects:

- Child-related risk factors and strengths;
- Parent-related risk factors and strengths;
- Family-related risk factors and strengths;
- Type and nature of past maltreatment;
- Availability of necessary treatment services and family supports, as affected by the family's ability or willingness to use them to address the most critical risk factors (Holder & Corey, 1986).

Additionally, evaluation of readiness for reunification is based on interactions that take place during home visits between child and family, as well as subsequent reactions to those visits. Thus, practitioners need to recognize and

use the visiting experience as an assessment opportunity that can yield much needed information.

Practitioners should also appreciate that the risk assessment instruments currently available, while useful for guiding practice in certain circumstances, are imperfect and are not a substitute for professional interviewing skills, good analytical skills, and careful clinical assessment (Pecora, in press; Wald & Woolverton, 1990).

In addition to risk assessment, practitioners need to work with the family in evaluating such aspects as the family's and child's willingness to reunite; the parents' ability to meet the child's changing or changed needs; the family's conflict resolution and other problem-solving skills; the strengths and potentialities that make reconnection possible; and the supports available to maintain the reconnection (Maluccio, Krieger, & Pine, 1990). Such a comprehensive assessment is essential in all family support programs, as highlighted by McCroskey, Nishimoto, and Subramanian (1991):

> Workers must understand the environment, the parents, the child, and their interactions if they are to intervene quickly and effectively. The dynamics of in-home work demand that workers focus on the parts and the whole almost simultaneously. They often do not have the luxury of a lengthy assessment period, particularly when families need immediate help for complex pressing problems. (p. 20)

Re-entry into a Changed Family System

In each case, it is essential that workers appreciate the ways in which the family system has changed since the child's removal and assess what needs to be done to facilitate his/her re-entry. For example, parents often have to be helped to cope with the lack of privacy, frequency of visitors and phone calls, and financial responsibilities that can accompany a child's return home.

Workers need to help family members identify perceived differences or changes in family "rules," patterns, and behaviors on the part of each family member. This understanding can then be used to plan for cognitive and behavioral changes that might help family members cope with the impact of the child's re-entry. Thus, in some case situations, the family can be helped to anticipate certain problems or pressures as one of its members, who has also changed, returns home. As another example, the impact of separation and placement on a particular child and family needs to be understood; and the child

or other family members may need help with their feelings of loss, grief, anger, etc.

Family-child visiting can be used as a vehicle for providing such help, for helping parents learn or re-learn parenting skills, and for preparing everyone for reconnection (Hess & Proch, 1988; Hess & Proch, in press). Even when it becomes clear that the optimal level of reconnection -- return home -- is not attainable, parents can be helped to play care-giving roles that strengthen bonds with their children. Visiting can be planned to provide opportunities for parents to recognize and appreciate their children's achievements, find ways to help their children to feel positively about themselves and other family members, and share cultural rituals and family celebrations.

Finally, foster parents can serve as valuable resources to children and parents on their path towards reconnection. They can support and promote visiting efforts, share sensitively with parents' knowledge about the child, and collaborate effectively with other service providers on behalf of the family. At the same time, foster families also must be supported throughout the process of reunification, lest their separation and loss issues negatively affect the child's transition back into his/her home. Many children are sensitive to and easily upset by the messages of guilt and sorrow directly or indirectly conveyed by the most competent foster parents.

Intensity and Duration of Services

A specific challenge in family reunification is how to apply the concept of time-limited, intensive services that are fundamental in the philosophy and practice of IFPS. Many of the families to which children return are likely to be crisis-ridden and to have continuing needs in multiple areas such as health, housing, income assistance and family functioning (Jenkins, Schroeder, & Burgdorf, 1981; Polansky et al., 1981; Shyne & Schroeder, 1978).

In light of the combination of environmental problems and crisis-ridden quality in the families, it would seem that intensive, time-limited services often need to be complemented with ongoing services and supports (Barth & Berry, 1990). While some programs use a brief and intensive approach (Haapala, Johnston, & McDade, in press), most family reunification programs employ a longer service period than is typical of IFPS, or incorporate long-term follow-up services.

The application of IFPS principles and strategies therefore requires flexibility in relation to duration and intensity of services. Challenges for workers include:

- Identifying the intensity as well as types of services required during each phase of the reunification process;
- Providing concentrated services, especially during the initial phase of re-entry when the family system is more likely to be in a state of crisis and, thus, more amenable to change;
- Linking the family with informal and/or formal supports;
- Ensuring that the range of service providers work in concert to meet the needs of children and families;
- Providing services as long as they are needed to maintain the reunification, including knowing when to contact families to provide interim supports; and
- Balancing the concern for protecting the child and supporting the family with the risks of perpetuating dependency and intruding into the family.

Conclusion

Attention to family reunification is one expression of the renewed emphasis in child welfare on preserving families. Effective family reunification practice requires extensive resources and commitment on the part of administrators, policy makers, practitioners, foster parents, and other service providers. It should not remain the province of a few exemplary or demonstration projects here and there, but become an integral, regular part of the services provided in each community for all young people in care and their families. Additionally, family reunification requires initial attention as soon as it is determined that a child should be placed; intensified and persistent attention throughout the placement; and provision of follow-up services to maintain the reconnection. The values, principles, and strategies of IFPS can help guide and support such attention. Indeed, the unique challenges of preserving families that have been separated through placement require new thinking, revised practice strategies and emphasis on hope and compassion for the most vulnerable families.

Reference Notes

[1] The chapter draws on the findings of a two-year project just completed by the authors. Its purpose was to produce a range of educational and training materials aimed at improving the ability of agency staff to strengthen families so that more foster children can return home from placement and remain there. (Child welfare training project on "Promoting Family Reunification through Agency-School Collaboration", 1988-1990. Funded by The Annie E. Casey Foundation and the U.S. Department of Health and Human Services, Office of Human Development Services, Administration for Children, Youth and Families, Grant Nos. 90-CW-0942/01 and 02).

[2] This section has been adapted from Pine, Krieger, and Maluccio (in press).

[3] See Krieger, Maluccio and Pine (in press) for a range of teaching modules and other training materials in the area of family reunification practice.

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Appendix A
Classroom Exercise
Planning For Reunification Within The Context of Intensive Family Preservation Services

Purpose

This exercise encourages students to think broadly and imaginatively about planning for reunification of children in out-of-home care with their families, within the context of IFPS. Through participation in the exercise, students will be able to:

1) Apply selected IFPS concepts and strategies to family reunification practice;

2) Become aware of the importance of thoughtful and early planning toward family reunification; and

3) Identify the kinds of policies, programs, and practice strategies that can help promote family reunification.

Directions

Ask students to read the case summary at the end of this appendix ("The Green Family") and come to class prepared to discuss questions such as the following:

1) What is the potential for reunification of this child with his family? Which case goal(s) might this family be helped towards? What service plan would you formulate to accomplish the case goal(s)?

2) How could the application of IFPS practice technology facilitate the reunification of the child with his family? Which unique IFPS values, principles, and techniques could promote reunification plans and goals for this family?

3) What are the family strengths and potentialities that could support the above case goal(s)? What are the potential risks in reunification?

4) If you think that reunification of this child with this family is not feasible or desirable, what would be your recommendations for a future plan for him (e.g., continued foster home placement; adoption; etc.) and for his continuing involvement (if any) with members of his biological family? What steps would you and the agency take to achieve this plan?

5) What additional information would you need to help you in your assessment and planning in this case?

6) What implications does this case suggest in relation to policies, programs, and practice strategies that would be useful in promoting family reunification for children in out-of-home care in general, and the application of IFPS technology in particular?

THE GREEN FAMILY*

Andy, age 5, voluntarily placed in foster care by his mother when he was 3.

Julie, age 26, Andy's mother. Grew up in foster care; no family support.

Jack, age, 28, Andy's father.

Paul, age 31, Julie's live-in boyfriend.

Andy has been diagnosed as having an attention deficit disorder and was placed on Ritalin. He has suffered from seizures and is known to walk in his sleep. He has destroyed stuffed animals, started fires, demonstrated acts of self mutilation and at one point drank a bottle of Tylenol. There is concern that Andy has been physically, sexually, and emotionally abused and emotionally neglected. Andy has been placed in three different foster homes. The first move was at the foster parents' request because of Andy's behavior and the second move was the result of physical abuse by the foster parent and sexual abuse by a foster brother. Andy says he doesn't think anyone wants him.

Andy's behavior is overwhelming to Julie and her interest in Andy can best be described as ambivalent. She has been irregular in her visits, and missed many scheduled appointments. She has, however, followed through on plans to phone Andy, and both report that they look forward to their times on the phone.

Andy's father expressed an interest in Andy but was frequently inconsistent in following through with agency requests. He visited less than offered, was slow to establish paternity as ordered, and failed to follow through with a psychological evaluation. Jack has a history of substance abuse and, according to Julie, has a tendency to become physically abusive. Julie states that he seriously injured her back in their last confrontation.

Julie has a relationship with Paul, whom she describes as her live-in boyfriend. Julie admitted that there were some problems between Paul and Andy. Paul is "extremely short tempered" and Julie is afraid he may seriously hurt Andy. Julie said she would sign papers for an open adoption, but believes that will terminate her parental rights, giving Jack the decision-making power over Andy.

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*The authors are grateful to Peg Hess and Gail Folaron, of the Indiana University School of Social Work, for providing this case example.

Julie believes that there needs to be institutions set up for young children so that they can have one place to live -- a place where they can stay and won't have to move. In terms of placement in her own home, Julie says, "I'd have to make a choice if they decided to return Andy. I'd have to choose Andy, of course, because he is my child. But I don't know. So I'm not making any choices."

ADOPTION PRESERVATION SERVICES

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Older child adoptions have increased in proportion to other forms of adoptions in the last decade and will continue to do so. Adoption is a form of family formation with many similarities to stepparenting and marriage. In keeping, not all older child adoptions succeed--the difficulties of creating a new family are at times too great. Efforts to strengthen older child adoptions, the focus of this chapter, have implications for allied efforts to preserve other family relationships.

Older children placed for adoption are children who have been abused or neglected and freed from their parents' custody after efforts to return them home failed. Legislation in 1980 (PL 96-272) mandated the preference of adoption when foster children could not be returned home. There are roughly 15,000 adoptions of older children (usually defined as children aged three or older) each year (Maximus, 1984). As reports of child abuse add to the numbers of older children who will be removed and freed from abusive homes, and as infant adoptions become less available, older child adoptions will grow in number.

Older children are adopted after considerable time in the child welfare system and have varied histories that always include abuse or neglect and often include parental problems of substance abuse or mental illness and other unfortunate environmental and economic conditions. These conditions are reflected in the child's behavior and understanding of family life and have an impact on his/her adjustment to adoption. Therefore, problems of older child adoptions are more common than infant adoptions. Numerous studies (Boyne, Denby, Kettenring, & Wheeler, 1984; Groze, 1985; Nelson, 1985; Zwimpher, 1983) inform us that older adopted children may display dramatic and problematic behavior.

Because of these difficulties, older child adoptions are more likely than infant and stepparent adoptions to be short-lived. Nonetheless, 89% of older child adoptions are successful and 11% are unsuccessful. If an adoption is unsuccessful or "disrupts," the child is returned by the adoptive family to the agency (Barth & Berry, 1988; Partridge, Hornby, & McDonald, 1986; Urban Systems Research and Engineering, 1985). Adoptions can be termed "successful" to varying degrees. While most adoptions remain intact, the adoptive families of older children may expend enormous amounts of patience, energy and time endeavoring to stay together.

Given conventional adoption services, 1,500 of the 14,400 adoptive older child placements each year will disrupt. For younger children (i.e., ages 3-6 at the

time of placement), the disruption rate is 8%. For youth adopted as adolescents, the disruption rate approaches 25% and for sub-groups (children in their second or third adoptive home) the rate is higher (Berry & Barth, 1990). At least 2,000 of these children will be at risk of disruption but many of their families will find an alternative. In most situations, families turn to informal support systems to seek assistance and in other cases they call on the agencies to assist them in preventing disruption. In one study, however, families that recovered from the brink of disruption rarely credited conventional social services and referral to psychotherapy as a significant contributor to the stability of their adoption (Barth, 1988). Conventional child welfare services to prevent disruption also seem to have minimal success. Although family formation includes some (usually worthwhile) risk of dissolution, the personal and financial costs of disruption to the child, family and children's services agency calls for additional knowledge and reformed practice to prevent unnecessary disruptions.

The Limits of Conventional Services to Prevent Disruption

Many families experiencing difficulties in adoptions are encouraged to bring their children to psychotherapy despite the general lack of evidence that conventional psychotherapy is effective (Levitt, 1971; Barrett, Hampe, & Miller, 1978). Most therapy involves the referral of the child instead of the entire family. Parents interpret this as another indication of the secondary status of adoptive parents with little control over the treatment of their children (Barth & Berry, 1988). Hornby (1986) also reports that disrupting parents complained that they received no tangible assistance from agencies; they were given nothing more than interpretations of the children's behavior. Few therapists were knowledgeable about adoptions and/or foster care. Thus, they did very little to promote the understanding of therapy to parents or to involve them in the process of altering their interactions within their children's environment to support more acceptable and competent behavior. Families dropped out of therapy because they did not receive support and consideration of what the family system could or could not do to accommodate the children. Reitnauer and Grabe's (n.d.) study of the therapy provided adoptive and foster families indicates that the families seek help because of "behavior-centered problems" (p. 17). The type of therapy most often used was child or play therapy, even with children ages 9, 12 and 15. A large portion of the children were exposed to non-directive counseling that was evaluated by parents to be of little use. According to Reitnauer and Grabe (n.d.), "the non-directive approach is not useful in most situations with foster/adoptive children" (p. 19).

Overall, the most satisfied parents are those who received help with behavior management from therapists, even though the families were left to rely on themselves and their social workers to address specific issues related to adoption (Barth & Berry, 1988). These families did not see the unresolved issue of adoption as the key contributor to problem behavior, although there were a few exceptions, e.g., when youth had not disengaged from birth parents. Rather, the problem behavior was the key barrier to resolving ambivalence about the adoption. Adoption specialists often view unresolved issues about the adoption as causing the problem. This has some truth, but other studies suggest that children's difficult behavior typically preceded the adoption.

Alternatives to Conventional Treatment

What alternative to referrals to conventional child therapy might pre-empt disruptions? The first is to prevent the need for referral to therapy. Tremitiere (1979) argues that "the use of a realistic educational process prior to placement" can markedly reduce the need to refer to psychotherapy--less than 5% of families in her agency attend therapy. The more typical recourse for these families is to contact other families with whom they participated in group home studies. Families involved in group home studies continue to rely on contacts developed during this period for a range of consultative, recreational and legal resources during their placements. The likelihood of useful referrals to therapy for placements that could benefit from such resources can be increased by inviting therapists and special education personnel to participate in group home studies. They learn about adoption and the concerns of families and families learn about the availability of resources.

A second alternative is to rely on therapeutic resources that emphasize not only the child's past and/or personal experiences but the importance of the child's current family and educational experiences (Barth, 1986). The importance of obtaining regular or special education resources for children was consistently identified as a pivotal point in determining the outcome of the placement. As a starting point for helping the agency decide which therapist a family should consult, the agency or family should ascertain whether the therapist will have direct contact with the school. This is a strong indicator of the therapist's willingness and ability to obtain a complete picture of the child. If the therapist indicates that he/she does not have the time or talent, or that such contact violates his/her therapeutic notions, then another resource should be considered.

Therapists who are knowledgeable about adoptions and family and behavior management are scarce and valuable gems. Partly because of our personal experiences and partly because of our review of the literature and data

from this study, we argue that families come to therapy to look for specific strategies to reduce the most difficult behaviors of children. The origins of these behaviors can be better understood with knowledge of the many stressors suffered by adopted children, but the most fundamental knowledge required of social workers and therapists has to do with strategies for changing difficult behavior. Even if they have never heard of adoption, experienced social workers and cognitively oriented child therapists can help families find positive incentives for improved behavior, help families improve on their non-aversive strategies for reducing problem behaviors (e.g., clarifying how time out or an equivalent might be used more effectively) and by supporting a gradual and focused change effort.

Many agencies have introduced support groups of adoptive families for parents and children (Cordell, Nathan, & Krymow, 1985; Tremitiere, 1979; Gill, 1978). It is often helpful for new adoptive parents and children to talk to fellow adopters and adoptees in order to identify what is normal in adoption and to share realistic expectations and feelings about the process. These groups also facilitate supportive relationships that parents and children can resort to in individual need. We suspect that these groups operate best when relationships are initiated during home studies, but we have seen successful versions developed to support high-risk placements.

Intensive Family Preservation Services for Adoptive Families

Intensive in-home adoption preservation services may be needed. In the last decade such services have emerged in most of our states but have been primarily reserved for preventing entrance into the child welfare or mental health systems. Generally, adoption agencies have not called on these services to help preserve adoptive placements.

Recently, Medina Children's Services, a Seattle-based agency specializing in adoption of older and special needs children, and the Behavioral Sciences Institute (parent of HOMEBUILDERS) collaborated to develop and evaluate intensive family preservation services for Special Needs Adoptive Families and to provide training. As in all HOMEBUILDERS interventions, each full-time therapist in the project has a caseload of two families, the intervention consists of four weeks of in-home therapy, and the therapist has contact with the family as often as needed, usually three to five sessions of two hours or more. One year after these special services were initiated, 59% of the adoptive families who indicated that they were experiencing adoption crises and were at risk of disruption did not disrupt.

The synopsis of a case (Johnson, 1987) from that special IFPS project illustrates the manner in which intensive adoption preservation services transcend

conventional post-placement services. Intervention with the Avery family lasted four weeks and included approximately 40 hours of contact time. Darlene, Abe, and their children, Pam (now 17 but adopted at age 10) and Daniel (age 5) were referred to the HOMEBUILDERS Adoption Services Project after Pam ran away and stated that the situation at home was so bad that she wanted to cut her wrists. A neighbor reported hearing the father tell Pam that he wished she was dead. She was in a receiving home at case opening, but the family agreed not to relinquish her if she would participate in counseling.

The night the therapist brought Pam home from the receiving home, Abe was so mad at her that he broke down in tears and would not look at her. The intervention addressed the goal of improved communication among family members. Parent training promoted Abe and Darlene's ability to praise and be positive with Pam. Pam learned ways to refrain from lying and to build better social relationships with peers through role playing and homework assignments. The therapist encouraged the family to involve themselves in various activities and worked with them until they formed specific plans. As a result of the intervention, the parents and Pam renewed their commitment to a permanent relationship. Abe and Darlene changed their view from "the adoption didn't work and we made a mistake," to "we are having trouble parenting our child but we are learning to do so." By the end of the intervention, all family members reported enjoying each other more and using improved communication. Abe changed from reporting that he is not bonded to Pam and that she was never part of the family to reporting that she is more a member of the family than ever before.

What is remarkable about the intervention is not the activities, with the exception of logs and role plays; but many seasoned therapists in the treatment programs discussed earlier would have proceeded in a similar manner. More critical was the timing and intensity of the efforts. Pam was home before the family could solidify their decision to relinquish her. The therapist worked with them nearly every day for a month to take advantage of this crisis period to make significant changes. A more typical 90-minute per week family therapy session would be unlikely to provide such facilitative timing and intensity.

Of the 22 children served by the pilot Medina and HOMEBUILDERS collaboration and whose outcomes were known at the one-year follow-up, nine remained with their adoptive families, nine families petitioned to officially end their placements, and four youth were not at home but had not experienced disruptions (Jill Kinney, personal communication, December 12, 1990); they were in various forms of group care or living on their own. Thus, the disruption rate is 41% and could go as high as 59%, depending on the final outcome of the four youth in transition. Because some of the adopted children had been placed with relatives or adopted by a new family, one half of the children were living at home

after one-year; thus, the family preservation rate was 50%. (Although available data does not indicate the ages of the children at the time of their adoptions, the anecdotal reports of their experiences after disruption--often involving prostitution and drug abuse--suggest that this was a particularly old and high-risk group of children.) Although lower than the HOMEBUILDERS programs usual family preservation rate, the services resulted in a higher adoption preservation rate than conventional services; roughly 80% of families that consider disruption and contact the agency for assistance will later disrupt (Barth & Berry, 1988).

Project Impact in Massachusetts also has been providing a range of intensive adoption preservation services. In addition to providing a full month-long intensive family preservation services program, Project Impact has developed several derivatives. One such variation involves the use of temporary respite care from other families who have experience and ability with adoptive placements. Thus the effort to preserve the placement may involve temporary out-of-home care. A second approach entails a shortened intensive intervention which occurs over a weekend or slightly longer time. This approach appears to fit well with the needs of the adoptive family to involve themselves in an intensive intervention to prevent running away, to resolve immediate family issues, and to develop a plan for the future. This approach may be especially fitting with employed and busy families who have many communication and behavior management skills and can execute a service plan without continued assistance. In those families, the social worker's role may be to help the family negotiate a specific impasse and develop a plan of action that will ultimately yield a decision about whether the placement can continue. This may be achievable in an intensive (up to 20 hours) meeting over a long weekend. The derivative Project Impact approaches have not been evaluated but suggest possible strategies that recognize the unique characteristics of adoptive families.

The Post Adoption Family Therapy Project (PAFT) is housed in the Oregon Children's Services Division (OCSD) and consists of an adoption worker and a family therapist experienced in home-based services to provide treatment to adoptive families at risk of disruption. Each family receives a maximum of four months of family-centered services which involves approximately nine hours per month of family therapy. PAFT has attempted to operationalize the "imminent risk of disruption" by requiring that families who are referred for services are in the third stage of the disruption process as described in Partridge, Hornby, and McDonald (1986). That is, families must have begun to "go public" and express to others that the adoption might not work. Families are eligible before or after legalization of the adoption. The program is based on successful pilot work done by OCSDs family therapy teams with adoptive families which indicated a better than 85% adoption preservation rate (W. Showell, personal communication,

February 29, 1988). A more recent report (Prew, 1990) indicates a 94% disruption prevention rate (but no duration for the follow-up period is given).

Another program that can best be described as adoption preservation services is called PARTNERS (Post Adoption Resources for Training, Networking and Evaluation Services). This program was designed by the University of Iowa School of Social Work and Four Oaks, Incorporated to address the needs of families who have adopted children with special needs (Groze, 1990). The service is twofold: (1) intensive adoption preservation services and (2) sustained adoption counseling services. These services are provided by a team composed of a family therapist and a child behavior specialist who are available up to 10 hours a week for 45 to 90 days to work with the family at home. Access to a short-term out-of-home shelter placement also is available. The family-centered counseling services are available for two hours a week, three to six months. Data is not yet available on the effectiveness of the program.

Cost Effectiveness of Intensive Family Preservation Services for Adoptive Families

Once placements are made, fewer services are provided to adoptive families than to birth families, with a lesser chance of providing adequate developmental resources to a special needs child. Adoptive families are given equivalent statutory rights as birth families, but not equivalent services. Yet, the costs of disruption to the agency also are substantial. Estimating the savings from making and maintaining an older child adoption is feasible but not easy given the limits of cost-effectiveness analysis. To do such, the projected cost savings of a stable adoption above foster or group care are adjusted by the present value of those savings (to account for other ways the agency could have invested the money) and compared to the net investment. The amount that the cost savings exceed the net investment is the financial value of disruption prevention services to the agency.

Since intensive family preservation services preserve at least 50% of adoptions and only 20% of families that consider disruption and contact the agency will not later disrupt (Barth & Berry, 1988), IFPS continues to out-perform conventional services. Agency costs for those that are averted would include subsidies and social worker efforts to stabilize the placements, as workers made an average of 12 face-to-face contacts and 19 phone calls to the highest risk and disrupting families. Of the children who disrupt, about 45% will be adopted again (Young & Allen, 1977; Festinger, 1986). Each of these placements will require home study and placement costs, assuming that there are no additional court costs (though court costs in certain cases are inevitable). Additional subsidies also

will accrue. These disruptions and replacements will typically occur about two years after placement and include a stint of at least six months in residential, group or specialized foster care at a considerable rate. According to Donley (1983) and Kagan and Reid (1986), between one-half and two-thirds of these placements will again fail and we have not added these additional costs. Youth who are not adopted a second time are likely to reside in specialized foster care. When the total costs is calculated, the expense of our current approach to preventing disruption costs nearly $60,000 per child during the years from age 8 to 18.

Intensive adoption preservation services. Let's assume that an agency is committed to the most intensive adoption preservation services needed. Depending on the needs of the case, the agency can provide a disruption prevention package of one month of respite group home care or one month of intensive home-based services to stabilize an adoption. Furthermore, based on the aforementioned results from pilot projects, between 10% and 40% of such placements will continue to disrupt despite these efforts. This estimate is taken from reports of HOMEBUILDERS work with families on the verge of adoption disruption. HOMEBUILDERS project that they prevented disruption in 59% of cases at one-year follow-up (Jill Kinney, personal communication, December 21, 1990).

The cost of intensive adoption preservation services, additional adoption worker services, and adoption subsidies comprise the net investment amount. For the purposes of this illustration, we will assume the most conservative (i.e., expensive) case that the subsidies would have been incurred for the full 10 years (since these are more difficult children with greater needs) until the child would have been emancipated from the child welfare system. Savings in foster, group or residential care and additional agency administrative costs comprise the cost savings. (Although many other benefits would be received by the child that could be added to the cost savings of the equation, we will not include those in this discussion.) This, then, is a comparison of the agency costs of services to maintain a high-risk older child adoption vs. the cost of not maintaining the placement.

The cost of intensive adoption preservation services if provided by a program like HOMEBUILDERS is roughly $3,000 per family according to 1990 figures. We expect that social workers would make about one-half the number of face-to-face and phone contacts to arrange these services as would be made with conventional services. The average disruption prevention package would total $3,500 per child, in the short run. Of approximately 40% of children who disrupt despite the intensive intervention, 55% will not be re-adopted or will disrupt again. Using an eight-year period for foster or group care at $7,500 per year and a 10% per year discount rate (chosen as the high end of what an agency could

yield if the money were otherwise invested), the costs for the children whose placements would disrupt and who would stay in long-term foster or group care are much lower than for the conventional group. We assume that 45% of the children who disrupted despite intensive services and whom the agency attempted to replace for adoption were readopted and that placement costs and subsidies did accrue. Even if all of the original families kept their subsidies for 10 years, which is not likely, the overall cost per child served is $45,000.

Using intensive adoption preservation services, the average saving per child is $15,000. If these services are provided to approximately 2,000 children in the United States in need each year, implementation of adoption preservation services would save an additional $30 million across the land. This ignores the additional family benefits to the children whose placements last. If the findings of Jones and Moses (1984) are accurate, our estimates of agency savings also should include additional long-term costs for providing foster care services to a disproportionate number of children whose parents grew up in foster care. The many long-term social and economic gains from having a lifetime family also are not included.

This analysis does not adequately address the source of funds for disruption prevention. All of the savings identified as "agency" savings, especially reduced foster care costs, do not actually accrue to the agency. The costs of post-adoptive services for families with subsidies are typically restricted to those covered by Medicaid. Intensive home-based services and voluntary placements can be covered under Title IV-B, although these monies are capped. Legislation to fund uncapped post-legalization adoption preservation services is needed. Such legalization can accompany (but should take precedence over) other efforts to fund conventional post-legalization counseling services. Services would be paid for under this authorization only if there is imminent risk of disruption.

Given that adoptions provide almost a total environmental intervention, the value of each dollar spent to preserve a placement may comprise one of government's greatest returns. The risks of wounding the spirits and hopes of young people are only a few of the costs of disrupted adoptions or the decision not to try to place a child for adoption. These children also are kept from obtaining substantial dowries of permanent memberships in families. Agencies incur considerable expense when they fail to make or maintain adoptive placements. Since intensive interventions are effective in preventing disruptions, agencies should see that they nurture intensive family preservation services for use by families at risk of breaking up at every point in their child-serving system. A growing number of agencies have standing arrangements to provide such intensive services to families just entering the child welfare system but have no

mechanism for using these arrangements to prevent the disruption of existing adoptions. This should be remedied in every agency.

Much needs to be learned about providing intensive adoption preservation services. Most curious is the comparatively low (59%) adoption preservation rate for the HOMEBUILDERS pilot project. To date, we have few specifics about the characteristics of these successful and unsuccessful families. Although adoptive families, on the whole, have more economic and educational advantages than traditional child welfare families who receive placement prevention services, those advantages may not work in favor of family preservation. Studies of the satisfaction of foster and adoptive parents have found that more educated families have less satisfaction with their children than less educated and lower income families (Barth & Berry, 1988; Fein, Maluccio & Kugler, 1990; Rosenthal, Groze, & Curiel, 1990). This may call for different approaches to adoptive preservation. In addition, adoptive families may receive less support from relatives who may not have a strong knowledge of or attachment to the child. This would surely diminish family preservation efforts. Also, given the short-term nature of the HOMEBUILDERS and Medina collaboration, their initial success rate may have been enhanced over time by some of the lessons they learned from each other and their 22 families (David Haapala, personal communication, December 14, 1990). Research on intensive adoption preservation services is in its infancy. Given the continued concern about the need for post-adoption services, the heralded cases of disruptions well after finalization that have been in the American media in the last year, and the growth of family preservation resources, it is time to apply research lessons from conventional intensive family preservation services to adoption preservation services and answer some basic questions about their ability to promote what level of success with what families and children.

Discussion Questions

1. What characteristics of adoptive families might distinguish them from birth families? If adoptive families have less commitment to their child than birth families, what interventions might be used to bolster that commitment?

2. What are possible strategies for developing teamwork between post-adoption services specialists and family preservation specialists? Are other team members needed to develop an ideal adoption preservation response?

3. Adoptive families have been shown to appreciate the knowledge and support of other experienced adoptive families (Barth & Berry, 1988; Rosenthal, Groze, & Curiel, 1990). How can other experienced adoptive families be engaged in adoption preservation efforts?

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GUIDELINES FOR PRACTICUM PLACEMENTS IN INTENSIVE FAMILY PRESERVATION SERVICES AGENCIES: THE HOMEBUILDERS EXPERIENCE

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Introduction

Intensive family preservation placements provide a unique experience for and place unique demands upon MSW students when compared to other field placements. Students are available to their client families at a high level of intensity, meeting several hours at a time with families in crisis who are experiencing domestic violence, child abuse, substance abuse and a host of other problems. They make themselves available on a flexible schedule to meet fully the specific intervention needs of the family.

Schools of social work considering intensive family preservation placements may be tempted to structure the placement traditionally or to otherwise decrease its intensity. Although sometimes difficult we believe that only by being exposed to the realities of being an intensive family preservation therapist will students adequately learn the skills needed to successfully perform this work.

Schools and agencies can work together to help students deal with the intensity of an intensive family preservation placement. Careful screening of students for these placements, realistic planning for added demands on students, and the availability of intensive supervision and consultation are all necessary to support students adequately in an intensive family preservation placement.

For more than a decade, the Behavioral Sciences Institute HOMEBUILDERS program has been providing practicum placement experiences for MSW students at the University of Washington School of Social Work. These students have consistently rated their HOMEBUILDERS placements as valuable learning experiences, and many have continued as HOMEBUILDERS employees.

By describing the HOMEBUILDERS placement experience, we hope to show that an intensive family preservation placement can be successfully integrated into an MSW program. This paper will discuss the practicum placement goal, preferred student characteristics, placement structure, necessary

intervention skills and methods of instruction, and evaluation of student and field instructor performance. For the purpose of this paper, we will assume that the reader is knowledgeable concerning the basic requirements of MSW student placements. We will, therefore, confine our comments to the unique features of an intensive family preservation practicum, rather than describing elements that this type of placement has in common with other placements.

The Practicum Placement Goal

The goal of an intensive family preservation practice placement is to educate students in the delivery of short-term, intensive, home-based interventions with children and families. A major focus of the practicum is learning and practicing intervention skills designed to help families resolve problems that place them at risk of disruption through placement of the child.

The practicum also is the place for students to integrate information and learning from the MSW curriculum. Theory, policy and practice come together under the guidance of experienced intensive family preservation agency staff.

Preferred Student Characteristics

Over the years, HOMEBUILDERS staff members have observed that certain student characteristics are associated with greater student success in the placement. Also. student placement satisfaction appears to correlate with these characteristics. HOMEBUILDERS has used these criteria as guidelines for selecting second-year MSW students for placements.

Commitment to Intensive Family Preservation

The most basic and essential student characteristic is a commitment to intensive family preservation services, values and strategies. Students need to believe that, in most cases, the best place for children is with their natural families and that intensive family preservation services can help achieve this goal. This includes seeing the value in working with clients as colleagues and believing that people are capable of making significant changes in their behavior.

Openness to Diversity

Students will be working with a population that is ethnically, culturally and economically diverse. As in all social work placements, students need to

accept clients whose lifestyles and values are different from their own. However, this acceptance of diversity can be especially challenging in intensive family preservation services placements since therapists must quickly establish rapport and actively share power with clients who may smell bad, yell at them or abuse their children. In order to effectively help these families, students must believe that these clients know what they need and that they really want to be good parents.

Theoretical Compatibility

Throughout their classroom and practicum experiences, students learn skills and interventions that operationalize theories. Students report that congruence between the theoretical orientation of the placement agency and their course work is extremely helpful to them in learning and implementing clinical interventions.

Flexibility and Availability

The agency must understand and respect the students' other school and personal responsibilities. However, students need the flexibility in their personal schedules to meet with clients in the evenings, on weekends and on days other than designated placement days.

Students need to understand the rationale for being available to clients in crisis situations, either by phone or in person. They must be willing to stay with clients as long as necessary to help resolve the crisis and structure the situation for safety. A student who needs to work part-time may, therefore, need to find a job with flexible hours. A single parent must be able to secure child care that is available evenings, weekends, and on short notice.

Tangible Resources

There are a number of tangible resources that students must have in order to be available to clients. Students must be able to drive and must have a car. Since intensive family preservation services workers transport clients, students also must have auto insurance. A student's living situation must be stable enough for clients to reach him/her. Students must also have a phone to allow for client access.

Placement Structure and Time Frames

HOMEBUILDERS practicum placements for second-year MSW students at the University of Washington cover three academic quarters of nine-to-ten weeks each. Students work approximately 25 to 30 hours per week in their placements. Unlike most placements, which are confined to two or three specific days each week, HOMEBUILDERS students learn to balance coursework with personal and placement responsibilities. Fortunately, because of the intensity of the intervention, students see families frequently enough so that they rarely need to schedule client appointments at times that conflict with classes.

Another unique feature of the HOMEBUILDERS placement is the amount of time the field instructor is available to the student. Not only do field instructors accompany students to client appointments as needed, they also are available to students on a 24-hour, seven day a week basis. Consultation is as frequent as every day, depending on the client's situation and the student therapist's skill level.

The First Quarter

The three quarters of placement coincide with three distinct phases of the practicum experience. The focus of the first quarter is orientation to the HOMEBUILDERS model and observation of the field instructor's work. As early as possible, students attend four days of in-service training regarding the clinical aspects of the HOMEBUILDERS model. This training emphasizes the basic skills of intensive family preservation service provision. In this training, students learn and practice the details of basic intervention techniques to be used with client families. A follow-up two days of training that covers more advanced clinical techniques is provided two to three months later.

Early in the first quarter, students work with their field instructors as observing co-therapists with two consecutive families. The student is present for sessions from intake through termination. While the field instructor takes the lead with the first family, the field instructor and the student plan and debrief each session together. As the intervention progresses, students generally become more active in their co-therapists roles. Usually, the students begin by active listening, advocating for clients, or teaching simple skills through modeling or direct teaching.

The field instructor and the student see the second family together. In this intervention, the student takes the lead-therapist role while the field instructor observes and helps out as needed.

The Second Quarter

The second quarter practicum experience is designed to help the student function autonomously as an intensive family preservation services therapist. In order to do this, the student must expand his or her knowledge of assessment and intervention skills. One student summarized her experience by saying:

> "For the most part, working independently this quarter proved to be exciting and challenging. It gave me an opportunity to further use and develop skills which I learned and also gain confidence in my ability to practice autonomous social work."

Field instructors accompany students to the intake sessions for the two families seen this quarter and, if needed, to additional client sessions. The student and the field instructor continue to plan and debrief each session together. The student and field instructor may use planning sessions to organize, to set tasks for the student, and to anticipate or to role play situations that may occur in sessions.

The Third Quarter

Once again, in the third quarter, students complete interventions with two families. This quarter's focus is to increase independence and skill. Students consult less frequently with field instructors and, instead, utilize other resources.

As the quarter progresses, the student functions more as a HOMEBUILDERS team member, more actively participating in case consultation and other team activities. Frequency of supervision decreases depending on the skill level of the student and the client situation. The field instructor and student no longer plan and debrief each session together as they did before. While formal and informal supervision still occur frequently (two- to five-times a week), it is spent reviewing client sessions and discussing the student's plans for upcoming sessions. The student and field instructor may brainstorm ideas together or role play clinical situations. The student generally chooses the focus of the activities and asks for help in specific areas.

Skills Learned in HOMEBUILDERS Placement

Just as the HOMEBUILDERS model empowers families by teaching skills, the focus of the HOMEBUILDERS practicum is skills teaching. Students learn the

following intensive family preservation services intervention skills in their HOMEBUILDERS practicums:

- Engaging families quickly;
- Working with families in their home settings;
- Motivating clients to participate in counseling;
- Assessing and utilizing family strengths;
- Assessing, modifying and utilizing the environment;
- Assessing family/individual functioning levels and problem areas;
- Assessing and utilizing social support networks;
- Assessing the risk of child abuse, neglect and suicide;
- Structuring the family's situation to prevent violence;
- Defusing potentially violent situations;
- Delivering a combination of concrete and clinical services;
- Providing support through active listening, affirmations, availability and resource mobilization;
- Teaching skills to family members using cognitive behavioral techniques including: communication, parenting, mood management, behavior management, problem solving, decision making, negotiation and assertiveness skills;
- Advocating and consulting on the client's behalf;
- Completing the HOMEBUILDERS clinical practice evaluation, including Goal Attainment Scaling;
- Developing maintenance plans that include the use of social network resources and referrals to ongoing services;
- Developing therapist self-care plans.

Methods of Instruction

From the initial in-service training to role-playing clinical situations with their field instructors, HOMEBUILDERS practicum students are taught the preceding intervention skills in several settings through a variety of methods. Methods of student instruction include:

- Modeling skills;
- Assigning readings;
- Coaching students when practicing skills;
- Role-playing skills;

- Breaking skills-acquisition down into small steps;
- Giving verbal and written feedback;
- Encouraging self-awareness;
- Encouraging self-assessment;
- Outlining areas for skill development;
- Encouraging questions;
- Reviewing audiotapes and videotapes of practice sessions and client sessions;
- Giving rationales for skill building;
- Providing reinforcement;
- Helping to problem solve;
- Helping to find learning resources, e.g., readings and experts (university and community);
- Listening attentively and helping students to think through and evaluate their experiences;
- Debriefing incidents, consulting and providing guidance to to students;
- Motivating students;
- Explaining concepts;
- Relating practice to theory; and
- Challenging students to find their own solutions for clinical issues;

Evaluation of Student Performance

At the end of each quarter, the field instructor and student complete a written evaluation of the student's performance based on specific learning goals established at the beginning of the quarter.

A number of evaluation tools that are routinely used within the agency provide information about student performance. Goal Attainment Scaling (GAS), which measures client progress on targeted goals, also may provide information on the student's ability to motivate and teach clients. Utilization reviews, which involve review of case files, evaluate the student's ability to complete necessary paperwork and also their clinical proficiency. Consumer satisfaction surveys and caseworker surveys generate feedback from client families and from referring children's services workers concerning relevance of targeted goals, success of intervention methods and adherence to components of the HOMEBUILDERS model.

Direct observation by the field instructor of student activities provides the most information for evaluation of student performance. Students are observed

on an ongoing basis during client sessions, weekly team case consultations, individual consultations with field instructors and tutorial sessions between students and field instructors. Field instructors utilize feedback from team supervisors, staff trainers, intake workers and support staff in their evaluation of student performance.

Evaluation of Field Instructor Performance

The field instructor's performance is evaluated by the student and the field instructor's supervisor. The performance indicators used are: availability to the student, organization skills, teaching skills, and supervision skills. This information is shared with the field instructors to help improve their performance.

Discussion

A successful intensive family preservation services practicum depends upon an effective collaboration between the University and the intensive family preservation services agency. Both need to be committed to the goal of providing students with an intense and integrated placement experience. The School needs to operationalize this commitment by offering intensive family preservation services content in course work (see, for example, Morgan, Marckworth, LeProhn, Sampson, and Pitkin, 1991) and by providing an active liaison to the agency. This commitment is operationalized by the agency through its allocation of staff time and material resources.

In order for students to be successful in their family preservation practicum, it is of paramount importance that the school and agency be as realistic as possible when describing the challenges and benefits of the placement experience to potential students. Students need to be given as much information as possible to help them decide whether this placement is compatible for them and to aid them in planning for the experience.

The other essential element for a successful intensive family preservation services placement is support for the student throughout the experience. Assistance is especially important during the first quarter when students are adjusting to the placement and attempting to integrate its demands into their academic and personal lives. The agency provides not only technical assistance with the clinical aspects of the job but also training, consultation and support around self care, organization and time management. To support the student, the School must recognize the unique aspects of the placement, especially the flexibility of the schedule.

Since intensive family preservation services programs are currently one of the fastest growing career opportunities in social work, agencies may be very open to collaboration with schools of social work in the development of practicum placements. Also, students may be increasingly interested in curricula and field placements related to family preservation. Although intensive family preservation services placements are demanding, students who complete them are aware of the realities of work in this area and, if they enter the field, do so with a commitment based on understanding.

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THE HOMEBUILDERS MODEL*

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HOMEBUILDERS is an intensive in-home family crisis intervention and education program designed to prevent the unnecessary out-of-home placement of children in state-funded foster care, group care, psychiatric hospitals or corrections institutions. The families, who are referred by state workers, have one or more children in imminent danger of placement. The presenting problems may include child abuse, neglect, other family violence, status offenses, delinquency, developmental disabilities, and mental illness of either children or parents. Families' problems rarely fall into these neat categories. One family, for example, might involve a very depressed mother with a history of suicide attempts, a teenage daughter who is not attending school and may be prostituting on the side, and an infant who is failing to thrive.

Once they are accepted into the program, these families are provided with intensive services. Therapists are on call twenty-four hours a day, seven days a week for a one-month period to help defuse the precipitating crisis and, further, to teach families new skills that will help to prevent the crisis from recurring. Almost all of the work we do with families takes place in the homes, neighborhoods and schools of our clients. We may work with a mother at home on housecleaning, see the teenage son at the local McDonald's and go with him to school to help assess what is making it so punishing for him and how the setting could be made more rewarding.

Workers serve only two families at a time. They provide these families, as needed, with a wide range of services, including helping with basic needs such as food, shelter and clothing, and counseling regarding emotions and relationships.

Begun in 1974, by the end of 1990 HOMEBUILDERS had seen 5,314 cases. Three months after termination, 95% had avoided placement in state-funded foster care, group care, or psychiatric institutions. Twelve month follow-up data available after September 1982 showed that placement had been averted in 88% of the cases. Service catchment areas include both urban and rural settings. HOMEBUILDERS programs operate in ten Washington State Counties--King,

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Pierce, Snohomish, Whitman, Yakima, Kitsap, Thurston, Skagit, Jefferson and Spokane. Since 1987, HOMEBUILDERS has also had a program in the Bronx, New York City. This program was transferred to the City of New York in 1990. Together, the ten sites in Washington serve over 780 clients each year. We also provide a good deal of training to other agencies wishing to begin family preservation programs. We have provided some type of training or consultation in every state and to groups within 11 countries. In 1990, we responded to 344 requests for information, provided training or consultation to 617 groups, and gave 66 presentations at conferences or other meetings. Table 1 shows how the agency has grown over time.

Program Philosophy

Why Avert Placement?

HOMEBUILDERS is built upon several beliefs and values we hold about providing services to families. The most fundamental is that, in most cases, it is best for children to grow up with their natural families. We believe that there are many benefits for the child, the family, and the community when families remain intact and problems are solved within the context of the family, rather than through placement. In almost all of the families we have seen, we cannot help but notice incredibly strong intertwined emotions that cannot be severed without great pain. Even where these emotions are mixed and interactions are sometimes painful, there are usually parallel feelings of connectedness, concern, yearning, hope and love that can blossom as family members learn new ways of coping with their problems and differences. In one case in Tacoma, for example, a teenage girl had nothing but bad things to say about her mother, most of them unprintable. When the girl earned money by doing her chores, however, she spent two hours at the local shopping mall searching for a gift for her mother, a special kind of jelly beans that her mom really liked.

We think it's best for most families to learn to handle their own problems rather than continually relying on the state to rescue them when things get rough. Family preservation services reinforce tenacity, hard work, commitment and duty; they discourage avoidance, dependence, and hopelessness.

In the HOMEBUILDERS Program, families learn new behaviors in the environment where they will need to use them. In the majority of cases, parents can learn to set limits, control their emotions, and provide for their children's basic needs. Children learn to assess their own goals and to control their behavior in ways that lead to more reward and less punishment. HOMEBUILDERS is not

1974
1976
1977
1978
1979
1980
1982
1983
1984
1986
1987
1988

Table 1
Development of the HOMEBUILDERS Programs

1974	Project begins in Tacoma, Washington, with four therapists, under the auspices of Catholic Community Services. Serves children from any referral source as long as imminence of placement is documented. Success rate during the first year is 92% 3 months after termination.
1976	Project expands by three therapists with funds from U.S. Department of Health, Education and Welfare, Administration for Children, Youth and Families. Referrals from the Pierce County Juvenile Court involve tracking of overflow cases to see if placement occurs. Success rate 12 months after intake is 73%. Seventy-three percent of comparison cases are placed.
1977	HOMEBUILDERS Training Division begins providing training to other organizations as well as HOMEBUILDERS staff.
1978	Project expands to Seattle, Washington. Initial success rate 3 months after termination is 100%.
1979	Washington State Legislature funds mental health project to see if referrals from the Pierce County Office of Involuntary Commitment can be prevented from entering Western State Psychiatric Hospital. Success rate is 80%. One hundred percent of cases that were not seen because the program was full were placed!
1980	Washington State Department of Social and Health Services (DSHS) funds pilot project to prevent placement of developmentally disabled children in more restrictive settings. Success rate 3 months after termination is 87%.
1982	HOMEBUILDERS create their own new parent organization, Behavioral Sciences Institute.
1983	Washington State DSHS expands program to Spokane County. First year success rate at 3 months after termination is 92%.
1984	Washington State DSHS expands program to Snohomish County. First year success rate at 12 months after termination is 96%.
1986	Administration for Children, Youths and Families funds joint project between Behavioral Sciences Institute and Medina Children's Services to test model with adoptive families with special needs children. 3 month success rate is 86%.
1987	New York City Human Resources Administration and the Edna McConnell Clark Foundation fund program in the Bronx, New York. First year success rate is 87% 3 months after termination.
1988	Washington State DSHS expands program to Kitsap and Whitman Counties.

a cure-all. It does not produce perfect families. When service is terminated, however, most families are in better shape than they were at the point of referral, and family members are able to make it together.

Children who are separated from their families can miss out on significant portions of family history which makes it difficult for them to ever regain their original firm sense of belonging and continuity. It makes a difference when families aren't together for birthdays and Christmases. It is difficult to regain original strong bonding when there are fewer and fewer shared milestones. Moreover, when family members participate in solving their problems together, individual family members are less likely to feel rejected, inadequate, or like failures, and are less likely to use blaming, separating and giving up as ways to solve problems. Children in placement may feel envious of siblings remaining at home. Children in group care may use other troubled children as role models. Children in any placement may be labeled as deviant by their peers or feel torn loyalties between natural and foster parents or group home staff. Children in placement are also apt to suffer the effects of frequent caseworker turnover and frequent moves from one living situation to another. For some, there are no real reference people, no one to count on. This discontinuity can make it hard for them to establish an identity, to feel like they are important, or to plan for the future.

With the belief of the importance of the family as the foundation of the program, several other important values, attitudes and beliefs also influence the strategies of the model.

First, experience has led us to conclude that <u>one cannot easily determine which types of families are "hopeless," and which will benefit from intervention</u>. For example, in one of our first cases in Tacoma, in a multi-racial family, a mother had had a serious fight with her husband. He had grabbed her keys and run out and started to drive away in her truck. She had run after him and reached in through the window to try to turn off the key. He had rolled the window up on her arm and dragged her for three blocks. She had been in the hospital for a week and was now home trying to recuperate. She could barely move one side of her body and was unable to keep her job. She had no money and no food. Her car didn't work. Her fourteen-year-old son had dropped out of school. She had seen him trying to strangle her six-year-old son. During the second session we found out that the sixteen-year-old daughter was pregnant.

Just hearing about this, we felt overwhelmed and discouraged. How could all of this ever get resolved? We sat down with the mother at her kitchen table and she wrote down all the different problems and then all the different alternatives for coping with them. Then we all worked on the pros and cons of each alternative. We found a mechanic training program that would fix her car

for free. We found a food bank. She got emergency public assistance. Her employer agreed to rehire her when she became physically able to work. The daughter decided to have an abortion. The teenage boy got into an alternative school program. The mother learned better parenting techniques for managing her younger son and he stopped doing the things that triggered the older son's attacks. As the older boy did better in school, he felt less frustrated.

We still hear from this family every once in a while. Ten years after the intervention, the older kids had graduated from high school and were married and working. The younger ones were doing fine. The mother was trying to refer a friend who was having trouble to HOMEBUILDERS. During our first week of involvement with this family it would have been difficult for us to believe things could have worked out so well.

Now, after thirteen years of experience, the only group we are reluctant to serve are parents who are so addicted to hard drugs that their entire lives are focused on obtaining them and in surviving in very dangerous drug cultures. We feel it is too dangerous to leave children in situations where addicts are climbing up fire escapes, breaking into each others' apartments, selling each others' food and threatening each other with butcher knives when payments are not available.

Aside from this population, and even after numerous computer analyses of the relationship of success to various client characteristics, we cannot predict ahead of time which families will not benefit from the services. Sometimes referrals will involve discouraging case histories, documented failure of many previous services, and alarming presenting problems. Many have been seen by psychiatrists and others who "should know" if a family is hopeless or not. Some have diagnoses like "schizophrenia" or "manic depressive psychosis." Although workers are often concerned about these referrals, we now believe that, except where the potential for violence leaves family members at too much risk, all families deserve a chance to learn to resolve their problems together. Families who have previously had parenting classes, family therapy, police intervention, and out-of-home placement (and remain troubled) are still capable of learning to resolve their problems. At the same time, a family whose initial complaint is that the teenager daughter only soaps her hair once when she washes it may end up having the daughter placed outside the home.

It is our job to instill hope. Most families seen in intensive home programs have good reasons for not wanting to try very hard anymore. Most have been through numerous programs and been assigned a succession of workers and have experienced very little success. A large proportion of our families have a plaintive refrain during our first session, "But I've had counseling, and it didn't work." The task, then, is to help them see that HOMEBUILDERS is not just counseling and

that there are many, many alternatives left to try before we're willing to believe their problems are hopeless. In the past, failure has been built upon failure. Is it any wonder that the families come to additional services out of resignation rather than optimism? They have little reason to believe that another try will succeed where all else has failed.

We can best instill hope by minimizing barriers to change, making it easy for them to see us, talk to us, like us, and understand what we are trying to do. We can also help them, and ourselves, by defining realistic goals and by continually working on our own creativity, enthusiasm and optimism.

Clients are our colleagues. We don't think that there are two types of people, healthy and sick: one group who can manage on their own and another group that probably will never be able to do so. Everyone needs help sometimes. The power for change rests within the client. It is the worker's job to help clear away barriers for change so that the clients' power may be better utilized. Almost all of the families we see want to get along with each other, to be respected and liked, to feel they belong, to make it in society, and to make it on their own. They want to grow and become more competent in running their lives. We can't help but be moved as we listen to a third-generation welfare mother talk about how she yearns for "just one" of her six children to graduate from high school, to "get out of here, somewhere safe and clean." It is very important that we listen to these people and believe in their budding hopes as well as their good reasons for thinking some of our ideas are nonsense. They have more information about their own lives than we, with all our professional insight, will ever have. They also have information about potential constraints and resources which can make our wonderful ideas and interventions sink or swim.

If we believe clients have valuable information and viewpoints, and treat them as colleagues, they sense our respect. They also are more likely to treat us with the same respect and tact that we show to them. When workers treat family members with dignity, it sets a foundation for pleasantness and cooperation during the entire intervention. Even when a worker initially has bad feelings about a client, if the worker behaves respectfully, the client is more likely to respond in a similar way, making it is easier for the therapist to like the client.

It is relatively easy to hold these beliefs about respect and liking with articulate, cooperative middle-class clients who come to offices and talk politely about their problems. It is more challenging to hold them with people who smell bad, go after each other with butcher knives, leave fingernail tracks in their kids' faces, and swear at counselors. We believe it is imperative to be as non-judgmental as possible when hearing clients' stories. Who wants to tell somebody something if they will be ridiculed or put down or punished for it? On the other

hand, how can we possibly help people if we don't know what's really going on with them? Almost always, when we really understand, it is not hard to feel compassion. It's when we jump to conclusions and close ourselves to the complexities of people's lives that it is most difficult to refrain from judging and blaming. We try hard to maintain the position that inside every frantic, overwhelmed, unpleasant client, there is a decent person struggling to get out.

People are doing the best they can do. With the information, energy, and resources any of us has at any one point in time, most of us are doing the best we can. Rarely do we hurt others out of sheer spite. Often, abuse is a side effect of our personal struggles to manage to get through our days. When we are frustrated, hurt and confused, we are likely to lash out at whatever or whomever is closest at hand. All of us can relate to snapping at our spouses after a hard day's work. It's not difficult to imagine a distraught mother--after a day of cleaning up after six little kids, having an extended family member take the last box of oatmeal, having mice eat part of the mattress, and discovering bug bites all over her legs--slapping the child who tugs at her skirt and whines for comfort or candy or a better life.

Even in the worst presenting situations, HOMEBUILDERS workers often observe that family members care a great deal for one another. Although they may hurt each other terribly, people usually do what they do with reasonable intentions. We believe that people usually hurt each other out of lack of information regarding skills such as anger management, and wrong information such as believing severe punishment is necessary in parenting. In many situations a mistake, such as an overly harsh word, triggers a protective retaliative gesture, which starts a destructive chain. Most of us can remember ourselves as teenagers. Our mothers would ask where we were going and we would say, "Nowhere." She would feel shut out and say, "You have to tell me." We would feel rebellious and say "Mind your own business." She would feel angry and say "You can't go." Some of us would go to our rooms. Others of us would run out the door, slamming it. A few of us might have ended in a physical tussle with our mothers. One thing leads to another. In some families fairly innocuous comments can snowball into serious physical fights. These same families can usually learn to break the chain at low levels of emotion.

By striving toward a more compassionate view of families' problems, we, as professionals, are less likely to be caught up in the blaming that is common in families experiencing pain. We are less confused and frightened. Calming people down will be easier because we'll be capable of hearing family members' cues about how hard they're trying and how much they care about each other. For example, when we listen, we can usually hear a mother's fear for her daughter's

well being, behind her anger as she discusses her daughter's running away.

We can do harm as well as good. We must be careful. Our potential to help families can work both ways. With sophisticated technologies come certain dangers, and we must be careful not to hurt our clients by prescribing treatments that can end up making their situations worse. Knowing that certain techniques "should" work may encourage some therapists to inflict them rigidly on clients. Manipulating, strategizing against, or tricking clients can reinforce client feelings of impotence and confusion. If workers set expectations too high, clients feel overwhelmed. If we ask clients to do things the clients may not want to do, such as talking in detail about their childhood or sharing good feelings about one another when they're angry, clients feel frustrated. If we blame clients for being resistant, the clients may feel guilty, increasing their feelings of inadequacy. If we tell clients that they don't understand their own family problems or how the problems might be solved, family members feel less strength and self-esteem than before they were "helped."

Too frequently, we, as therapists, feel we have to do something. Often, however, we don't know what to do. So we recommend unnecessary placement, or side with the "scapegoat," or teach assertiveness training to a mom we can't really support, or stir up marital issues we won't be around to help resolve. We believe we cannot ethically avoid the responsibility that comes with the power we hold. If we believe we can help people change for the better, we must also admit that we can help them change for the worse. We must be careful.

Since we can do harm, we'd better scrutinize our actions carefully to insure against the measure of our authority. We can tell if we are being helpful or destructive by objectively describing how the family's situation was when we began and by keeping track of whether things are getting better or worse for our clients during our involvement. We owe it to the clients to be able to tell them what we are doing (helping them learn new ways of coping with their problems,) and why we are doing it (because we believe most families are happiest when they work things out together, rather than placing their children outside the home). We also owe it to them to state that they will have to give a substantial amount of time and effort in order to gain a happier family life. We owe it to the clients to listen to their responses both during and after the intervention so our methods can be as helpful and comfortable for them as possible. A final core belief to the approach is that we need to provide the same supports for staff that we provide for clients. Supervisors and administrators need to be available 24 hours a day, seven days a week. We need to listen to staff and respond to their concerns. We also need to provide them with the skills that they will need to do the HOMEBUILDERS job and live a reasonable life. We see training as a key,

ongoing support for all staff. A list of training modules delivered to all therapists is shown in Table 2.

Basic Components Of The Model

The beliefs, attitudes and values heretofore explained have influenced the important components of the HOMEBUILDERS service delivery model. All are related to each other as well as to the program philosophy. We believe their interaction makes the approach more powerful than if any of the components was to be used separately.

Therapist Availability

As stated, we think it helps families use their existing motivation to change if there are few barriers to receiving services. We also think it is helpful to utilize their pain to work toward change; therefore the worker must be available to the family at those times when the members are hurting the most. For these reasons, we use a number of strategies to make services easy for the families to access.

Workers are available to clients whenever the families feel that their services can be helpful. Schedules are defined by client need rather than by worker or program convenience. For example, if a family is having the most trouble at 6:30 in the morning, when their children must be made ready for early classes, that may be the best time for the therapist to be in the family's home, even though it is probably not the hour she would have chosen for the start of her workday.

By making therapists available at the convenience of the clients, we increase the chances that all family members will be willing to participate in the intervention. Moreover, clients in pain are highly motivated to change and try new ways of coping. It is more difficult for them to say they don't need help when one of their members is sobbing, or the children only have T-shirts and the temperature has suddenly dropped to 20 degrees. When therapists are involved during this highly emotional time and are available when needed, clients are more likely to trust them with a large amount of information. A personal bonding occurs between client and therapist which greatly facilitates further cooperation.

When clients are first accepted into the program, based on certain criteria and on worker availability, a face-to-face meeting takes place within 24 hours. Thereafter, therapists are on call to the client families at all times (24 hours a day, seven days a week) and are available to be in the client home immediately or

Table 2
HOMEBUILDERS Line Staff Training Modules

1. INTRODUCTION
   The history of the HOMEBUILDERS program, a description of HOMEBUILDERS clients, and information on cost and treatment effectiveness. An introduction to crisis intervention and a discussion of the "headset" for training.

2. STRATEGIES OF THE HOMEBUILDERS MODEL
   The strategies, characteristics, and guiding beliefs of the HOMEBUILDERS model.

3. STRESS MANAGEMENT FOR THERAPISTS
   Strategies therapists and others can use to maintain their physical and emotional well-being; the use of cognitive restructuring in stress management.

4. DEFUSING, ENGAGING, AND CONFRONTING CLIENTS
   The use of active listening and other skills to defuse and engage clients. Trainees participate in exercises and behavioral rehearsals to practice these skills.

5. ASSESSMENT OF THE POTENTIAL FOR VIOLENT BEHAVIOR
   The major issues surrounding the prediction of violent and dangerous behavior and ideas for improving therapists' skills in assessing the potential for violence in families.

6. STRUCTURING BEFORE VISITS
   Strategies for structuring the family's situation to prevent violence from occurring prior to a visit. Participants practice specific structuring techniques in behavior rehearsal situations.

7. ASSESSMENT AND GOAL SETTING
   The HOMEBUILDERS method of assessing families and developing intervention goals; the use of active listening to obtain information; and techniques for prioritizing problems and developing realistic goals.

8. STRUCTURING DURING VISITS
   The use of cognitive, environmental, and interpersonal strategies for structuring the situation to prevent violence during a visit to a family's home.

9. STRUCTURING BETWEEN VISITS
   Environmental and behavioral strategies for structuring the family's situation to prevent violence and other harmful actions from occurring between therapists' visits.

10. TEACHING SKILLS TO FAMILIES
    Three methods of teaching skills to families--direct instruction, modeling, and using consequences--and the use of additional aids to enhance the teaching process.

11. TEACHING FAMILIES BEHAVIOR MANAGEMENT SKILLS

The design and use of behavioral intervention strategies to encourage desirable behaviors and discourage problem behaviors; specific behavior management skills to teach families, including the use of contingent consequences, behavior charts, motivation systems, and contracts; methods for tailoring the intervention to the family and helping families implement behavioral interventions.

12. TEACHING COMMUNICATION SKILLS

Methods for teaching families the basic communication skills--active listening and using "I" messages.

13. TEACHING FAMILIES COGNITIVE INTERVENTION SKILLS

Methods for helping clients recognize that their cognitions (their self-talk) can elicit feelings and behavior and how they can examine and change their cognitions.

14. WHEN PROGRESS ISN'T OCCURRING

Some issues to examine when the intervention is not progressing and when a therapist feels "stuck."

15. TEACHING ASSERTIVE SKILLS TO FAMILIES

Use of a territorial model of assertiveness; how to teach clients to recognize levels of irritation, to respond with assertive behaviors, and to decide when to be assertive.

16. ANGER MANAGEMENT WITH FAMILIES

The use of cognitive and behavioral interventions in anger management and specific ideas for working with angry or assaultive clients.

17. DEPRESSION AND SUICIDE

Strategies for intervening with depressed clients.

18. MULTIPLE IMPACT THERAPY (MacGregor et al., 1964)

A structured multiple-therapist intervention technique, used when a therapist is feeling stuck and when communication within the family is weak.

19. TEACHING FAMILIES PROBLEM-SOLVING SKILLS

Basic problem-solving methods therapists can teach to parents and children; how therapists can help clients to use these problem-solving skills in their daily lives.

20. TEACHING INTERACTIONS

The use of the teaching interaction, a direct and positive approach for teaching skills and correcting behavior, and how to teach it to parents; the use of preventive teaching and corrective teaching; dealing with ongoing behavior. Participants practice these skills in behavior rehearsal situations.

21. TERMINATION ISSUES

Guidelines for the termination of intensive, in-home services and for the extension of services: the process of termination; the use of networking; and referrals to ongoing services.

within a few hours, if a new crisis arises. All clients are given the home phone numbers of their therapist, their therapist's supervisor, and program administrative staff. Because we strongly believe in the advantage of continuity of care, however, the primary worker is expected to let the client know where he or she can be reached, especially during periods when the family seems most fragile. If, by some rare chance, all these staff members are unavailable when needed, clients are able to call a beeper number where a project therapist is always on call.

We have heard concerns expressed that this availability and flexibility might foster dependence. HOMEBUILDERS workers, however, feel that the client would not be calling unless something was wrong, and if that is the case, resolving the issue is part of the therapist's job. Loneliness, lack of skills in using resources, or in controlling emotions are all seen as very valid problems, deserving of the therapist's time and effort when the client feels ready to address them. The majority of clients are extremely thoughtful about phoning their therapists. Those who do make frequent calls may need to know there really is someone around whom they can trust; only then will they find the courage to try some new coping behaviors. Most clients are very impressive in their desires and abilities to work through close helping relationships into self-sufficiency.

We are, however, continually concerned about making clients dependent instead of strong. We try wherever possible to encourage them to make decisions about every aspect of the service delivery and their lives. We might attempt to summarize their problems for them, but rapidly we begin asking, "Which is most important to you to work on? Here are some alternatives that we might try. Which one makes the most sense to you?" As soon as we possibly can, we want them to be working on their problems themselves. We might go with them to get food at a food bank, to support them and model interactions with the agency; but the goal from the beginning is to teach them how to do it on their own, not to have us do it for them.

Flexible Scheduling

Workers have a flexible schedule, with only two families at a time, allowing them to give clients as much time as needed. We will stay long enough during the defusion stage of the intervention to be sure clients are calm and can be left alone. After the initial visit, appointments are scheduled as often as needed, at times most convenient to the client, including weekends, evenings and holidays.

A typical case might require four hours the first day, three hours the second day, telephone contact the third day, four hours the fourth day, three

hours every other day for about a week, and three hours three or four times a week for the remaining weeks. Often, there will be one or two additional four hour emergency sessions within this period. It is possible, however, for several staff members to work together on especially difficult cases. There have been a few cases in which teams have spent up to sixty hours a week on site. These have usually been cases with a very high potential for violence, where we felt harm might befall one or more family members if there were no outsiders present. In one case in Seattle, eight- and ten-year-old boys had pinched and punched their mother until her body was covered with bruises. The boys overturned furniture and tore out the stuffing. When she tried to set limits on them by putting them in their rooms, they climbed out their windows onto the roof and threatened to jump off. With this family, therapists took shifts so that someone would be there to back up the mother during every waking hour until the situation got under control. In this case, for one boy, it never did. He was placed in a group home. His brother remained at home and the rest of the family settled down. About a year after termination with this family we saw that the boy who was placed had been kidnapped from the group home. Often, if a case requires shifts of workers, we are not able to help them to the degree we would like. As time goes on, we are less likely to try these superhuman efforts for a very long period of time. It is very difficult for workers, and the chances of success are not great. Where necessary, workers can spend the night if either parents or children are worried someone will say or do something harmful before morning. Usually, however, it is possible to bring the situation under control without such extensive measures.

Location of Services

Although the bulk of HOMEBUILDERS interventions occur in the clients' homes, therapists go where the problems are surfacing--frequently schools, community centers, and teenage hangouts. Although some teenagers are embarrassed to be seen with their therapists, some HOMEBUILDERS staff are young and attractive enough to be viewed as status symbols. Teenage clients feel important and involve their friends with their therapist. This can be very beneficial. If we can influence a whole peer group, our client is much more likely to retain progress he or she has made. Sometimes it is helpful for family members to be seen individually, but there is no privacy available at home. A good deal of counseling takes place in restaurants which are often a treat for harried parents. McDonald's therapy can be very beneficial. It is amazing how many teenagers still prize the little toys that come in Happy Meals. It is amazing how many parents prize a little time in peace with a sympathetic adult. Therapists notice that many withdrawn teenagers will talk while they are being driven somewhere. A

car or a park may be a better place than an office or even a home to do therapy with a child or teenager. In the Bronx, there are few children who won't suddenly look a therapist right in the face if a visit to the Bronx Zoo is a possibility.

It is possible to reach a much wider range of clients and it is possible to reach much more seriously disturbed clients by seeing them on their turf. In times of crisis, many families are too disorganized to get themselves scheduled for and transported to office visits. In addition, many have had past unsuccessful social services and feel ambivalent about trying again, so that any barriers to service delivery may discourage them completely. No-shows, drop-outs, and cancellations are very rare if services are brought to the client.

Workers are able to make much more accurate assessments because they can see processes in action. They can observe family members using new behaviors, revise plans as needed, and provide support until clients experience success. We can be there when a mother first attempts to put her three-year-old in his room for time out. We can, with her, hear him tear the drapes down. We can support her in taking the drapes out and closing the door again. We can, literally, if necessary, hold the mother's hand while the child yells. We can model and encourage her in welcoming him back when he calms down. We can have a cup of hot tea with her and congratulate her when it's over. Clients know that the therapists have directly witnessed and experienced their family's problems, instead of just hearing about them and possibly making incorrect assumptions about what happens. It increases a therapist's credibility if a mother knows the therapist experienced a rat running across her foot in the family's apartment, or heard the language a teenage girl used to curse out her father when he asked what time she would return.

Ultimately, families need to be able to use new skills at home. If they learn them in the office, it is often difficult to carry the knowledge to a new situation. Many new behaviors never transfer to the environment where they are really needed. Families can hear about rewarding good behavior, but it is very difficult to understand all the little behaviors involved by just hearing about them. When they watch a therapist praise a child for accepting "no," it becomes much clearer. When the therapist is on the spot coaching them on how to reinforce the child next time, they begin to feel confident they might be able to pull it off. Usually, generalization or transfer of learning is greatly facilitated if all services are provided in the natural environment of the client. Therapists can model skills in the situation where they will be needed.

When intervention takes place in the home, it is more likely that all family members will participate. It is more convenient for them. They get a chance to observe for themselves that no one is being blamed or pushed around. Even if some family members don't participate directly--if they sit in another room and

pointedly ignore the therapist--therapists often are surprised to learn how much information these family members pick up by just being in the background. Eventually their curiosity forces them into the foreground. More often than not, they do join in. In one family in Tacoma, the therapist was six months pregnant. Although she met the father during the first session, he never came into the living room after that. After about the first two weeks, though, he started darting out of the bedroom to give her gifts as she was leaving. Once a banana ("Bananas are good for pregnant women"), once a bag of marshmallows. One time, the therapist was ill and a male team member substituted for her. The father gave him a Playboy magazine as he left. Clearly the father was involved and appreciative even though he chose not to participate directly.

Family members like in-home services. Not only is it more convenient and functional for them, but many comment that it helps alleviate some of their embarrassment at having to ask for services. They feel less subservient and vulnerable and say that it's more like having a friend or family member come over to help. This conceptualization is more comfortable for most than that of the traditional caseworker, social worker, or doctor/patient roles. Clients are more likely to experiment with new options when they feel comfortable.

Flexibility in Services Delivered

In addition to flexibility in scheduling and length of sessions, we think it is important to tailor service packages to the needs of individual families.

The goal of all services is to enable families to resolve their own problems. They may request help in meeting such basic needs as food, clothing or shelter. They may work on using public transportation, budgeting, nutrition or relationships with school or other social service personnel. Help is also available regarding child development, parenting, communications, anger management, assertiveness and general problem-resolution skills. Staff members are expected to have such a wide array of options available to them in any one situation that they can feel free to respect client values and beliefs about interventions. If family members are uncomfortable with behavioral interventions, they may like Rational Emotive Therapy. If they don't respond to Rational Emotive Therapy, they may feel comfortable with values clarification. The service options are limited only by the creativity of the worker and her teammates.

We have been asked why we use highly trained workers, usually with master's degrees, to help clients meet basic needs. There are many reasons we believe it is important to involve highly skilled professionals in hard service delivery rather than delegating those tasks to a paraprofessional. A basic goal of intensive family preservation services is to teach families the skills necessary to

provide for themselves. While it appears to take fewer skills to provide many concrete services, and in some communities it is fairly easy to find food, housing, or transportation, it is very complicated to teach clients how to perform these tasks and to advocate for themselves. Particularly in New York City, it is an extremely difficult, stressful, and time-consuming task to navigate and manipulate even the simplest of agency procedures for obtaining services.

Dividing a family among helping professionals according to tasks that need to be addressed, such as using a professional for therapy and a paraprofessional to deliver concrete services, is often difficult to coordinate and can prove confusing for the family. What's more, we have found that providing concrete services, such as cleaning an apartment or driving a client to the grocery store, is a terrific way to engage clients. Most client families have already been through many therapists. They often believe that the therapists cannot or will not really help. When a therapist provides a concrete service, the client is often surprised and grateful to see that the therapist actually can help. This client is often more willing to begin sharing information or to accept the workers suggestions once the therapist has demonstrated that she/he does more than "Talk Therapy."

We also have found that clients often are the most open and willing to share information when they are involved in doing concrete tasks with their therapist such as washing the dishes, or going to the food bank. Somehow, when people have part of their minds on other things, it often becomes easier for them to let out their deeper, more vulnerable, more complicated feelings and beliefs. It is important that the person who receives this information is the one who is best able to respond and act on it. That person is the therapist.

Using one worker to provide both hard and soft services also helps reduce the compartmentalization of family difficulties and provide a better overall plan. A worker learns a lot about the clients when they spend time on hard services together. It's a good way to observe client's skills in being assertive, handling frustration, etc. More important, the therapist can take advantage of "teachable moments" when providing concrete services, while a less experienced or skilled individual would be unable to do this. Overall, the worker has a more complete perspective and firsthand impression of the problems or difficulties the family is experiencing.

Intensity

We have chosen to provide as intense a service as possible because we believe that the most change can occur when people are really upset. We want to be able to see families when they are in crisis, and to respond rapidly and

thoroughly to mini-crises that occur during our involvement. In order to maintain this capacity for rapid, comprehensive response we need to keep our caseloads very low. In order to keep our costs reasonable, we need to keep the length of intervention to the minimum necessary to safely stabilize the family without placement.

Worker Caseload

At HOMEBUILDERS, workers carry two cases at a time. This allows them the time to provide specific psycho-educational interventions as well as to help meet the basic hard-service needs of the family. Overall, HOMEBUILDERS therapists see the same total number of families in a year as do therapists in many traditional counseling programs, but the services are concentrated to take advantage of the time when the family is in crisis and experiencing the most pain, and as a result, most open to change.

Workers lose accessibility when they see more than two families at a time. They cannot be as responsive to the needs of six families as they can be to two. Despite the existence of a good back-up system, this lack of accessibility could compromise client safety and possibly result in a tragic event.

Therapists also lose flexibility when they deal with more families. It is harder to stay on with one family, when they happen to need more time, if another family is scheduled shortly thereafter, and maybe another one after that. In addition, therapists with larger caseloads are on call to more families. Clients who are in crisis or experiencing multiple problems seem to benefit most from immediate responses from their therapist. The smaller the caseload, the more likely it is that the therapist can respond quickly to client crises and concerns, and the greater the impact the therapist can have.

Time constraints can also limit the hard-services aspect of the intervention. Providing hard services and teaching families how to gain access to those services is often the most time-consuming part of the intervention. An entire afternoon or day can be spent at the welfare office, a doctor's office, or enrolling a youngster in an after-school program. It would be difficult to find that kind of time if one had to carry responsibility for many families.

We have heard concerns about costs of the two-family caseload being prohibitive. Some who voice these concerns feel more comfortable with therapists seeing six families for three months, or 12 families for six months. Ironically, these patterns lead to an identical number of families being seen per worker per year: 24. (Actually, most HOMEBUILDERS and other family preservation workers serve around 20 families per year because of time for vacations, illnesses and case extensions.) It is important to consider the total number of cases handled during

a year rather than just the total being served at any one point in time.

With more traditional services, for example, child welfare guidelines suggest 20 cases per child protective services worker (Child Welfare League of America Standards for Child Protective Service, Revised Edition, 1973, page 60). Often these cases are open for a year, leading one worker to serve a comparable number of cases per year to the average HOMEBUILDERS therapist. Group homes may serve fewer than ten children per year with six to ten workers. This could mean only one case (or fewer) per worker per year. Psychiatric hospitals can have a similar staff to client ratio. Viewed with a yearly perspective, 20 cases per therapist per year is not an unreasonably low expectation.

We also like to keep the caseload low because of concerns about worker burnout. Most families served by HOMEBUILDERS are very needy in a number of areas and the therapists' experiences with each family are often very intense. Without adequate time to spend with client families, it is difficult for the therapist to keep track of everything that is going on. In addition, trying to cover more than two families at a time can make being on 24 hour call such a burden as to be unfeasible.

Brevity

HOMEBUILDERS usually see families for only four weeks, although extensions (up to a total of eight weeks) are not uncommon, especially in the Bronx, where the wheels of bureaucracy turn more slowly than in the West. We originally adopted the short time period because crisis intervention theorists (Parad, 1965) believe crises and the opportunities they present usually last no longer than six weeks.

Four to eight weeks seems like a very short time to many. Often others in the community are skeptical that significant change can occur in a month or so. Clients, too, often express a desire for more time. It is possible that more could be accomplished with some families if the intervention were longer. Therapists sometimes say they would like more time to work with their clients. A longer intervention would possibly give therapists more time to link their client up with community resources that have waiting lists.

Why, then, have we set four weeks as a goal? For one thing, experience has shown us it's usually long enough to prevent placement. There are many differences between HOMEBUILDERS and more traditional approaches that make it feasible for HOMEBUILDERS to produce change more rapidly. Clients are in crisis. They are seen, sometimes for long, consecutive periods of time, in the settings where the problems are taking place. They see therapists when they need them, for as long as they need them. Because of the low caseload carried by their

workers, it is possible for clients to get, in four weeks, the equivalent number of hours that one would receive in one year of outpatient therapy. One participant in a training workshop referred to the short-term approach as a "microwave" intervention, where the outcome is comparable to longer term models.

There are a number of advantages to an intensive, short-term intervention. Paramount is the expectation that change can occur rapidly. The HOMEBUILDERS therapist discusses the four week time frame with the client family during the first home visit and continues to refer to it frequently throughout the intervention period. For many families, it is an astounding notion that things could just change, rapidly. They are flattered by someone's belief that they can achieve goals. This expectation seems to influence the client and the therapist so that both are more willing to "give it their all." The expectation that change can occur rapidly is positive for many clients. They are relieved to hear that their problems may not drag on for months or years. It helps clients gear up for a big effort.

The brief time frame also helps keep both the therapist and the client focused on the specific goals, as well as on what interventions are or are not working. Furthermore, when they know there is a definite time period available, it is much more likely that they will use the time productively. With their therapist, families are continually reassessing priorities and possible avenues of change. We believe this assessment process is an important skill for them to have and we hope they use it long after we are gone.

After four weeks, many clients have reached a plateau and are ready to take a break from the hard work of changing their lives. Having the intervention go beyond four weeks also makes it more difficult for workers to maintain the intensity of their effort and keep their energy level up. Usually, the crisis is over within a month. Once it is past, we lose many of the motivators of a crisis and make much less progress on goals in subsequent weeks. Continuing to push for progress may be counterproductive beyond this point. For many it's like going on a successful diet and getting into a size 12 dress. Not everyone is interested in becoming a size 8 or 10.

Moreover, we have found that the success rate of averting out-of-home placement does not appear to be influenced by the length of the intervention. Over the years at HOMEBUILDERS, we have tried varying the length of the intervention. We have experimented with eight-week, six-week and four-week interventions, maintaining identical goals and intensity. The gradual decrease from an average of eight weeks to four weeks because of pressure to serve more clients did not make a difference in our overall success rate. Informal data at HOMEBUILDERS indicate that if a family has not been able to profit from the 4-to-8-week intervention, it is unlikely that things will really turn around after that

time. When we do extend cases for much longer, our success rate drops significantly.

For the agency, the time limit helps us to keep costs down, serve more cases, and make possible lower caseloads per therapist. Longer interventions cost more (unless we also increase the caseloads). The increased cost and/or length of the intervention can be difficult to justify to funding sources that want to pay only for prevention of placement and can point to documentation that it is possible to prevent placement with four to six weeks of service. In addition, a shorter intervention helps prevent worker burnout and stress by limiting the amount of time that staff are expected to cope with any one set of problems.

Even though we recommend a four-week goal for the intervention period, this time limit should be considered a guideline, not an absolute limit. It is important to remember that, although most cases can be terminated in four weeks, there will be some families that need more time and some families that need less time. It is also important to remember that this guideline must always remain secondary to the program's basic goal of helping most families avert placement by learning to cope with their problems.

Limited Objectives

Our comfort with the short time limit of our intervention is closely related to our program goals. At the end of four weeks, we are very rarely finished to the point where clients feel they have accomplished all that they can, or where therapists feel they have offered all that they are able to provide. Usually, there is some unfinished business. Most families are getting along much better, but most still have some problems coping with their emotions. Their houses are not always clean. The children do not go to school 100% of the time.

Our goal is not to make the perfect family. For one thing, we don't know what perfect families look like. If the goal of our service was to have the maximum effect on the family, to help them change as much as they possibly can, the total hours needed could be unlimited. In our experience, no one is ever finished growing or learning.

If the goal is to prevent out-of-home placement, then one needs only as many hours as it takes to resolve the immediate crises and teach whatever skills the clients need to be able to maintain the family without intensive help. At HOMEBUILDERS, program goals are limited: to prevent the need for out-of-home placement and to teach families the basic skills necessary to remain living together. In some cases, families still need services. What we have done is help them to attain a level of functioning that will allow them to benefit from more traditional services. For example, most of our families could not get themselves

to weekly appointments at a counseling agency at the time they were referred to us. They were too disorganized, too angry, too discouraged to make it. At the end of HOMEBUILDERS intervention, however, they may have different ideas about what "help" can be like. They have had an experience where putting in time with a therapist began to pay off for them. They are usually getting along quite a bit better with each other and have more energy for getting to appointments.

We also believe that some of the situations facing our clients are not problems that can be resolved, no matter how much time is available with a therapist, but rather predicaments to be endured as gracefully as possible and coped with as effectively as possible. For example, a woman bound to a wheelchair is going to have a difficult time raising two young children by herself. Parenting skills will help. Social support will help, but it's still going to be rough. Similarly, the wife of a navy man is probably going to feel lonely, frightened, resentful and abandoned some of the time she is left home with five kids. She can learn to decrease the panic she feels. She can make new friends and develop more positive relationships with her children, but she will still be lonely, and there will still be a big gap in her life. In the Bronx, many families live in dangerous neighborhoods with substandard housing and drug abuse all around. They can learn to be assertive with landlords and to use housing advocates effectively. They can learn to stay off the streets at night and to teach their children to "say no." They can learn to bear some of the pressures with less emotional strain. But life will still be difficult. All family members will still live in far more danger than any of us would like to see. Life offers all of us some challenges and most of us some burdens. Social services like HOMEBUILDERS cannot and should not be expected to fix everything.

Staffing

We believe that the most efficient, cost-effective, and least intrusive structure is to use a single therapist per case, with team back-up. Each therapist is responsible for conducting the entire intervention for each of his or her clients, but has ready access to the larger team for support and back-up.

Using a team of two therapists, one professional and one paraprofessional, to see families can seem appealing, especially when you consider the intensity of the service, the 24 hour accessibility of the therapist, the severity of the problems faced by the client population, and the emphasis on accountability. A team of two therapists would probably be safer going to and from families, especially in some urban areas. The team approach may also feel more comfortable to some planning groups that are concerned about finding one person who is willing or able to provide a wide range of hard and soft services.

In general, two heads are better than one, and two observers are better than one. Most therapists initially believe they would like working in teams. Using two therapists might reduce the total number of weeks necessary for the intervention because two people would be working with each family. In addition, the two therapists could share being on call. It also is helpful to have two people to model good communications and problem solving for the family.

There are, however, a number of compelling reasons for using a single therapist supported by team back-up. For one thing, a major goal of intensive family preservation services is to develop a no-lose consensus plan for each family. The therapist's duty is to everyone. If one person is responsible for all family members, he or she is motivated to get as much information as possible from all family members for a good synthesis. If family members are assigned to different workers, the therapists sometimes tend to advocate for their particular clients rather than for the family as a whole.

It is easier for the family to learn to trust and relate to one person rather than two. It is difficult enough to talk with one stranger about all your weaknesses and perceived inadequacies, about all the times you were hurt and didn't know what to do about it. We think it may be more than twice as hard to really open up to two new people. For many clients it may be impossible. For many families, one of their problems is having so many different workers pushing them in different directions. One worker may think the mother needs to be more firm. The other worker may think she needs to be more understanding. Minimizing this pressure and confusion is helpful.

Using a team takes more planning, debriefing, and record-keeping time. Information can easily be lost between the two team members, and neither may really have a view of the big picture. It is also more difficult to do spontaneous interventions; that is, to identify an opportunity and to take advantage of it and teach. Often a therapist is responding to the immediate situation and has no time to plan or coordinate with someone else about the skill that needs to be taught. In addition, it is not uncommon for team workers to disagree about family directions. Control can become a big issue between team members and any hard feelings between the two workers can have an impact on the intervention. Family members also find it difficult to know whom to call when they are in a crisis. It can also be very time consuming for co-therapists to consult about and coordinate their interventions.

There are also disadvantages in dividing the work in the intervention according to task, such as using a professional for therapy and a paraprofessional to provide concrete services. Frequently, the person who provides concrete help has a much closer relationship with the family as a result of the amount of time spent with its members. Due to the closeness of that relationship it is not only

difficult for the hard-service person to keep family members from talking about "therapy" issues, but it is also possible for the "therapist" to feel left out of or impeded by that relationship. The paraprofessional may also feel upset that he or she is paid much less than the professional team member despite the fact that he/she probably has accomplished just as much or more with the family.

Using a team to see each family can blur accountability. Therapists often do not feel as much of a sense of accomplishment when things go well because they have to share credit with another team member. In contrast, when things are going poorly, it is hard to determine whether the problems lie with one worker or the other, or the interaction between the two.

In addition, especially during the beginning of the intervention, it is helpful to minimize the number of "helpers" on the scene. We have had clients referred with as many as fifteen different case managers, each one thinking he or she was in charge. Sometimes the number of conflicting messages received by social service personnel can itself be a major problem. We want to help reduce confusion and fragmentation, not add to it.

Workers usually feel safer in teams, and in some situations this may be the case. There is some evidence, however, that when they travel in teams--especially at night--two workers may appear more threatening to clients who are upset. In Seattle, for example, pairs of mental health commitment officers are more likely to be attacked by clients than are individual workers.

All these aspects of the model--the rapid response to referrals, the accessibility of workers at home during evenings and weekends, the time available for families, the location of the services, the staffing pattern, the low caseloads, and the brief duration of services--interact to form a much more powerful intervention than one utilizing only one or two of these components. It is impossible to have the intensity and flexibility we would like with a large caseload. It is impossible to maintain focus, responsiveness to crisis, and accessibility if the intervention drifts on for too long a period. We urge others considering replication of HOMEBUILDERS to try the whole package first and tailor it to their communities if they encounter difficulties. If they eliminate one aspect, such as the short time frame or the low caseload, they are likely to decrease the power of the overall intervention way more than they can realize without first attempting it whole cloth.

We believe that most families deserve strong, effective support in attempting to learn productive ways to cope with overwhelming problems before children are placed outside the home. So far, this combination of program strategies is the most powerful we have seen.

Evaluation

The HOMEBUILDERS Program has been evaluated in many different ways. At this point, we would like to summarize a number of the methods of evaluation and results of various studies. Each has its own set of limitations, but taken as a whole, we believe they provide encouraging evidence that we do prevent placement and help families learn to resolve some of their presenting problems.

One of the most basic issues has been the program's ability to actually prevent placement. We track clients by phone, letter, and the Washington State Department of Social and Health Services computer systems to see whether or not they get placed. Until 1982, we followed clients for three months past intake. Although client populations varied slightly, an average of 94% avoided out-of-home placement for at least three months. Since 1982, we have tracked clients for one year after intake. For this time period, 88% avoided placement. Placements include state-funded foster, group, psychiatric or correctional care settings. We do not count situations where a child goes to live with extended family members or another parent as placement. We also do not count brief respite care of less than two weeks as placement.

Once the issue of placement is addressed, we are then concerned with the cost effectiveness of the model. We want to know how the costs of HOMEBUILDERS compare with the costs of out-of-home placement. In Washington State, we obtain information regarding the average costs of different out-of-home placements from the Washington State Department of Social and Health Services. We take the average cost per time period and multiply it by the average length of stay to get the average cost per client. We compare these costs to the actual costs of HOMEBUILDERS. Assuming all cases would have been placed, costs of HOMEBUILDERS are $31,646,857 less than average costs of placement would have been. A summary of this information is shown in Table 3.

This information is heartening. Using these cost differences, we can also make some hypotheses about the number of placements that would have to be averted in order to justify the initial cost of a program. For example, if an average group care placement costs $22,373 and it costs $200,000 per year to begin a program, only 8.9 placements (200,000 divided by 22,373) must be averted in order to recoup program costs.

These figures are very interesting to legislators and policy makers, but they do have some limitations. We don't know for sure that clients we see would have been placed. The cost comparisons are narrow, involving only the cost of HOMEBUILDERS and out-of-home placement when, in actuality, many other

Table 3

HOMEBUILDERS Cost Effectiveness with Various Client Populations, 1974-1986*

The cost effectiveness of HOMEBUILDERS family preservation model has been evaluated by comparing the average cost of HOMEBUILDERS with the average costs of projected out-of-home placement. The average cost of HOMEBUILDERS is obtained by dividing program costs by the total number of clients served. Costs of placements are obtained by multiplying the average costs per day or month by the average length of stay, 1986-87 costs of placement were obtained from the following Washington State Department of Social and Health Services figures:

	Average Length of stay	Average Cost per month	Total Cost per client
Homebuilders			2,600
Foster care: CPS	19.4 mos	370	7,186
Foster care: FRS, DD, Delinquent, Mental Health	19.4 mos	435	8,440
Group Care	13 mos	1,721	22,373
Residential Treatment	13 mos	2,206	28,678
Acute Psychiatric Hospitalization	4 mos	11,250	45,000
Long-Term Psychiatric Care	14 mos	7,350	102,900

Client Population Category	Numbers Served	Success Rate 3 Mos After Termination**	Potential Placements	Cost of Potential Placements	Cost of Homebuilders	Difference Between Placement/HB
Families in conflict	1,262	94%	66% foster care 32% group care 2% psychiatric care	7,030,520 9,038,692 1,125,000	3,281,200	13,913,012
Child abuse/neglect	1,198	95%	88% foster care 9% group care 3% psychiatric care	7,574,044 2,416,284 1,620,000	3,114,800	8,495,528
Delinquency	250	92%	37% foster care 63% group care	784,920 3,512,561	650,000	3,647,481
Child mental health	123	83%	13% foster care 87% residential treatment	135,040 3,068,546	319,800	2,883,786
Child mental health study***	25	83%	100% long-term psychiatric care	2,572,500	128,250	2,444,250
Developmental disability	45	95%	100% foster care	379,800	117,000	262,800
TOTAL	2,928	94%		39,257,907	7,611,050	31,646,857

* Portions of 1982 data are available due to change in parent agency.

** Since 1983, follow-up data are available for one year after intake. Those data show an overall success rate of 88%.

*** Specific Mental Health Project conducted in 1979.

services and resources may have been involved.

We have conducted two studies designed to examine the issue of whether clients referred to HOMEBUILDERS really would have been placed. The first, in 1976-77, involved overflow clients who were status offenders referred from the Pierce County Juvenile Court. In this group, 73% of the clients who were seen by HOMEBUILDERS were not placed. Seventy-two percent of the clients who were not served by HOMEBUILDERS (because we were full) were placed. The second comparison study involved overflow mental health cases referred by the Pierce County Office of Involuntary Commitment. In this study, 100% of the comparison cases and 20% of the treatment cases were placed.

Of course whether or not a child gets placed is only part of our concern. We want to know not only if a child is placed but how he and his family are functioning. We have tried to find out if they are really better off after HOMEBUILDERS involvement. One of our best ways of tracking client progress is the Goal Attainment Scaling that is the foundation of our recordkeeping system. Two to four goals are set with each family and then rated weekly regarding progress. If progress does not occur, the treatment plan is changed.

We have also used a number of more formal measures of client functioning. In the 1980 Mental Health Study, we found improvements on the Global Assessment Scale and the Child Behavior Checklist.

One limitation of these methods is that they involve verbal reports about behavior instead of actual observations of the behavior. There is also the possibility of a regression phenomenon. If we get clients in crisis, it is reasonable to believe that there would be improvement on some of these measures over time without intervention.

We have also relied heavily on client feedback as a means of assessing the effectiveness of our intervention and the degree to which goals were actually met. We contact clients routinely now, three and 12 months after intake. A summary of one year's client feedback information is shown in Table 4.

In the previously mentioned mental health study, we also obtained ratings from parents regarding improvements on presenting problem behaviors. A summary of those reports is shown in Table 5.

In one study funded by the Administration for Children, Youth and Families, client mothers, children and therapists were interviewed within 24 hours after a session to determine events that were helpful or non-helpful, the degree of helpfulness/non-helpfulness, the responsibility attribution for the event, and the correlations of all these with the ultimate outcome of the case. Trained judges were able to reliably assign 1,120 critical incidents into eight thematic categories. The most significant finding in this study was the importance of the provision of concrete services in helping to avert placement.

Table 4
HOMEBUILDERS 1985 Client Feedback Survey: King, Pierce, Snohomish and Spokane Counties

1. Do you think this outcome is the best for your family at this time?

   a. For families where child is living at home:

Yes	204	(85%)
No	21	(8%)
Not sure	16	(7%)

   b. For families where child is living out of home:

Yes	13	(59%)
No	5	(23%)
Not sure	4	(18%)

2. Was HOMEBUILDERS helpful or not helpful to your family?

5	Very helpful	190	(67%)
4		58	(20%)
3		25	(9%)
2		5	(2%)
1	Not helpful	4	(1%)
0		2	(1%)

3. Did you find HOMEBUILDERS more or less helpful than other counseling you have had?

More helpful	151	(87%)
Equal	13	(8%)
Less helpful	8	(3%)

4. How helpful was the previous counseling you had?

5	Very helpful	27	(27%)
4		8	(8%)
3		16	(16%)
2		19	(19%)
1	Not helpful	28	(28%)
0		3	(2%)

5. Would you recommend HOMEBUILDERS to a family in a situation similar to your family's?

Yes	263	(97%)
No	5	(2%)
Not sure	3	(1%)

6. Was it helpful that your therapist came to your home for appointments?

Yes	269	(98%)
No	5	(1.5%)
Not sure	1	(.5%)

7. Did you feel that your therapist really cared about your family?

Yes	202	(99%)
No	-	
Not sure	2	(1%)

8. Did your therapist schedule appointments at times that were best or most convenient for you?

Yes	274	(99%)
No	1	(.5%)
Not sure	1	(.5%)

9. Did you feel that the therapist really listened and understood your situation?

Yes	269	(97%)
No	7	(2%)
Not sure	2	(1%)

10. Was your therapist available to you when you really needed him/her?

Yes	272	(99%)
No	2	(1%)
Not sure	-	

11. Was your therapist on time for appointments?

Yes	180	(97%)
No	5	(3%)
Not sure	-	

12. Did your therapist ever seem to take sides?

Yes	11	(5%)
No	225	(94%)
Not sure	3	(1%)

Table 5
Parent and therapist ratings of improvement of presenting problems in HOMEBUILDERS Mental Health Study

Problems	# cases with problem at intake	Parent/therapist ratings of condition at termination		
		worse	same	better
Disorientation	5			100%
Delusions	3			100%
Hallucinations	2			100%
Inappropriate affect	8			100%
Assault to others	13			92%
Social isolation	9		44%	56%
Lack of cooperation	11		10%	90%
Lack of motivation	7			100%
Dependency	12			100%
Depression	16	6%	6%	88%
High suicide potential	8			100%
Drug abuse	6	16.5%	16.5%	67%
Alcohol abuse	6		75%	25%
Learning disability	4		75%	25%
Sexual assault to others	1			100%
Thought disorder	1			100%
Affective disorder	5			100%
No school	10		30%	70%
Anxiety	17	6%	18%	76%
Medical problems	2		100%	
Problems with anger	17	6%		94%
Sleep disturbance	3		33%	67%
Hyperactivity	7		14%	86%
Impaired judgment	15		20%	80%
Impaired communication	13		15%	85%
Obsessional rituals	2			100%
Speech impairment	2		100%	
Delinquent acts	8	12%	25%	63%
Poor impulse control	12		25%	75%
Psychosomatic illness	3		33%	67%
Phobias	7			100%
Peer problems	11		36%	64%
Physical handicap	1		100%	
Assault to property	9		22%	78%
AVERAGES		1.5%	17%	81.5%

Limitations of client feedback measures are that clients may be telling us what they think we want to hear. Also, their comments may not be linked to actual changes in problem behaviors.

HOMEBUILDERS have also been evaluated formally and informally by many outside auditors and evaluators, including the American Criminal Justice Institute, the Washington State Legislature, the Washington State Department of Social and Health Services, the Washington State Office of Research and Evaluation, and the National Institute of Mental Health. Outside auditors and evaluators have limits, too. They usually begin by focusing on goal attainment ratings and costs, but as they get closer to the client stories in the records, and if they talk with clients themselves, they rapidly shift to concern about what is really happening in families' lives. Objectivity suffers as compassion rears its subjective head.

More recently, we completed a study funded by the Department of Health and Human Services to evaluate and compare the HOMEBUILDERS Program in Washington State with Family Preservation Projects in Utah. Results from this study demonstrated significant improvement in parent and child functioning and social support over the course of the treatment.

As we have mentioned before, however, some of the most important measures of the program's validity are personal accounts of what has really happened with one or two cases. To that end, we present two case summaries.

The Clark Family: Child Abuse

The Clark family was referred to HOMEBUILDERS by a public health nurse [Note 1]. The nurse requested that the HOMEBUILDERS intervention coincide with the release of the Clark's infant daughter from the hospital. The baby had been born prematurely and had spent the first three months of her life in the hospital.

The nurse requested intensive services because she was concerned about the family situation. The Clark's three-year-old son recently had been diagnosed as hyperactive and as having some brain damage. Children's Protective Services and the nurse were also questioning three concussions that the boy had had over the last year. The nurse and CPS were certain that unless HOMEBUILDERS was available to see the family, both children would have to be placed in foster care.

The nurse discussed her concerns with the parents, and they consented to allowing a HOMEBUILDERS therapist to come to their home. The family had no phone, so the therapist dropped by unannounced for a visit. Mrs. Clark was home at the time, so the therapist asked if she could stay awhile and talk.

After sitting down, the first thing the therapist noticed was the smell of

gas leaking from the furnace. Mrs. Clark said she thought she had smelled gas, but hadn't felt up to walking to the public phone to call her landlord. The family's pediatrician had ordered her to get a telephone installed because of the uncertain condition of the baby, but since her husband was not working regularly, they couldn't afford to pay the installation fee.

The therapist suggested that Mrs. Clark dress herself and the children warmly, open the window and turn the furnace down. While she did that, the therapist went to a public phone and called the landlord to send out a repairman.

When the therapist returned, Mrs. Clark talked about her situation. She said she had been very depressed since the baby's birth, and that she often felt that the child did not belong to her. She was also extremely upset about her son's "wild" behavior. She wondered if the boy had a "bad seed" in him like his uncle who was in prison. She had begun to think that she might kill him rather than watch him grow up to be a murderer like his uncle.

Mrs. Clark was very thin, pale and weak. She had a chronic cold, and had lost her front teeth due to poor health. Now 22, she had had three children and four miscarriages in five years of marriage. She also said she was very lonely. Her husband usually was away from the house from mid-morning to late at night. He worked as an insurance salesman, but he had not sold a policy in five months. The woman told the therapist that every other counselor they had seen had told her that her husband was "rotten" and that she should leave him. She said she loved him and that he didn't beat her. The family had moved to Washington from Idaho several months previously so that they could remain married, yet still be eligible for state aid. Currently they were receiving funds from the WIN program.

The next day the therapist approached a local charitable organization and got the $25 needed to have a telephone installed. She also got two old bedsheets that could be nailed up as curtains, since Mrs. Clark had expressed fears about sitting alone at night with no curtains for privacy. She had told the therapist that one night recently a strange man had been peering in her window. She had been raped once before and was scared it might happen again.

During the next home visit, they focused a lot on the three-year-old son. Mrs. Clark said that she did not love him and described a variety of what she labeled as self-destructive and wild behaviors that he engaged in. She reported incidents such as him throwing himself backwards off furniture, touching the hot stove and laughing, turning on the kitchen burners, banging his head against the wall until he passed out, biting, scratching and hitting other people. Although he was three, he still had not started talking. She was concerned that Children's Protective Services would think she was abusing him because he hurt himself so much and because they locked him in his room at night. The Clarks did this

because the boy only slept two or three hours at a stretch, and if he was not locked in his room, he would go into the kitchen and eat until he vomited. She said CPS thought she should put him in an institution because she couldn't handle him. He would not kiss or show any affection to people. She said he had been removed from the home by Children's Protective Services in Idaho the previous year when she had "a nervous breakdown" and was hospitalized. Since moving to Tacoma, the parents had already voluntarily placed the boy once for 72 hours because the mother felt she "couldn't cope" with him any longer. She was also afraid she might harm him because he made her so angry sometimes.

Before leaving that day, Mrs. Clark and the therapist made a list of what she could do if she felt her son's behavior was so bad that she would want to place him again. The Homebuilder let her know she thought it was a good idea to lock him in his room sometimes and explained the concept of Time Out. The list also included calling the Homebuilder (the family's phone was to be installed the next day). Then they made an appointment to take the son to Mary Bridge Children's Hospital Learning Center to see about enrolling him in a special school program. Finally, the therapist talked with the mother about making some free time for herself and volunteered to babysit for several hours later that week. Mrs. Clark accepted the offer.

Later that week, the Homebuilder was alone with the children for five hours while she was babysitting. She learned a lot about the young boy. She observed him engage in some of the behaviors Mrs. Clark had reported. By the end of the day, however, she determined that he responded to positive reinforcement and Time Out. During the afternoon she taught him to play a kissing game. The information gathered that day was invaluable. It was proof for both the therapist and the mother that the little boy could change, and that he did care about people. His mother cried the first time they played the kissing game.

During the second week of the intervention, Mrs. Clark began to talk more freely about her discontent with her marriage. She said that she knew her husband wasn't really working all the times he was gone. She expressed resentment over the fact that he dressed nicely while she had only one outfit, that he was free to play all day and night while she sat confined in their apartment, that he would not let her get a driver's license but also would not drive her places. Feeling she had reached a teachable moment, the Homebuilder began to talk about territoriality and assertiveness training. The Homebuilder also called the woman's DSHS caseworker and got authorization to get her front teeth replaced.

Mr. Clark was beginning to get curious about what was happening. One day he stayed home to meet the therapist. While his wife was at the dentist, he and the Homebuilder spent several hours talking. He shared his own frustrations

about having to be on welfare. The Homebuilder told him that she wanted him to be a part of the counseling process and he agreed to attend the next session. After their discussion he seemed more willing to participate.

During the last weeks of the intervention, the therapist focused primarily on teaching the parents some behavioral child-management skills. The son had begun attending Mary Bridge school program, and Mrs. Clark rode the bus with him every day. The Homebuilder was pleased to see this, as it gave the mother a chance to watch the teachers, and to make friends with the staff there. Mrs. Clark reported having some positive feelings about her son, and no longer felt she should send him away. She also began to feel much better about herself. She had temporary caps on her teeth, and began to smile more. She was also beginning to gain a little weight.

As the end of the intervention approached, the therapist and Mrs. Clark explored ways she could continue counseling. She decided that she wanted to go back to a counselor at the mental health center. She had seen the counselor a couple of times right after the baby was born last summer, and thought she could trust her. She made an appointment.

During her last week with the family, the therapist helped the Clarks move to a better apartment in the neighborhood where they felt safer. It wasn't until after the move that the family found out the Mary Bridge bus would no longer be able to transport the boy to school. Mrs. Clark became very upset, but quickly de-escalated herself and began to problem solve. She talked with the counselors at Mary Bridge and followed their suggestion to see if the boy could be transferred to Child Study and Treatment Center's day care program. There were no openings at the Center but he was put on the waiting list.

A follow-up call from this family several months later revealed that although there had been a number of upsetting events that had happened after the Homebuilder left, they were still together as a family. Mrs. Clark had been seeing her counselor and had continued to work on being more assertive. She and her husband were also going for marital counseling. Mr. Clark had quit selling insurance and was enrolled in a job training program. The son was attending the new school, and the mother was participating in a parent education program required by the school. The Clarks reported that their son was starting to talk and did not seem as "wild". The infant daughter was doing fine as well.

Homebuilder costs for the Clark family intervention totalled $2,937. If the mother had been placed in a psychiatric hospital, the cost of hospitalization would have been $5,926. If the two children had been removed by Children's Protective Services, the cost of their placement would have been $15,000 or $7,500 each. Total costs would have been $20,926.

Gary: Mental Health

This case was referred to HOMEBUILDERS by the Office of Involuntary Commitment. There were several major problem areas. Gary, a 15-year-old boy, had severe behavior problems and was suspected of being pre-psychotic or of having a severe character disorder.

Gary had violent temper outbursts daily; he would scream obscenities and end up on the floor sobbing he should be killed or that he would kill someone else. Gary had punched dozens of holes in the walls and doors of his parents' house. Once he put all his bedroom furniture in a pile and chopped it into little pieces. His 12-year-old sister was in a body cast from a spinal operation. He would spit in her face and hit her. One time a babysitter locked herself in the parents' bedroom during a fight with Gary. He took a pellet gun and shot at the door.

When the therapist went to the home, it became evident that the family was violent, not just the boy. During one disagreement the stepfather put a gun to Gary's head and marched him out to the car, tied one of the boy's legs to the bumper, and threatened to drag him if he didn't shape up. The stepfather had said, "I'm going to kill him or me if this doesn't get better." At other times, the stepfather had hit Gary with pieces of wood and scratched his face with his fingernails. The mother spat at Gary.

Many fights centered around Gary not doing chores, even though he was around home all day. He had been expelled from school. Teachers said, "Everybody hates him. You can't trust him for a minute. The only emotion he feels is anger." The parents' relationship was very strained due to family problems; the stepfather had walked out twice in the last six months. Both parents told the therapist that a divorce seemed imminent.

The therapist spent several days just listening in order to let everyone make sure their version of the problem had been fully understood. All expressed relief and all expressed interest in learning different ways to cope. The mother was the first to make a major change; she learned active listening so that when Gary started to yell at her, instead of yelling back, she was able to help him calm himself down. This resulted in a rapid reduction of his outbursts. The boy was also trying to notice what triggered his anger. He began to learn Rational Emotive Therapy to tell himself calming statements. The stepfather also began working on other ways of expressing his frustration. All family members learned to recognize when their frustration and anger was beginning to build and to construct "I" messages before the situation got out of control.

The stepfather began leaving lists of chores for the boy to do each day. Gary's allowance was contingent upon task completion. The school was unwilling

to give Gary another chance, so the therapist arranged for a tutor to come to the home.

At the end of five weeks, there had been only two major outbursts. Gary was doing 80% of his chores and getting almost straight A's in his work with the tutor. His mother said, "I don't feel afraid anymore." On one occasion the therapist provided child care so that the parents could take a brief vacation, during which they renewed their commitment to their marriage. The relationship between Gary and his stepfather remained strained. Since the family lived in a remote area of the county and it would be difficult for them to locate appropriate ongoing services, the family decided they would rather have weekly follow-up sessions with the Homebuilder therapist instead of one extra week of intensive service.

Two years later, the therapist ran into the boy at the county fair. He was still living at home. Out-of-home placement was no longer an option. HOMEBUILDERS cost was $4,200. Hospitalization would have cost the State of Washington over $36,000.

Reference Note

[1] Currently all referrals are routed through the Department of Social and Health Services.

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TRANSFERRING THE PRINCIPLES OF INTENSIVE FAMILY PRESERVATION SERVICES TO DIFFERENT FIELDS OF PRACTICE

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Social Work Fields of Practice

One of the earliest and most persistent debates in social work education is the question of how best to enable students to develop specialized knowledge and skills while insuring that they acquire a core identity and common knowledge base. Repeated efforts have been made to define the common or generic elements of social work practice and to specify criteria for distinguishing areas of specialization.

The concept of "field of practice" has been emphasized at different times in social work history as a device for defining areas of specialization. The term has traditionally been used to refer to a loose combination of population, problem and service structure; but ironically, as Dea (1983) points out, the profession has never developed a clear definition of what constitutes a field of practice. Sometimes the term is used to describe a relatively narrow service system, e.g., child protective services; other times it is used to convey a more broadly conceived range of services, e.g., family and children's services.

The fact that the field-of-practice concept keeps reappearing in the professional literature suggests that it has obvious utility as a device for distinguishing and organizing different types of social work interventions. But the definitional ambiguities remain, and there are persistent tensions in social work education regarding the relative emphasis that should be given to generic versus specific knowledge.

The experience of introducing curriculum content on intensive family preservation services in various schools of social work provides a clear illustration of the advantages and limitations inherent in using fields of practice as an organizing principle for developing and disseminating new practice knowledge. This paper will examine intensive family preservation services from the perspective of different fields of practice, demonstrating how a practice technology developed and taught primarily for use in child welfare settings also is being implemented by practitioners in other fields of social work practice.

Because the principles inherent in intensive family preservation services appear to be useful for professionals in other types of settings, we conclude by proposing that faculty in schools of social work find ways to introduce this content in courses that cut across field-of-practice interests.

Evolution of Field of Practice Concept

Because social work evolved as an organization-based profession, the early practitioners tended to define and organize themselves by agency setting, e.g., medical social work, school social work, family casework, and psychiatric casework. Practice knowledge was developed and disseminated in each specialty area; only later, as more formal, university-based institutions for social work education developed, did practice theorists begin to concern themselves in any systematic way with identifying the common or universal elements in practice that might transcend agency-specific concerns.

The Milford Conference, which met regularly from 1923-1928, was convened in part to define the various fields of casework specialization and to identify the common elements in casework practice. The final report of the conference concluded that despite the importance of the various fields and the specific demands placed upon its practitioners, "...the outstanding fact is that the problems of social casework and the equipment of the social caseworker are fundamentally the same for all fields" (American Association of Social Workers, 1929:11).

During the next three decades, social work educators and theorists placed increasing emphasis on the importance of developing the various methods of social work practice, and social workers began to specialize and organize by the method in which they were trained, i.e., casework, group work, community organization and research. The National Association of Social Workers (NASW), established in 1955, was formed by the merger of six specialized professional organizations as well as the American Association of Social Workers. One of the first challenges confronting this new organization was the need to highlight the commonalties among the various methods and fields of practice. Its Commission on Practice proposed the first professionally sanctioned working definition of social work practice in 1958 (Bartlett, 1958).

Paralleling the developments in the professional practice community, the Council on Social Work Education (CSWE) began to move away from emphasis on method specialization during the 1960s. Repeated efforts were made during the next decade to define specializations around what Bartlett defined as the "common base" of social work practice (Gordon, 1983). In the mid-1970s NASW and CSWE established a joint Task Force on Specialization. Although this task

force endorsed social work's historic focus on the interface between the person and the environment, it proposed that the segments of the environment (home, work, school, etc.) that are connected with the potential mismatch between a person's coping capacities and his/her impinging environments constitute the natural basis for specialization.

This definition of specialization is conceptually satisfying but difficult to implement because there is no clear consensus about how the environment should be sectored. Moreover, the conceptual distinctions proposed do not necessarily match the realities of the practice world as currently structured. Thus, the Task Force eventually selected "social needs and the social institutions formed to meet those needs as the major sectoring device" (Gordon, 1983;978). The Task Force also suggested that in order to be considered a practice specialization, there must be a sufficient number of people with a common condition to be altered, there must be social work competency to address this condition, and there must be a substantial specialized knowledge related to intervention (Brieland, 1987:750).

This concept of specialization is consonant with traditional definitions of fields of practice and takes account of the demands of the practice world for specialized knowledge. At the same time the Council on Social Work Education's requirement that all students be exposed to a generalist practice base before moving into a specialized area of advanced training insures retention of a common professional base. Consequently, when the Task Force on Specialization released its report in 1979, it was widely endorsed. NASW gave increased emphasis to the importance of specializations in 1985 by announcing the creation of five practice commissions designed to serve the diverse practice interests of its membership: education, employment/economic support, family and primary associations, justice, and physical and mental health (Brieland, 1987:750).

Although these moves toward increased specialization were intended to make the professional social work community more responsive to the needs of agencies for staff with very specialized knowledge and skills, the fields of practice identified by CSWE and NASW are still very broadly defined and strive for a conceptual coherence that is not reflected in the realities of the practice world. Consequently, agencies continue to push schools of social work to provide more specialized training, while many educators continue to question the wisdom of teaching specific practice technologies that may not have utility across practice settings.

The questions that have been raised about the appropriate place for introduction of content regarding intensive family preservation services (IFPS) in the curricula of schools of social work provide a clear illustration of the dilemmas that must be encountered if the profession is to develop a more satisfying relationship between academic course work and the field.

IFPS in the Context of Courses on Child Welfare

IFPS interventions evolved in the context of changing policies and practices in the child welfare field and are taught most readily in courses on family and children's services. Although the HOMEBUILDERS program was initiated prior to the passage of P.L. 96-272, the Adoption Opportunities and Child Welfare Act of 1980, the rapid expansion of the program and the proliferation of other types of related IFPS programs during the past decade can be attributed to the mandates of this legislation and the funding it has made available for the provision of services designed to prevent child placement. Given the increasing prominence of IFPS programs in the repertoire of state child welfare services, it has become almost imperative for courses on child welfare to include a section on IFPS practice. But these courses are usually electives taken by only one segment of the total student body. Moreover, there are very real time constraints on the amount of attention that can be given to any one practice technology in a course that must examine a wide range of services. This means that in most schools of social work today only a minority of students are exposed to intensive family preservation services; they receive only a brief exposure to this subject.

This is problematic for several reasons. First, there are an increasing number of interesting job opportunities in IFPS programs for new graduates. Second, early research findings suggest that this new practice approach has a utility far exceeding that of many more traditional approaches widely taught in schools of social work. Third, as discussed in some of the other papers in this sourcebook, IFPS is essentially a "whole cloth" service strategy that requires knowledge of policy, programming, research and practice technology in order to be effectively implemented. Since these topics are customarily taught separately when the curriculum is organized by method rather than by field of practice, it is very difficult for an instructor to introduce all the relevant content about IFPS in a single course. Finally, as we hope to demonstrate in the remainder of this chapter, the practice principles and technology inherent in IFPS programs may be as relevant in a number of other fields of practice as in child welfare. If this is true, then we would argue that course content on IFPS should be introduced to all students in schools of social work, regardless of their particular field of practice specialization.

Relevance of IFPS Programs Across Fields of Practice

The legislation undergirding social service provision in most fields of practice is generally very targeted and problem-specific. However, the Title XX Social Services Program enacted in 1975, the only comprehensive, federal social services program, identified five broad goals for the delivery of social services: (1) promoting self-support, (2) promoting self-sufficiency, (3) preventing abuse and neglect and preserving and reuniting families, (4) preventing inappropriate institutional care, and (5) securing appropriate institutional care and services.

Funding for this program, which was folded into the Social Services Block Grant with passage of the Omnibus Budget Reconciliation Act of 1981, has never remotely matched original expectations. However, the policy principles inherent in Title XXs service goals closely parallel those identified in a number of the more targeted federal laws governing service provision to discrete high-risk populations in different fields of practice. These principles reflect increasing societal recognition of the importance of preventing dependency, enhancing informal family support systems, maintaining people with special needs in the community, using institutional placements only as a last resort, and minimizing the detrimental impact of institutional care. Thus, recent moves toward deinstitutionalization and increased reliance on family and community care in the fields of health, mental health, mental retardation, special education, aging and juvenile justice can all be viewed as very consonant with the objectives of the Title XX Social Services Program. Since these objectives have encouraged the rapid growth of IFPS programs, the practice principles and technology utilized so effectively to deliver intensive family preservation services in child welfare settings should be equally valid in work with similar populations in other service systems. To date, limited experience with such experiments in other fields of practice suggests that this is a direction that should be actively explored by social work practitioners and educators.

Although often portrayed solely as a child welfare service, HOMEBUILDERS was originally designed to help families deal effectively with a wide range of serious social and behavioral problems, including family violence; aggressive and delinquent behavior; school problems; and difficulties meeting basic needs for food, shelter and clothing (for a more complete description of the HOMEBUILDERS model of intensive family preservation services see Kinney et al., this volume and Kinney, Haapala and Booth, 1991). In everyday life, families and the problems they experience seldom fit neatly into professional categories or fields of practice. Families come in different forms (e.g., single-parent, blended, adoptive) and from different income levels; their problems are varied and include

interpersonal, intrapersonal, social, educational, health and economic difficulties, and occur in different settings (e.g., in the home, community and school).

There is great similarity among many children and families served by child welfare, mental health, juvenile justice, public health and various developmental disability programs. The type of service a client does or does not receive primarily depends on the service door through which the child (or family) walks, rather than the nature of the problem presented. The HOMEBUILDERS model of intensive family preservation services was designed to be flexible and to address the wide variety of problems that parents and their children experience at home, at school and in the community. This flexibility across people, problems and settings allows IFPS programs to be implemented across different fields of practice.

As discussed earlier, over the past few years there has been rapid development and expansion of IFPS programs within the child welfare field. At the same time, there has been a growing recognition of the usefulness of IFPS practice technology in the mental health and juvenile justice fields, with many states moving in the direction of developing IFPS programs to serve families in these fields. While there also has been some interest in the use of IFPS practice in the fields of developmental disabilities and aging, there has been more experience with these programs in mental health and juvenile justice, so we shall limit our discussion to these fields. Some states have developed IFPS programs that serve a combination of child welfare, mental health and juvenile justice populations; others have developed separate but similar programs to serve these populations. Often, it is the funding stream that determines whether the IFPS program will serve mental health, juvenile justice or child welfare clients, or some combination of these youth.

As a result of the growing number of programs that serve multiple populations, it has become increasingly clear that there are more similarities in IFPS programs across fields of practice than there are across many service programs within specific fields of practice. Intensive family preservation services cut across fields of practice, often blurring the differences and distinctions between them.

In the following discussion we shall describe the development of IFPS programs in the mental health and juvenile justice fields, identifying the modifications in service structure necessary to ensure the transferability of this practice approach, and then present two case examples. In the final section we shall analyze the implications of the developments for social work education.

Mental Health Field

Over the past decade there has been growing concern regarding psychiatric hospitalization and the lack of alternative community mental health programs for children (Knitzer, Steinberg & Fleisch, 1990). With the introduction of the National Institute of Mental Health's Children and Adolescent Service System Program (CASSP) initiatives, many states have developed community based "systems of care" that include an IFPS program component. In the mental health field, IFPS programs are designed to serve children who are in imminent danger of placement in a psychiatric hospital or residential treatment center.

Program structure. IFPS programs that utilize the HOMEBUILDERS model to serve mental health clients have adopted a similar program structure with a 4-8 week intervention and caseload of two families per worker. While most programs use a single worker to provide the service, some use teams to conduct the initial session. However, this is not unlike some IFPS child welfare programs that use teams for the initial or other specific sessions when the risk of danger might be high.

IFPS programs are located in a variety of mental health settings including hospitals, public and private comprehensive mental health centers, private human services agencies and child guidance centers. Referrals are generally accepted 24 hours a day and therapists are on call 24 hours a day, seven days a week. The programs do not utilize waiting lists.

Referral services and populations served. Unlike child welfare programs, a variety of different referral pathways have been developed for mental health IFPS programs. They range from hospital emergency room physicians to self-referrals. An IFPS program operating out of Buffalo General Hospital in New York, for example, accepts referrals through a mental health emergency clinic, where a physician must document that without intensive family preservation services the children would be admitted to the hospital's psychiatric unit. When HOMEBUILDERS operated a mental health program from 1979 to 1981, clients were referred from the State of Washington Office of Involuntary Commitment (Kinney, Haapala, Booth & Leavitt, 1990). In Missouri, referrals to their Families First IFPS programs come from a number of sources, including the Department of Mental Health, the Division of Family Services, Juvenile Court, private mental health therapists and counseling centers. Self-referrals are also accepted by certain programs.

The primary population served by mental health IFPS programs are children between the ages of 5-18 who are considered "emotionally disturbed" and

who are in "imminent" danger of out-of-home placement, usually because they are a threat to themselves or others. Compared to child welfare cases, children receiving services from mental health IFPS programs tend to be older. Typical presenting problems include aggressive/assaultive behavior, suicidal threats and attempts, substance abuse, conduct disorders, parent/child conflict, school problems, thought disorders and hallucinations. Children referred to these programs often have past histories of psychiatric involvement, hospitalization and other placements. While it is not clear how this population, their families and their presenting problems differ from child welfare and juvenile justice populations, the children referred to the majority of the mental health IFPS programs must be diagnosed using the DSM III-R during the initial week of intervention. This is one of the major modifications in service strategy that has been made to transfer the IFPS technology to a mental health setting. The routine use of mental health diagnostic labels runs counter to the HOMEBUILDERS model that instead promotes the use of behaviorally specific descriptions, an ongoing assessment process, a focus on client strengths and the family's identification of problems. While the use of an official diagnosis is often tied to the funding of services, IFPS staff report that once the diagnosis is made, very little attention is paid to it. Instead, their focus is on the specific behavior problems and goals identified by the family.

Services provided. Mental health IFPS workers provide a wide range of interventions and services. As in child welfare programs, the families' needs and problems vary and a range of interventions from cognitive and behavioral change strategies to helping meet basic needs is provided. Mental health programs report less reliance on concrete services and more emphasis on teaching parents and children anger management and other self-control strategies, contingency management interventions (e.g., point systems, reward charts) to change behavior patterns, communication skills and problem-solving techniques. Since clients referred to IFPS programs are often assaultive and/or suicidal, safety is a major concern and interventions often include suicide contracts, structuring daily routines and close monitoring.

Staffing. Unlike a number of child welfare IFPS programs that employ bachelor's-level workers, IFPS mental health programs are staffed primarily by master's-level staff. However, exceptions have been made in rural areas where master's-level therapists are difficult to recruit. Another staffing difference in certain programs has been the introduction of a consulting psychiatrist to the IFPS team. In these programs, a consulting psychiatrist may staff the cases weekly and/or be on call to staff for medical and psychiatric consultation.

Acceptance of IFPS in the mental health community. Overall, IFPS programs have been well received by the local mental health communities. In some communities these services are among the few community-based services available for emotionally disturbed children and are eagerly welcomed. Various programs, however, have noted skepticism and controversy among traditional mental health providers regarding the short time frame and the focus on the family rather than on an "identified patient." This latter issue, which has important implications for the assessment process, paperwork system, billing procedures, interventions and follow-up services, often presents administrative and clinical hurdles for IFPS programs in relation to their parent agency and/or funding service.

In some communities there has been a professional hesitancy to embrace the program because of the long-standing conviction that treatment needs to occur in a controlled setting (e.g., a treatment center). The IFPS approach also has raised issues concerning the hierarchy of professional disciplines and the roles of psychologists, psychiatrists, and mental health specialists in service delivery.

Juvenile Justice Field

While not as prevalent as in the mental health and child welfare fields, IFPS programs are now beginning to be transferred to the juvenile justice arena. In states such as Washington, Utah, New Jersey and Michigan, IFPS programs routinely accept referrals of delinquent or status-offender youths, often through youth services or child welfare channels. Programs developed in the late 1980s in New York City, the state of Virginia and Contra Costa County, California serve children and their families directly identified and referred by juvenile court and probation staff.

Program structure. Although many IFPS programs serving delinquent or status-offender youth follow a four- to six-week time frame, programs in New York City and Virginia are experimenting with a longer intervention period. In Virginia, the time frame has been extended to a maximum of 90 days (60 day average) to allow the IFPS worker to be involved in the various court hearings. As a result, the maximum caseload size has been increased to four cases per worker. The Family Ties programs sponsored by New York City's Department of Juvenile Justice, which now uses a four- to six-week intervention, are considering increasing the time limit to eight weeks in order to provide additional time to provide services to some families (e.g., parents who are substance abusers, families involved with multiple social service agencies). IFPS workers in juvenile justice programs, like those in child welfare and mental health programs, are on

call 24 hours a day, seven days a week, providing an array of counseling and concrete services in the families' homes.

Referral sources and populations served. Families are referred to juvenile justice IFPS programs either directly from the courts or by probation workers. The introduction of IFPS programs into the juvenile justice field has involved careful planning and collaboration with juvenile and family courts and probation staff. IFPS juvenile justice programs accept youths who are in imminent danger of placement into juvenile facilities, including detention, minimum security residential centers and group homes, and maximum security facilities. Common presenting problems of youths referred to IFPS are severe family conflict, assault, grand larceny, possession of controlled substances, and school problems. The age range of children served is 7 - 17 with an average age of 15.

Services provided. Services and interventions provided are very similar to those provided to child welfare and mental health clients. Special emphasis is given to teaching skills to the teen-age population, including anger management, resisting peer pressure, problem solving and dealing with school problems. Since many of the youths have dropped out of school or have major problems in school, the IFPS practitioner works closely with school personnel, often providing advocacy for educational and vocational services and programs.

Staffing. The few programs that solely serve juvenile justice clients are primarily staffed by bachelor's-level workers and master's-level supervisors. Programs serving a combination of child welfare, mental health and juvenile justice clients are generally staffed by master's- or bachelor's-level workers, depending on the location of the program. Programs in rural areas, as well as those in larger inner-city areas (e.g., New York City, Detroit) tend to have difficulty recruiting master's-level workers and often hire staff with bachelor's degrees.

Acceptance of IFPS programs in the juvenile justice community. Careful planning and coordination with juvenile courts and probation workers has been a key element in the successful implementation of IFPS programs in the juvenile justice field. Both the New York City and Virginia programs spent months developing relationships, designing referral processes and coordinating activities. IFPS workers in these programs have worked closely with court and probation staff to ensure appropriate referrals and coordinate referrals to ongoing service once intensive family preservation services have been delivered.

Since the juvenile justice field traditionally has not worked directly with families, the introduction of IFPS technology into the field has also involved educating court and probation staff members as well as representatives of other community organizations about these services and how they fit in a continuum of services to youth and families.

Case Examples From Mental Health And Juvenile Justice

To aid in understanding the utilization of IFPS programs in mental health and juvenile justice fields of practice, two case examples are presented, courtesy of the Edna McConnell Clark Foundation and the two IFPS programs responsible for these vignettes.

Mental Health Case Study: The Brown Family,* Buffalo, New York.

At age 11, Sam Brown burned down his neighbor's garage and was sent away to a residential youth facility in upstate New York. Two years later he returned home. The adjustment wasn't easy. Sam was constantly fighting with his two younger brothers, and their mother was having a difficult time handling them. Sam's dad worked at night and was reluctant to discipline the children, fearing he would lose his temper. With all three boys home from school for summer vacation, tensions in the house mounted. One afternoon, while playing outside, Sam and his nine-year-old brother, Frank, got into a violent battle. When Sam began choking Frank, a neighbor called the police. Sam, accompanied by his mother, was taken by the police to the psychiatric emergency room of the Erie County Medical Center.

The hospital called in an IFPS worker from the Home Based Crisis Intervention Program[1] at Buffalo General Hospital, which works with kids ages 5-18. The worker, trained in psychiatric nursing, drove Sam and his mother, Anne, home and returned the next morning to begin working with the family.

Over a six-week period the IFPS worker spent almost every other day with the family and was able to closely observe their daily routines. His first discovery was that Sam was not always the instigator of the fights with his brothers. Frank, another son, often started a brawl and then complained to his mother that Sam was to blame. While Sam was away, Frank had assumed the role of "number one son" and was upset about relinquishing this status to his older brother. The worker made Anne aware that Frank was frequently baiting Sam and that she needed to direct her discipline toward all three boys and not just her oldest son.

*Names have been changed to protect the family's privacy.

The worker counseled Anne at home and during frequent phone conversations. They worked on building her confidence in her parenting skills and her ability to take charge when a fight broke out between her sons. "Anne had good parenting skills," the worker recalls. "What she needed was a lot of reassurance that she could handle them."

With the help of the IFPS worker, Anne and her husband, Raymond, devised behavioral charts to identify a few things that they wanted their sons to do, such as going to bed on time and getting along better. Each week, the boys earned stars and points for what they accomplished, or received an early bedtime or no TV when they did not follow family rules. Sometimes the worker would treat the boys to dinner or a day in the park for doing well. Eventually the worker was able to transfer this responsibility to the parents, especially to Raymond, who was encouraged to spend more quality time with his sons.

The IFPS worker concentrated on helping both parents to build their self esteem. Anne frequently called about problems at home. "She panicked if the boys kept fighting or refused to listen to her," the worker said. "I'd give her reassurance that it was o.k. for her to do certain things to discipline the kids, such as separating them from each other until things cooled down."

Anne had been managing the boys on her own and needed more of her husband's support, but his own lack of confidence had kept him uninvolved. "Raymond had a negative image of himself. I think I was probably one of the first people who really listened to what he had to say. He cared a lot about his family; he just needed to know that he was needed and that he and his wife had to work together."

The younger boys responded well to the behavioral charts. Sam still had a difficult time controlling his temper and getting along, but he worked hard and showed some improvement. When school reopened, tensions at home eased and several months after counseling ended, the family was still together and doing well. Arrangements were made with other agencies to coordinate additional social services that the family still needed, such as a special education program for Sam, welfare benefits, and supplemental employment assistance.

"When I began this case, I had some doubts as to whether I was going to be successful," the IFPS worker recalls. "Sam was acting out and fighting a lot. I came close to bringing him back to the hospital a few times. By working with Anne, Raymond, and the boys as a family, we managed to bring everyone together. What became critical to Sam's progress was giving him the message that he wasn't going to be sent away again, no matter what he did. Sam may have tested them by behaving badly; he just wanted to be sure they really wanted him around."

Juvenile Justice Case Study: The Austin Family,* Brooklyn, New York.

Michael Austin was kicked out of school and into the courtroom for assaulting one of his peers. When threatened by a gang to either fight or be beaten up himself, Michael fought. At 13, he had committed his third offense. Michael's family had a long history of problems--one brother was in a youth detention facility, another was in prison at Rikers Island. His mother had given up hope of helping her youngest son avoid a similar fate.

After spending several weeks in a group home, Michael was referred to the Family Ties program, an intensive, home-based service run by the New York City Department of Juvenile Justice[2]. In making the referral, the judge warned Michael that this was his last chance to avoid long-term placement in an upstate youth facility.

The IFPS worker assigned to the Austin family's case began by meeting with Michael and his mother to hear their concerns and explain what the program was about. Both Michael and his mother were eager to work with the worker, although they held different opinions about the nature of the problems.

"Michael thought he could handle himself on the street," the worker recalls. "He didn't feel that he had a problem controlling his anger or responding to peer pressure, although his mother thought those issues were getting him in trouble. She felt that his friends saw him as a leader and she wanted me to teach him positive things that he could also pass on to them."

The worker had almost daily contact with Michael and his mother. They set goals and began to work on specific skills, including anger management, peer pressure reversal and better family communication.

Michael and his IFPS worker frequently met alone in the afternoon at a nearby fast food restaurant. They called it "McDonald's therapy." The atmosphere made it easier for Michael to talk about what was happening at home or with his friends, to follow-up on a previous conversation, or discuss the behavior change assignments he'd been given the day before.

During their time together, the worker helped Michael learn how to stand up to peer pressure and control his anger. Together they came up with a list of ways to avoid negative influences, including a method to reverse peer pressure by evaluating a situation for trouble, anticipating the possible consequences of getting involved, and deciding what action to take.

Michael developed useful terms that incorporated street slang--"chill out" or "gotta go do something for my mother"--that his friends could relate to. He

*Names have been changed to protect the family's privacy.

worked on ways of easing tense situations with humor, or checking out the scene and asking, "Is this trouble?" before getting more involved.

With her third son in trouble, Michael's mother was depressed and frustrated, feeling she had failed as a parent. The IFPS worker emphasized that she should not assume sole responsibility for the boys' actions and that her relationship with Michael could improve. He suggested different approaches to disciplining and communicating with Michael and taught her parenting skills such as setting up a behavior chart on which good behavior was awarded positive points and negative behavior was penalized by subtracting points. Michael learned to work towards a weekly reward that varied from a later curfew to a higher allowance, based upon the number of points accrued each week.

After five weeks, both Michael and his mother had made great strides. Michael returned to school, and when the case was reviewed, the judge determined that probation, not placement, was in order. Before concluding his intervention with the family, the IFPS worker got Michael involved with the Citykids Foundation, a program designed to empower kids and build positive peer relations. He also referred both Michael and his mother to a new counselor who continued to work with them on a less intensive basis to keep in sight the goals they established in the Family Ties program.

IFPS Program Components That Facilitate Technology Transfer

As previously described, intensive family preservation services are being successfully delivered in child welfare, mental health and juvenile justice fields. The majority of the IFPS programs being developed today serve multiple populations, yet provide similar types of services. There are a number of salient characteristics that may account for the utility of this form of service across fields of practice.

First of all, many of the structural elements make it relatively easy for families to utilize the service. These structural elements include:

- Accessibility -- no waiting list, immediate response, 24-hour a day availability.

- Flexibility -- provision of clinical counseling services, hard services, and advocacy.

- Location of services in the natural environment -- services provided in settings where the problems occur (e.g., home, school, neighborhood).

- Intensity -- number and length of sessions designed around family needs rather than artificial time constraints.

- Responsiveness -- focus on problems and concerns identified by the family members, available during crises, flexible schedule.

A second key characteristic is the strong value system regarding families, individuals, and service delivery that is at the heart of the HOMEBUILDERS model (Kinney, Haapala, & Booth, 1991). The program design directly reflects staff convictions that troubled families and children can change, that people are trying to do the best they can and should be treated with respect and compassion, that clients are colleagues, and that clients often lack the specific skills needed to deal with and overcome many of their family problems. Consequently, clients served by IFPS seldom experience the sense of stigma or pathology so often associated with receiving services from more traditional child welfare, mental health or juvenile justice agencies.

Another important and often overlooked characteristic of the HOMEBUILDERS model that contributes to its replicability is the consistent use of data-based intervention methods. Many of the behavior change interventions used by IFPS workers have been demonstrated to be effective across a wide range of populations (e.g., children, adults, autistic and retarded children, juvenile delinquents), problems (e.g., noncompliance, aggressive behavior, educational and behavioral school problems, tantrums, phobias), and settings (e.g., home, school, juvenile delinquency settings). These findings suggest that the clinical interventions--the practice skills--employed in IFPS programs may generalize well across fields of practice.

A final, critical characteristic is that some federal funding is available to support state initiatives directed toward achieving the primary objective of IFPS programs, which is to maintain high-risk children in their own homes and communities. In recent years IFPS programs in various states have been supported, at least in part, by funds authorized under the provisions of such federal legislation as the Juvenile Justice and Delinquency Prevention Act of 1974; the Education of the Handicapped Act (P.L. 99-142) and the 1986 Amendments to this Act (P.L. 99-457); Title XIX of the Social Security Act (Medicaid); and Title XIX Part B of the Public Health Services Act (Alcohol, Drug Abuse, Mental Health Block Grant) and its Child and Adolescent Service System program (CASSP). (See Knitzer et al., 1990, & Federal Programs Affecting Children and Their Families, 1990, for further discussion of these laws).

In summary, family preservation services appear to be applicable in different fields of practice, because they are tailored to fit individual situations

and individual families. They are structured to be easily accessible, available and attractive to families. The underlying values help workers and families remain optimistic and hopeful about change; the skill-based interventions are often effective in helping people learn to cope and solve some of the problems they face. And the objectives of these services are consonant with the policy principles undergirding a number of federal laws that shape service provision to different populations at risk.

Intensive family preservation services, while focused primarily on child welfare, mental health, and juvenile justice populations, may also be a promising strategy for other fields and for other points along the continuum of services, from early intervention to reunification. The HOMEBUILDERS model has already been used with developmentally disabled clients to prevent placement into more restrictive settings and to help reunify children with their natural families after being placed out of the home (Kinney, Haapala, Booth & Leavitt, 1990). This service may also be an effective strategy for providing community-based services for developmentally disabled children and adults, autistic and retarded children and adults, adult mental health clients, substance abusers, and/or elderly adults who are having difficulty living independently or with their families. The core program characteristics and values have been successfully transferred across some fields of practice. How these characteristics and values can be applied at other service-delivery points remains a challenge for the 1990s.

Implications for Social Work Education

As suggested at the beginning of this paper, the social work profession has long struggled with the challenge of deciding how best to organize its educational programs to enable practitioners to develop a common identity and value base while also gaining the specialized knowledge and skill necessary to work effectively with different populations in different practice settings. The current system of requiring all students to acquire a common generalist practice base before moving into an area of advanced specialization is reasonably satisfying. However, once specialized knowledge is defined as advanced, it becomes more difficult to ensure that new practice technologies developed in one specialized area are transferred to other fields of practice or incorporated into the generalist practice base.

The traditional methods for encouraging dissemination of new knowledge are, of course, published in professional journals and conference presentations. Yet there is strong evidence that such efforts seldom result in actual research utilization. Practitioners may read or listen with interest, but most continue to rely primarily on the interventive approaches they learned early in their careers

and/or those that are reinforced by the culture of their agency settings. These same practice principles are then passed on to social work students in their field placements. Because of the saliency of field work in social work education, students seldom fully incorporate practice concepts that are not reinforced through field instruction. The result is a very conservative professional tradition related to the utilization of new practice knowledge and the transfer of new practice technologies across areas of specialization.

To counter these obstacles to knowledge utilization, social work educators interested in promoting use of the principles and interventive methods of IFPS programs in different fields of practice must find ways to "mainstream" these concepts in both classroom and field instruction. Faculty in many schools include a section on IFPS practice in child welfare courses, and a few schools are now offering special electives on this subject. But these initiatives do not serve the essential mainstreaming function. Meaningful dissemination of the concepts of IFPS practice requires that faculty introduce relevant content in the basic practice methods and background courses and that they work with field instructors to help them find ways to reinforce the practice principles in students' field work assignments. This can be accomplished only through faculty development programs for those who specialize in other fields of practice, special seminars for field instructors, and individualized consultation to field placement agencies.

The difficulties inherent in attempting to educate students in different fields of practice about IFPS programs highlight interesting questions about the way fields of practice are traditionally structured in social work education. The identification of child welfare or family and child welfare as a distinct field of practice is consonant with the way social service agencies have traditionally been structured and financed. However, in the past decade there has been increasing recognition of the overlap among the populations customarily served by child welfare, child mental health, special education, and juvenile practice programs. Child-serving agencies have become increasingly dependent on diverse funding sources to support their activities.

Children and youth who come to the attention of mental health, juvenile justice and education officials often have histories of abuse or neglect, and many of these youngsters have experienced one or more foster placements. Conversely, child welfare agencies are now often asked to meet the needs of children with severe developmental disabilities, mental health and substance abuse problems and behavioral disorders. This changing pattern of service utilization suggests that this may be an appropriate time for social work educators to re-examine the question of how best to organize their curricula to reflect appropriate areas of practice specialization.

If social workers in different types of child- and youth-serving agencies now require a common knowledge base related to the social, educational, physical and emotional needs of their clients and the resources available to meet these needs, it could be more effective for schools to offer a specialization in child and family service than to maintain traditional boundaries between the health, mental health, education, social service and juvenile justice systems. In such a specialized track, it would be much easier to facilitate the transfer of knowledge related to IFPS programs across relevant fields of practice.

Finally, it should be noted that although the results of the early evaluative studies of different IFPS programs are generally promising, there are some mixed findings; and little is known about which components of these programs lead to better client outcomes than more traditional service interventions. Therefore, social work faculty interested in disseminating the practice technology of IFPS programs must assume responsibility for educating students about the diverse research findings and encouraging them to contribute to the development of this knowledge base. The fact that a number of IFPS programs such as HOMEBUILDERS stress the use of data-based interventions and ongoing program evaluation should facilitate faculty efforts to engage students in class and field assignments designed to examine and build the links between research and practice. This orientation also means that there are important research opportunities for faculty who specialize in other areas to study the transferability of IFPS technology across fields of practice.

Reference Notes

[1] The Home Based Crisis Intervention Program at Buffalo General Hospital, launched in May, 1988, works with families of children, ages 5 through 18, who are at risk of psychiatric hospitalization. To date, 60 out of 63 families served have remained together, a success rate of 95%. Managed by George McNally, the Home Based Crisis Intervention Program is located at Buffalo General Hospital's Community Mental Health Center, 80 Goodrich Street, Buffalo, NY 14203; 716/845-1508.

[2] New York City's Department of Juvenile Justice (DJJ) Family Ties program provides intensive, home-based assistance to families and children involved with juvenile crime. This program began in 1988 and has worked with 45 families, avoiding placement in 75% of its cases. For information on Family Ties, contact Amy Sutnick at the Department for Juvenile Justice, 365 Broadway, New York, NY 10013; 212/925-7779.

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ISSUES IN EVALUATING INTENSIVE FAMILY PRESERVATION SERVICES

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This paper explores issues that the researcher should consider when planning and implementing a study of intensive family preservation services. It draws heavily on our experience with the Illinois Family First program and other recent evaluations.[1] Attention will be given to family-based, home-based and intensive family preservation services programs.[2]

The central purpose of an evaluation is to generate information that will contribute to decisions regarding program survival or program improvement (Jones, 1991; Rossi & Freeman, 1989). Interests of key actors (policy makers, administrators, program staff and researchers) shape decisions regarding the appropriate research design and the types and sources of data that are most relevant (Patton, 1978, 1982; Littell, 1986).

Evaluations of intensive family preservation services can have a variety of goals. First, they can provide descriptions of program characteristics and clients. The major purpose of this type of evaluation is to monitor service utilization; to provide data for purposes of program funding; program development or replication; or to monitor compliance with legislation that requires services to be provided to particular categories of clients. Second, evaluations may focus on outcomes to examine the effectiveness of home-based and intensive family preservation services in keeping families together and reducing service costs (Feldman, 1990; Pecora, Fraser, & Haapala, 1991; Yuan, McDonald, Wheeler, Struckman-Johnson, & Rivest, 1990; AuClaire & Schwartz, 1986).

Early reports of service effectiveness have led to widespread interest in the legislative and professional arenas regarding the potential of intensive family preservation services to reduce out-of-home placements. The HOMEBUILDERS model has been broadly disseminated and adaptations of it, as well as alternative approaches to intensive family preservation services (IFPS), have been developed.

Because of the variety of available programs, evaluation efforts can now be aimed at answering questions regarding the relative effectiveness of programs and at analyzing service components. Research is needed that will provide comprehensive descriptions of the programs and services provided, descriptions of clients served and examinations of multiple outcomes in relation to services provided. Much can be learned from large and small scale studies about service

characteristics and their relationship to client outcomes. Establishing these links is critical in order to understand better the kinds of services that are beneficial to different clients. Careful examination of the characteristics of clients who benefit from IFPS programs will lead to the improved targeting and refinement of services.

Investigators face a number of struggles in evaluating intensive family preservation programs. Many of the difficulties discussed below will arise regardless of the size and scope of the study or the type of social program evaluated. This discussion highlights issues as they may be experienced in evaluations of intensive family preservation programs.

Pressure for Premature Evaluation of Outcomes

Increasingly, evaluation is undertaken early in the life of social programs. While this has some advantages, evaluators must be cautious regarding conclusions about program effectiveness drawn from data obtained at an early stage of program development. The simultaneous initiation of service innovation and evaluation provides an opportunity to observe program evolution and to develop an understanding of the problems in getting services underway. Formative evaluations that focus on providing descriptive information about clients and programs are appropriate in early stages of program development. It may be difficult to resist pressure from program administrators who request premature answers to complicated questions. We believe, however, that it is critically important to give programs an opportunity to mature before subjecting them to rigorous outcome studies.

Program characteristics and implementation issues are likely to change over time. As start-up problems get ironed out (e.g., difficulties in the referral process are resolved) new problems arise (e.g., staff turnover, recognition of the unavailability of needed services such as drug treatment programs). Intensive family preservation services may be new to agencies or the agencies may lack experience working with particular types of cases (e.g., child abuse and neglect cases). A coherent philosophy or practice model may emerge, if one was not previously in place. New components of service are likely to be added and others removed according to perceived needs of the clients.

One option might be to respond to expectations of quick results by providing early and frequent reports describing the programs and implementation problems. For example, in the Illinois project, a series of short topical reports on issues of interest were produced and periodically updated as data became available. Brief reports have covered topics such as family problems and characteristics of services provided, subsequent reports of abuse and neglect,

placement rates, and the use of coercive authority with families. Other special reports have described case characteristics where substance abuse or housing have been identified as serious problems and the relationship between worker characteristics and their attitudes toward clients. Analyses of initial cases have been purely descriptive, while more sophisticated analyses will be the subject of later reports on the relationship of various client and service characteristics to outcomes.

Describing Program and Service Characteristics

A thorough understanding of program and service characteristics is necessary to be able to replicate successful programs and to determine the relationship between program components and desirable client outcomes. Programs are multi-dimensional and difficult to describe fully. They are never truly represented in program descriptions, proposals or contracts. Even if a known service model is implemented, it is important to obtain some measurement of the degree to which the proposed model is adopted. Programs must be captured on multiple levels by determining what it is that the workers do with and for clients. This means obtaining data on service characteristics such as the frequency and duration of interviews and length of service to obtain a measure of service intensity. It also is useful to gather information on the mix of concrete and counseling services provided in each case. Worker activities and techniques can be measured in a variety of ways, through direct observation and the coding of audio or video tapes or more indirectly through self-report instruments.

In the Illinois study, as in other projects, line staff are asked to identify the major activities and techniques that are used in their work with each case. They also provide information regarding court involvement, family problems, service plans, and case outcomes, such as progress on service objectives, reasons for case termination and out-of-home placements. Workers complete an annual survey on their attitudes toward the work they do, their work environment and the clients served by these programs. Information obtained in this way is likely to be biased by the usual problems that plague self-report measures, most notably difficulties in recall and the recording of what the worker may consider to be socially desirable responses. However, other sources of information can supplement data from surveys and service summaries.

In an attempt to achieve a thorough understanding of the programs and how they operate, administrators and line staff can be interviewed periodically to achieve an understanding of how the program evolves and of implementation issues faced in day-to-day program management. The Illinois project makes use of semi-structured interviews conducted by project staff who also serve as liaisons

to the agencies. The interviews provide a rich base of information that is otherwise elusive. They represent another perspective about what workers do with clients. From these interviews, we can explore the extent to which workers adhere to a well-defined practice model and we can examine variation across program sites in factors such as the enthusiasm or zeal of the workers. Information is obtained regarding the complex relationship between the public child welfare agency that administers the program and the private agencies who provide the services. Interviews also permit the observation of changes in implementation as the program matures.

Defining the Target Population

Because of the primacy of placement as an outcome variable, it is important that services be targeted at families that would have experienced the placement of a child in the absence of these services. The more families receiving intensive family preservation services who would not have had a child placed, the less able the evaluator is to detect placement prevention effects (Schuerman, Rzepnicki, Littell, & Budde, 1990).

Intensive family preservation services are typically aimed at families in which at least one child is at "risk of imminent placement." Defining the target population in this way is a very subjective judgment. The criterion assumes that the protective service worker, for example, can predict future placement or will follow through on making a placement in cases where the child cannot be adequately protected in the home. The term "imminent" is not well-defined and is likely to be interpreted in different ways by individual practitioners. Does "imminent" mean that without services a child will be placed today, next week or sometime in the future? To be a useful term, it must be operationalized.

We also know it is not possible to predict future behavior with much certainty. Workers frequently do not have a set of well-articulated guidelines to help them make reliable placement decisions. Each worker brings to this decision a set of criteria based on past experiences with similar kinds of families and practice wisdom. Furthermore, the most extreme cases of imminent placement, those that are the easiest to identify, may be viewed by referring workers as inappropriate for IFPS programs. Workers may fear that these children cannot be kept safe in their own homes while receiving intensive family preservation services.

The result is that public agency caseworkers may refer to IFPS programs many borderline cases where there is a low probability of placement even without the service. Not only have we observed this in our study, but recent findings of evaluations that have used experimental and quasi-experimental designs show

that comparison group placement rates are not very high (Feldman, 1990; Mitchell, Tovar, & Knitzer, 1989; Yuan et al., 1990).

The more administrators and evaluators know about the families served beyond basic demographic information, the more can be said about the kinds of clients who benefit from various services. Examples of descriptive information that may be useful include type of child maltreatment allegation or reason for referral and major problems faced by the family. This knowledge may help programs more adequately define appropriate target populations and permit better targeting of services to particular client groups.

Design Issues

The selection of an appropriate research design is dependent upon the questions the evaluator proposes to answer. The following discussion presents issues related to the application of a variety of designs to intensive family preservation services.

Single Group Quasi-Experiments

Studies using single group designs provide descriptive information regarding client and program characteristics and outcomes over time (e.g., family functioning levels and placement of children in substitute care), often including an examination of outcomes at several points following termination of services. The information provided is useful for monitoring the achievement of service objectives and for identification of factors associated with service outcome. A one group pretest-posttest design was used in Washington and Utah, for example, to identify child, parent, family, service, and system characteristics associated with treatment success and failure for cases in two programs using the HOMEBUILDERS' model (Pecora, Fraser, & Haapala, 1991).

Single group studies, however, cannot answer the question of service effectiveness. It is impossible to determine whether the observed outcomes are the result of program participation. This is particularly the case with administrative and case-event outcomes, such as placement rates and subsequent reports of abuse or neglect, which can be easily manipulated by changes in policy and resource availability. In addition, families who receive intensive family preservation services may be in the midst of crisis at the point of intake. The crisis can be expected to be resolved in a relatively brief period of time with or without services. Because client functioning is likely to improve under almost any circumstances, it is impossible to determine the particular effects of the program

without equivalent groups that differ only in the treatment they receive. Such a comparison provides information regarding the magnitude and rate of change attributable to intensiv family preservation services (Jones, 1991).

Multiple Group Quasi-Experiments

Multiple group designs offer control that permits the comparison of program outcomes to outcomes that would have occurred in the absence of the IFPS program. For example, fluctuations in placement rates and other case events may result from changes in placement policy and foster home availability rather than the provision of intensive family preservation services. In addition, the determination of client eligibility for the IFPS program is a highly subjective matter resulting in a diverse pool of clients. The only way to determine just how many families remain together as a result of intensive family preservation services is through the creation of another study group, equivalent in every way except for the services provided. A number of options exist for creating comparison groups. Quasi-experimental designs are appealing to evaluators because participants usually object to them less than to the random assignment of cases to intensive family preservation services and comparison groups. Their principal drawback is that the observed outcomes may not be attributable to IFPS programs but instead may be the result of initial differences between comparison groups.

Overflow comparison. The overflow comparison is often suggested to evaluators who want to include a control group in their research. Because cases are assigned to alternative services only after all IFPS slots are filled, this design is usually least offensive to those who have questions about the ethics of assigning families to an "inferior" service and to agency administrators who are concerned about their ability to keep treatment slots full if a significant portion of the eligible pool of families is siphoned off to the comparison group. It would seem to provide a reasonable way to ensure that the groups share the same characteristics while limiting the interference of the research design in program processes. However, several problems can be anticipated with an overflow control design.

Practitioner knowledge that an IFPS program is filled may affect decisions to identify families as "eligible." One result is that few families may be identified as appropriate for the comparison group. Another consequence may be the creation of a comparison group with different characteristics, particularly since workers are likely to be reluctant to identify difficult cases for the less intensive intervention.

Matched groups. In a matched groups design, a sample of cases not referred to the IFPS program are selected for the comparison group on the basis of characteristics similar to those of intensive family preservation services cases. However, given the subjective nature of judgments about the risk of placement and level of service need, it is difficult to pinpoint factors that distinguish those who are and are not appropriate for intensive family preservation services. Comparison cases may be fundamentally different from IFPS cases; otherwise they would have been referred to the program initially.

In the Family-based Intensive Treatment (FIT) Research Project, cases were matched during the data analysis phase for the Utah sample (Pecora, Fraser, & Haapala, 1991). IFPS cases were matched with cases from a small overflow comparison group on nine variables: race, gender, previous placement, child substance abuse, school attendance, family income, child handicap status, family structure and household size. Initial differences in placement rates between the IFPS and comparison groups were somewhat reduced as a result of the matching procedure, but remained significant. However, the possibility exists that other important matching variables which would have produced different results were not identified by the evaluators.

In states where intensive family preservation services are not universally available, it is suggested that cases for the comparison group might come from counties that do not have intensive family preservation services. Unfortunately, we cannot be sure that cases identified as eligible in the county where no IFPS program exists would actually have been referred if the program was available. In comparisons of cases from different areas, other factors may result in the creation of non-equivalent groups, such as differences in population demographics, resource availability and the court system.

Baseline comparison. In the baseline comparison design, the comparison group is drawn from cases handled prior to the introduction of the IFPS program. Like the other non-experimental approaches, the major limitation is the difficulty in determining whether cases identified as eligible in the absence of intensive family preservation services would actually have been referred. Other temporal factors may create differences between groups, such as changes in community and organizational characteristics.

Other comparison groups. Additional strategies include the assignment to groups according to the day of the week a referral is made or according to the case identification number. Both of these alternatives are subject to manipulation on the part of referring workers and may bias their judgment in designating families as eligible for intensive family preservation services, particularly if they

consider the alternative service to be less desirable than intensive family preservation services.

The overflow, matching and baseline comparison designs are non-intrusive in that they require no changes in case decision making and flow of referrals to the IFPS program. Assignment to treatment groups according to the day of the week or identification number do require that workers make referrals based on arbitrary case or referral characteristics. This makes these approaches less appealing to participants, but usually more appealing than pure random assignment.

However, there are currently several studies underway or recently completed that take advantage of the control offered by experimental group designs in an effort to determine whether claims of effectiveness by advocates of home-based and intensive family preservation services can be supported by empirical evidence (Feldman, 1990; Yuan et al., 1990; Schuerman, Rzepnicki, & Littell, 1990). It is hoped that findings from these studies can provide direction for the improvement of services.

Experimental Group Design

Because of the myriad problems in attempting to "build" comparison groups, the random assignment of cases to alternative services is the most assured way of achieving equivalence. An experiment involving random assignment can be successfully implemented only after a series of negotiations with referring and service delivery administrators, supervisors and line staff. Several issues typically arise during the course of these discussions.

Obtaining the cooperation of agency personnel. The importance of gaining cooperation of program staff and other stakeholders is always an issue, but is especially critical in preparing for an experimental evaluation that is likely to be somewhat intrusive on agency operations. Active solicitation of cooperation includes involving staff in initial decision making, thoroughly explaining rationale and methods, and listening to and responding to their concerns. Others whose decision making affects or who may be affected by the experiment should participate in evaluation planning. For example, juvenile court personnel and children's interest groups who might raise objections to the research can be visited by project staff as the study is planned and during implementation.

While administrators often see value in conducting an evaluation, line staff who provide the services and supply data for the study frequently do not. Even when line staff see the value of the research, they may resent the intrusion of evaluation procedures and data collection requirements into their daily lives. For

this reason, they need to be involved in many aspects of evaluation planning. If the evaluation is conducted by an independent agency, project liaisons can visit each IFPS program periodically and meet with all levels of personnel, from top level administrators to supervisors and line staff. They can provide an ongoing explanation of the study design, data requirements and findings to agency personnel. In our experience this seems to enhance a willingness to comply with data collection requirements. While the cost of such activities can be great in terms of time and energy, the reward is a workable research design and greater study validity.

Private agencies participating in evaluation studies using control groups may find their programs jeopardized by a low rate of referrals because the public agency staff are reluctant to refer when clients have only a 50% chance of being served. In Illinois, protective service investigators who make referrals to the Family First programs being evaluated protested the use of random assignment of clients to Family First and regular service groups, concerned that the regular service cases would get little help for their problems. These workers were already sold on the benefits of Family First services and wanted as many clients as possible to receive them. Three actions were taken in an effort to ensure their participation in the randomized study.

The random assignment procedure was adjusted so that any family would have a better than even chance of being assigned to Family First services (a 60%-40% split between the two groups). Further, the Department administration decided that regular service cases in the study would be given priority treatment. This meant that once referred for service, workers were directed to contact families promptly and a variety of services could be offered. Such a directive might have the effect of lessening the differences between home-based services and regular service cases. (We suspect, however, that the influence of this directive on the response times of regular service workers, many of whom have large caseloads, has been limited). Finally, referring workers were permitted to bypass the random assignment procedure on a small number of cases at each site in the experiment. The maximum number of exceptions was negotiated with the understanding that larger numbers could jeopardize the validity of the study results. It is important for evaluators to develop careful mechanisms for monitoring violations of the random assignment procedure. In our experience, reporting these violations to referral agents resulted in greater adherence to experimental protocols.

In Illinois, administrators of the agencies providing Family First services expressed concern regarding the effect of the random assignment procedure on their ability to fill program slots when eligible cases are assigned to other services or agencies. Recognizing that the number of cases entering the Family First

programs would be reduced by 40%, the public child welfare agency broadened eligibility criteria to reach a larger pool of families. This is proving to be problematic for the evaluation. By broadening the net of the program to accept families where there may be little risk of imminent placement, there will be an overall dilution of program effect on placement rates and perhaps other outcomes such as family functioning, as well. Hence, the population to which the results can be generalized is altered and perhaps less evident.

The early participation of agency staff in the development of instruments and data collection strategies helps ensure that the case information they provide is accurate and meaningful. Family First program staff were offered opportunities to provide feedback on early drafts of the data collection instruments which we revised in part according to their suggestions. Similarly, staff working with the regular service cases expressed reluctance to add the burden of completing another form to the paper work they must complete on their large caseloads. They were very agreeable, however, to meet with an evaluation team member to verbally provide the information we need, even though this alternative requires more of their time and our staff resources. Agency staff also were provided with frequent reports on the status of data collection (response rates) in their program site. The payoff for involving program staff in instrument development and close monitoring of data collection is more complete and better quality information on the families served.

Informed consent. A major issue in evaluations of intensive family preservation services programs is whether or under what conditions informed consent will be obtained from clients. Informed consent is required when evaluation staff obtain information directly from clients, because services may be affected or new risks introduced as a result of the data collection. When an experimental design is used, it is less clear whether it is necessary to obtain the client's informed consent to be assigned randomly to the IFPS program or alternative services.

Objections to the use of informed consent to the client's random assignment to services might be raised on several grounds. In certain programs, client status is involuntary and families are required to accept services as a consequence of the verification of child abuse or neglect. Under such circumstances, their participation is already coerced and the introduction of an informed consent procedure may be meaningless. If a client refuses to comply with the random assignment procedure, the alternative of other agency services may carry with it the increased probability of child placement out of the home. This alternative can be perceived as an implied threat which contradicts the notion of free and fully informed consent. Families who refuse random

assignment could not be referred to the IFPS program, because there would be little incentive for workers to encourage client cooperation with the random assignment procedure. Eventually, IFPS program slots would be filled with families who had not been randomly assigned and the control group, clients randomly assigned to regular services, would be lost.

Another objection, of particular concern in large-scale studies, is that the involvement of many workers and offices make it impossible to assure standardization of informed consent procedures. Because the Illinois evaluation is statewide and involves hundreds of workers serving as referral sources, this obstacle is particularly troublesome. Child protection workers are overburdened with large caseloads and numerous responsibilities related to the investigation of families reported for possible abuse or neglect. Furthermore, although these workers refer families to placement prevention programs, they vary in the degree to which they understand the evaluation methods, as well as the degree to which they could explain the random assignment procedure and its consequences accurately. Monitoring the informed consent process would have been extremely difficult. Due to these factors, the Illinois Department of Children and Family Services decided not to obtain informed consent for the random assignment of cases to Family First programs.[3] We will, however, obtain informed consent when our project staff interview a sample of families at termination of service and follow-up (Schuerman, Rzepnicki, & Littell, 1991).

Some Complications for Data Analysis and Interpretation

Where multiple agencies are providing intensive family preservation services, a certain type of client may be assigned to one agency, while another is assigned to a different agency. We have found that referrals are sometimes based on the perceived expertise agencies have with particular kinds of clients. When this happens, it may not be possible to preserve group equivalence, even in studies that randomly assign cases to experimental and control conditions. It then becomes difficult to separate agency effects from the effects of client characteristics. In addition, where specific components of service programs vary, as in our state, it is necessary to treat each site separately. The generation of adequate numbers of cases to examine particular combinations of case and service characteristics may be very difficult.

Since research findings must be viewed within a social context, another issue is the difficulty in generalizing program results to other agencies and locations. Placement rates and the type and number of cases opened and closed may be less related to the particular characteristics of intensive family preservation services than they are to the availability of resources such as foster

care homes, substance abuse programs for women with children, and homemakers. Case outcomes also are influenced by the perception of community support for intensive family preservation services, exemplified in the frequency and type of media attention the program receives and the support or opposition of juvenile court personnel (i.e., judges and state's attorneys, public defenders, and public guardians). These factors may affect the climate of the organization that makes referrals and of the agencies providing the services. The quality of services and families' experiences in these programs are likely to be enhanced or suffer as a result. To the extent possible, the researcher should have an understanding of the relevant aspects of the social context and how they are likely to contribute to conclusions drawn from the evaluation.

Community perceptions, organizational climate, structure and mix of services available to clients are likely to be affected by the introduction of new services and may, in turn, influence client outcomes above and beyond the program. The presence of the evaluation, which usually requires extra data collection, also may cause individual workers to behave differently from how they would in its absence. The ability to generalize evaluation results may be further limited because of these effects which are difficult to measure or replicate (Schuerman, Rzepnicki, & Littell, 1991).

Single-Case Designs

Single-case evaluations permit individual practitioners to determine the impact of their work with individual clients or families. The practitioner can choose from many designs depending on the nature of the problem being addressed through service provision, the type of intervention strategy chosen and client characteristics.

The least rigorous designs (e.g., the A-B design) enable the social worker and client to monitor progress on achieving problem-solving objectives. With continuous information on the implementation of service strategies and the client's problem status, these designs permit the timely adjustment of intervention strategies when there is little or no improvement in the client's problem situation.

The most rigorous designs are the withdrawal and multiple baselines. These designs permit the practitioner to analyze service packages or individual service components and draw conclusions regarding which aspects of service or techniques are most beneficial to clients. For example, the specific contribution of active listening techniques to the improvement of parent-child communication can be assessed by teaching family members how to use it, then systematically apply

and withdraw its use, observing consequential changes in parent-child problem-solving interactions.

Single-subject research does not demonstrate the broad-scale effectiveness of a particular program. Thus, its utility for policy purposes is limited. However, single-case replications in which particular interventions are applied with multiple clients or groups of clients can provide some beginning evidence of program effectiveness for the ongoing refinement of intervention strategies. Of course, a major requirement for their successful application is that the service components (including the worker's use of particular techniques and intervention strategies), client characteristics, and relevant outcomes are accurately described.

The purpose of the following discussion is not to review all the variations of single-case design but, instead, to describe how these designs address major objections to the use of group designs for evaluating IFPS programs. Specifically we are concerned with ethical considerations, the practicality of conducting large scale group comparison studies, and the averaging of effects (Barlow & Hersen, 1984). Some obstacles to the use of single-subject designs also are described.

Ethical considerations. As discussed earlier, a major impediment to the implementation of group experimental designs has been the concern that the control group clients receive a much less powerful treatment. Of course, this objection is based on the notion that the experimental program is beneficial, which is specifically what the evaluation is attempting to determine. Nevertheless, many professionals find it distasteful to withhold a valued service from clients in need. Single-subject designs can partially avoid this problem because individual clients provide their own basis of comparison, permitting the researcher to draw conclusions regarding causality of change when applying withdrawal/reversal or multiple baseline designs.

Other ethical objections can be raised, however, in the application of single subject designs to intensive family preservation services. It can be argued that the basic withdrawal or reversal design is manipulative, even dangerous, for use with families where intervention is addressing serious child abuse problems. In these situations it may be advisable to select another design, such as a multiple baseline across settings with an individual family or across several families with similar problems. Baseline data also might be collected retrospectively to avoid the postponement of service in high-risk situations.

Practicality of conducting a large-scale comparison. A large-scale comparison study is difficult and costly to implement. As discussed earlier in this paper, it is sometimes difficult to obtain a large enough number of families, particularly when random assignment or matching is needed to create equivalent

groups. Furthermore, additional staff and funding are needed to mount data gathering on a large number of cases. Single-subject designs provide needed control to evaluate service, while being implemented on a small scale. This means that a great deal of data can be compiled on a case-by-case basis at little additional cost. The worker is frequently the most suitable person to collect information regarding client and situational characteristics, as well as to monitor problem change through repeated measurement procedures. Reliability issues can be addressed by an independent observer also collecting problem and service related data on a few occasions for all (or a sample) of the cases.

Averaging of effects. One criticism of group studies is that the information they provide is averaged out so that the variability of effects is obscured. Although sophisticated designs, within group comparisons, and statistical procedures can largely overcome this problem, group studies may have limited usefulness to the individual practitioner who is not research-wise and may, in fact, misinterpret the findings. Intensive family preservation services benefit some clients and families more than others. Single-case evaluation permits the practitioner to observe variations in effects over time due to sudden changes in the family's situation, environment, or in the IFPS program. Replication studies permit the fine-grained analysis required to understand the range of effects better.

Defining and Measuring Outcomes

Outcome measures must reflect the content of the goals and objectives of any service program. Lack of connection between program goals and outcome measures is the result of ill-defined program goals, a failure to identify the correct variables or the result of the evaluator's enthrallment with an outcome measure without regard for its relevance to program goals. In any case, inattention to the important link between goals and measured outcomes will lead to disappointing results (Jones, 1991). There are three levels of outcome relevant to IFPS programs: (1) administrative and case events, (2) child and family functioning, and (3) system effects.

Administrative and Case Events

Administrative and case events include those outcomes that are usually direct expressions of program goals and objectives. While they have meaning for individual families, they are most important to the agency as aggregate data.

These outcomes are the most likely to affect policy decision making. They also are the most likely to be affected by system-wide changes. Examples of administrative and case events include out-of-home placements, subsequent reports of abuse and neglect, court orders, and service costs. Unfortunately space limitations permit the discussion of only two of these outcomes: (1) placement, the most important case event because of its direct relationship to the primary goal of intensive family preservation services, and (2) cost-effectiveness because of its relationship to funding decisions.

Out-of-home placement. Child placement into substitute care will undoubtedly continue to be an important outcome variable as long as IFPS programs are viewed as placement prevention services. Results of recent studies suggest that for families considered to be appropriate for intensive family preservation services, placement rates have been quite low regardless of service received (Yuan et al., 1990; Feldman, 1990; Mitchell, Tovar & Knitzer, 1989). In our experience, the families served by IFPS programs often have great needs and the services may well benefit them. While we do believe that evaluations should look at other aspects of functioning, a shift away from placement to focus on other outcomes is problematic unless it is preceded by a shift in program goals.

Placement prevention is measured through the observation of rates of placement of children into substitute care. It is probably unreasonable, however, to expect that placement can or should be prevented for all children receiving intensive family preservation services. Placement of a child in substitute care may mean that services to the family were flawed in some way, needed services may have been unavailable, or the social worker was unskilled.

On an individual family level, child placement may not be an undesirable event. It is quite possible that for some families the intensity of the program provides the social worker with more thorough assessment information than otherwise would be available. Knowledge of a family situation that cannot be made safe may unexpectedly lead the worker to recommend placement for the child at risk. Presumably such an action could have great benefit for the child in question (Schuerman, Rzepnicki, & Littell, 1991). Indeed, such action may be socially desirable.

Another issue in the use of placement as an outcome is that studies of family-based services have defined placement differently, making comparisons among them difficult. The kinds of living arrangements that are defined as placements have varied as has the minimal length of time in out-of-home care that is counted as a placement. The FIT Project evaluation of IFPS programs in Utah and Washington defined treatment failure as "the placement of a child outside the home for two weeks or more in a non-relative setting during the

provision of intensive family preservation services or within 12 months following intensive family preservation services intake" (Pecora, Fraser, & Haapala, 1991). An evaluation of 11 family-based child welfare programs counted children out of the home at termination of family-based services (children placed then returned home prior to termination were not counted as placements) and included placement with relatives (Nelson, Emlen, Landsman, & Hutchinson, 1988).

With the exception of a few studies, placement duration and stability typically have not been examined nor has time to placement (Au Claire & Schwartz, 1986; Fraser, Pecora, & Haapala, 1991). These are potentially important dimensions that contribute to the determination of service success or failure, since intensive family preservation services may have the overall effect of reducing the length of placements or enabling workers to make better placements resulting in fewer placement changes for children in substitute care.

An important question that remains unanswered is, How long should we expect families to remain intact as a result of services? Studies of IFPS programs have typically collected follow-up data on intensive family preservation services cases, but the follow-up period is often no more than 12 months. Given the brevity of service, which is typically 30 to 90 days, it may be unreasonable to expect gains to endure longer than a year. However, an effect of intensive family preservation efforts may be to postpone placement for some children. For this reason it can be argued that a longer follow-up is required, since such information is likely to affect cost analyses. Mere postponement of placement may be viewed as an inefficient use of resources since such cases incur both intensive family preservation services and substitute care costs. If, however, placement duration is significantly less than average, the combination of services may still be cost-effective.

Cost-effectiveness. Another outcome variable with direct implications for funding decisions is the cost-effectiveness of IFPS programs. If a control group is used, then calculation of cost-effectiveness may be made into a straightforward comparison of the average cost of services for families in each group. Of course, a truly accurate determination of cost-effectiveness may be very difficult to obtain. We have been told by workers in some agencies providing intensive family preservation services that they sometimes provide services for which they are only partially or not at all reimbursed (e.g., extra hours of service). Calculation of cost-effectiveness is particularly troublesome when an experimental design is not used. A comparison of actual costs of intensive family preservation services with potential substitute care costs for the population of children served by IFPS programs would not be an accurate representation of effects because not all children receiving intensive family preservation services would be placed in the

absence of the service (see discussion regarding the problem of defining the population). An alternative sometimes suggested is to compare total costs of services and substitute care for families receiving intensive family preservation services to regular service costs and rates of substitute care for the general population of clients receiving the agency's child welfare services. This method of calculating cost effects is also flawed, however. Without some approximation of an experimental design, service needs of clients receiving intensive family preservation services are likely to be different from those of the comparison families.

Child and Family Functioning

Data on individual and family functioning, while of interest to policy makers, are especially relevant to the practitioner. These data provide practitioners with information for case decision making. The most direct way to measure family functioning, through direct observation, is practical only on a small scale, such as when using single-subject designs to evaluate individual practice. For larger evaluations that examine program effects on one or more groups of clients, the researcher can select from a variety of standardized and individualized measures. Of course, these instruments are also appropriate for use in single-subject research.

Data are obtained most typically from caseworkers and case records. Client self-report has been used less frequently but provides a much needed perspective in evaluations of IFPS programs. Parents and children (depending on the child's age) can be asked for their perceptions regarding changes in problem status and other aspects of social functioning. Client views can be obtained regarding the IFPS program and its components, including the client's relationship with helping staff. In the Illinois study, these data will be collected from a sample of Family First and control-group clients at termination. Additional data on social functioning and receipt of further service will be obtained at a minimum of three follow-up points, six, twelve, and eighteen months later.

Standardized measures. A standardized measure is an instrument administered to all families or individuals. It is appropriate if the expectation is that all families will be affected by the IFPS program in those areas of life tapped by the measure. Because services frequently aim to increase the level of social support to the family and reduce risk of harm to the child, measures of social support and child well-being are often used in intensive family preservation services evaluations.

The technology for assessing and measuring change in levels of social support to families is currently undergoing vigorous development. Instruments vary in the degree to which they emphasize different aspects of the individual's or family's social system. Some primarily focus on creating a map of the client's social network and measuring the quality of those relationships (structural measures), while others measure the extent of supportive exchanges (functional measures). The selection of an appropriate social support instrument should be governed by concern for its comprehensiveness in measuring multiple types of social support (both formal and informal support), multiple functions (advice, emotional encouragement, information, material and physical assistance), and the presence of reciprocity as well as stress experienced in the supportive relationship. Distinctions have not always been made between the availability of social support and its actual use by clients. The social network map (Tracy and Whittaker, 1990) is a recently developed tool for use by social workers with their clients to help plan services. It overcomes many of the limitations of existing measures of social support. Although the social network map has been pilot tested with HOMEBUILDERS therapists, it has not yet been subjected to tests of reliability and validity nor used in a large-scale evaluation.

Child and family functioning instruments are typically completed by the worker, based on their observations and self-report by the parent. Sometimes instruments are completed by independent raters. This may be a problem if the instrument is intended for completion by the practitioner working with the individual or family. For example, the Child Well-Being Scales (Magura & Moses, 1986) were designed to be completed by a worker who has thorough knowledge of the family. In a study of family-based services, however, case readers completed the scales on the basis of information found in case records (Nelson et al., 1988). A portrayal of child well-being obtained from the case record may not have been very accurate. Case records are often incomplete or unbalanced and present a predominantly negative picture of client situations. At a minimum, validation checks with the actual workers should be made to determine the accuracy of case reader assessments.

A broad array of child well-being and family functioning measures have been developed and are reviewed elsewhere (see, for example, Weiss & Jacobs, 1988; Magura & Moses, 1986). Because few instruments have information available on their validity and reliability, caution is recommended in choosing appropriate measures. Selection of instruments should be governed by concern for the standard of acceptable functioning reflected in their items. Instruments may reflect social-class bias or may contain items that are not gender neutral or applicable across ethnic groups. Other considerations in the selection of measures include ease of administration (time and training required) and the likelihood of

obtaining socially desirable responses. Client-satisfaction instruments and other self-report measures are particularly susceptible to the social-desirability factor, especially when the respondent completes an instrument multiple times. Finally, great care should be used when interpreting results from measures of family or child functioning in single-group pre- and post- studies. Change over time may be due to statistical regression toward the mean or to factors other than the intervention. This caution also applies to the interpretation of results from individualized measures.

Individualized measures. Ratings of problem status or change and the Goal Attainment Scale (Kiresuk & Sherman, 1968) are tailored to the needs of individual clients. They are useful to the researcher and practitioner because families can be affected by intensive family preservation services in different ways. Their main drawback lies in the difficulty of aggregating data from different families and subsequent interpretation of results in large group studies. The measured level of functioning or degree of change is greatly affected by the definition of the original problem or goal and the expectations of client performance. While some practitioners are especially skilled at identifying problems and goals, others have unrealistically high or low expectations of client performance. Client outcomes reported by workers with unrealistic expectations may be skewed, reflecting worker style, rather than an accurate assessment of client functioning. These problems make group comparisons extremely difficult.

System Effects

The mounting of an IFPS program is likely to have effects beyond those experienced by the families and workers who participate in the program. In particular, success of the program is likely to have subtle but far-reaching effects on the system itself. For example, a successful IFPS program may force a change in the organizational culture and guiding philosophy of the larger system.

The central mission of the public child welfare system is the protection of children. The legislative push for the primacy of family preservation has created for caseworkers a very real tension between contradictory mandates of child protection and family preservation. While practitioners are attempting to reconcile these differences, a shift in practice may take place. A surrender of control and certainty by protective service workers may be exchanged for the acceptance of more risk in case decision making. Protective service workers may become less inclined to protect children aggressively by removing them from their own homes and be more willing to request in-home services. Skepticism on the part of

workers and administrators may be replaced by a more optimistic attitude about what can be accomplished with these families.

The impact of intensive family preservation services on the wider system may be most keenly felt in states or regions with high placement rates. For states with already low placement rates, there may be a ceiling effect and the impact of the program on the system may be less easily observed. In Illinois, for example, approximately 20% of substantiated cases of child abuse or neglect have involved the placement of children into substitute care. This figure has remained fairly steady over several years. Assuming that there will always be some cases in which children cannot be adequately protected in their own homes, it is possible that the introduction of Family First services cannot reduce this percentage. In addition, the fact that workers often refer families in which there is little risk of imminent placement for children may be further evidence that few unnecessary placements are made.

Other system effects are also possible. The public child welfare system may shift the focus of the IFPS program from placement prevention to other goals, such as enhancement of the assessment process and early introduction of services to a broader population of child welfare clients. This shift, proposed in Illinois, may be due in part to the presence of the Family First program. It is also due to administrative conclusions drawn from the evaluation on the basis of some early findings.

Conclusion

Public sentiment for intensive family preservation services is high. Our experience suggests that this can create obstacles for conducting a rigorous outcome evaluation, especially when the participants are already convinced that these services "work." These programs most assuredly will continue to have an important place in the child welfare system, although we don't yet know which families are likely to benefit most from particular sets of services and which families will benefit little or not at all. It is in the quest for these answers that the process of service delivery and its impact on the lives of families must be thoroughly understood. Ultimately, the job of the evaluator is to build this knowledge base for purposes of further program planning, funding, and to locate the appropriate place for intensive family preservation efforts in the service continuum.

Reference Notes

[1] The evaluation involves close collaboration between a state child welfare agency, the Illinois Department of Children and Family Services (DCFS), and a private policy research institute, The Chapin Hall Center for Children at the University of Chicago. A variety of programs are being evaluated through this project, some of which meet the criteria for intensive family preservation services, while others are less intensive.

[2] Intensive family preservation services are distinguishable from both family-based services and home-based services. The broadest category, family-based services, are directed toward families and include work with children and their parents in the office, in a residential facility, or in the client's home. Home-based services represent a type of family-based service provided in the family home. Intensive family preservation services are family- and home-based time-limited services with the goal of preventing the imminent placement of children in out-of-home care.

[3] The United States Department of Health and Human Services research guidelines for use of human subjects provides exemptions to the informed consent process for states conducting studies of public programs, and a number of such studies have been conducted.

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PROVIDING CULTURALLY SENSITIVE INTENSIVE FAMILY PRESERVATION SERVICES TO ETHNIC MINORITY FAMILIES

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Intensive family preservation services practice offers a promising new approach to preventing the escalation of ethnic minority children entering the foster care system (National Association of Black Social Workers [NABSW], 1986). The individualized nature of the intervention makes it particularly relevant and adaptable to the unique values, familial and behavioral characteristics that distinguish people of color in this multicultural society. The purpose of this paper is to discuss the knowledge and skills necessary to provide culturally sensitive intensive family preservation services to ethnic minority families. The chapter begins by defining ethnic minority status, including a brief discussion of each of the four major ethnic minority groups in the United States: African American, Asian American, Hispanic and Native American. The next section explores ethnic minority children in the child welfare system, including factors that account for their severe over-representation in the system. Next, the unique characteristics of families of color, including family structure, help-seeking behaviors and level of acculturation are examined. The major portion of this chapter discusses the HOMEBUILDERS model in terms of its appropriateness for practice with families of color. The chapter concludes with practice principles for using the HOMEBUILDERS model with ethnic minority families.

Ethnic Minority Families In the United States

The literature is replete with varying and conflicting definitions and interpretations of concepts related to people of color. Perhaps the best way to begin this discussion is to define how the terms ethnicity and minority will be used in this chapter. According to Davis, (1978) ethnicity refers to an identity set which reflects a common ancestry, national origin, religion and/or race. Ethnicity is expressed by assuming similarity in the life styles, values, attitudes, customs and rituals of people in their respective groups. Minority is defined as a group that is discriminated against and/or experiences differential and unequal treatment because of oppressive conditions (Davis, 1978). In this country, ethnic minority often refers to persons of color (African American, Asian American, Hispanic and Native American), although some authors include white ethnics (Poles, Greeks, Italians) and socioreligious ethnics (Jews, Amish, Arabs, Mormons

and Muslims) in their discussion of minority persons (Mindel, Habenstein, & Wright, 1988; McGoldrick, Pearce, & Giordana, 1982).

Following is a brief description of each of the four major minority groups including a discussion of distinguishing family characteristics. These descriptions should be viewed with caution. They should not be taken as standards, as this would result in stereotyping and oversimplifying very complex people and situations. In practice, each individual family might be compared to these general descriptions. Some of the characteristics will apply, and others will not. The similarities and differences are influenced by a number of different factors including socioeconomic status, educational level, urban vs. rural up-bringing, background, language, age, recency of migration/immigration, level of acculturation, family idiosyncrasies and regional differences.

African American

African Americans, descendants of West African slaves, are the largest and most visible ethnic minority group. They represent almost 12% of the total population in the United States (U.S. Bureau of the Census, 1981). Despite the oppressive working and living conditions during slavery, the African American family remained a very important institution. The importance and emphasis on the family continues today and in fact, the African American family is written about more often than any other aspect of African American people. Certain characteristics that are often associated with African American families include: strong kinship bonds and living in extended families (Solomon, 1983; Martin & Martin, 1978; Pinderhughes, 1983; Billingsley, 1968; Boyd-Franklin, 1989; Staples, 1971; Hill, 1972; Stack, 1974), flexible family roles and boundaries (Pinderhughes, 1982; Leigh & Green, 1982) and a strong religious orientation (Solomon, 1983; Hines & Boyd-Franklin, 1982; Boyd-Franklin, 1989).

Strong kinship bonds and extended family networks in African American families are attributed to African traditions (Noble, 1974). These relationships sustained families by providing help with money, child care/child rearing, housing, emotional support and other survival resources (Logan, Freeman, & McCoy, 1990).

Role flexibility is necessary in African American families because of the historically subjugated role of Black men (Billingsley, 1968). Oftentimes, African American women have greater access to employment and economic opportunities than men. Role flexibility allows men to perform traditionally expressive functions such as parenting, while women can be primary wage earners.

The church serves an important function in the maintenance of African American families. It offers members and non-members, alike, spiritual leadership, extended family, educational opportunities, emotional support, social change efforts, financial support, and socialization opportunities.

Asian American

The term Asian American incorporates persons from many different countries including China, Japan, Korea, Samoa, Guam, Hawaii, Philippines, Thailand, Laos, Cambodia, and Indonesia (Ho, 1987). While many similarities prevail among Asian Americans, many obvious differences also exist, including language, immigration history and political and economic policy. This discussion will be limited to similarities among Asian Americans, particularly as they relate to family life.

Relationships among Asian American families are characterized by three primary feelings and attitudes. The first is a feeling of obligation to family members, particularly to parents. One is obligated because of hierarchical relations (child to parent, child to teacher) and also through behaviors that incur obligation, such as acts of kindness or helpfulness (Shon & Ya, 1982). The second feeling that characterizes interactions in Asian families is shame. Shame is used to help support and reinforce societal expectations and appropriate behavior (Shon & Ya, 1982; Ho, 1987). The third and final characteristic is harmonious living, which requires showing compassion, moderation in behavior, self-discipline, modesty, patience, friendliness and selflessness to achieve a harmonious lifestyle (Shon & Ya, 1982; Ho, 1987).

Hispanic

Hispanics are the second largest and fastest growing ethnic minority group in the United States (Davis, Haub, & Willette, 1983). The umbrella term "Hispanic" actually includes people of various Spanish heritage. The largest subgroup is of Mexican origin, followed by Puerto Ricans and Cubans (U.S. Bureau of the Census, 1981).

Hispanics have a tremendous pride and respect for their families (Ramirez & Arce, 1981). Families not only nurture and provide stability for members but also serve as the primary vehicle for material and emotional support (Mirande, 1985). Mutual obligation and reciprocity are underlying values that nourish and maintain the social support system (Vega, Hough, & Romero, 1983).

A widely held stereotype of Hispanic persons is the concept of "machismo" and the associated interpretation of male dominance, aggressiveness and disregard for females (Mirande, 1985). This stereotype does not fit the reality of most Hispanic persons. While hierarchical relationships exist in the family (father is regarded as head-of-household; younger children must obey older children), genuine machismo is characterized by bravery, respect, courage, generosity, protection and provision for family, and respect for others (Mirande, 1985).

Native American

The Native American people are the only indigenous ethnic minority group in North America. There are over 400 Native Tribes and 280 reservations in the United States (Edwards & Edwards, 1984). Native people vary according to tribal membership, values, religion, language, and urban or reservation residency. Because of the tremendous diversity among Native people, one cannot assume that tribes, even in close geographic proximity, share common traditions. Therefore, when working with Native American families, it is wise not to overgeneralize what one may have learned about some Native American groups. It is imperative that a practitioner learn about a family's tribal history and current tribal experience when working with a Native family.

Academic research on the Native American family has not been nearly as extensive as research with other ethnic minority groups (John, 1988). However, there are several important and distinguishable characteristics about Native American families that are highlighted here. The first characteristic is family lifestyle differences. Native Americans living on reservations tend to operate within an extended family framework with open boundaries (Red Horse, Lewis, Feit, & Decker, 1981). Extended family membership is not limited to persons living in the base household but also includes other individuals and families. Contact between family members is frequent. A second characteristic has to do with the status and value of elder family members. Native Americans hold their elder family members in very high esteem (Ryan, 1980). They are fully functioning members of the community and often assume a heightened status as teacher of unique cultural traditions and art forms.

This brief discussion provides us with a beginning foundation for understanding some of the unique qualities of ethnic minority families. Readers are reminded that these overview comments are limited by space restrictions. Each of the four major ethnic minority groups have very rich and complex traditions and histories. These traditions must be taken into consideration when developing treatment goals for ethnic minority families. We now turn our

attention to an overview of how ethnic minority children and families have been served by the child welfare system.

Minority Children in the Child Welfare System

It is well documented that the child welfare system treats ethnic minority families differently than Caucasian families. For ethnic minority families, these differences include: a higher frequency and longer length of stay in out-of-home placements, fewer written service plans, fewer service goals of reunification and/or family strengthening, fewer overall services, and less contact with child welfare workers (Billingsley & Giovannoni, 1972; Chestang, 1978; Shyne, 1980; Olsen, 1982; Stheno, 1982; Washington & Van Hull, 1985; Jenkins & Diamond, 1985; Seaburg & Trolley, 1986; Close, 1983; Hogan & Siu, 1988).

African American children, particularly older children, seem to be the most neglected minority group. In addition to the lack of case planning that affects all minority children, African American children are placed in foster care at higher rates (Stheno, 1982) and spend considerably more time in the child welfare system (Jenkins, Diamond, Flanzraich, Gibson, Hendricks, & Marshood, 1983; Olsen, 1982; Jenkins & Diamond, 1985). Younger Hispanic children (under 6 years old) also tend to experience a higher rate of placement than would be generally expected (Close, 1983).

How does one account for the discrepancies in planning and providing services to minority children and families? Billingsley and Giovannoni (1972), in a landmark book describing the status of black children in child welfare, assert that racism is at the root of the problem. They state:

> The system of child welfare services in this country is failing black children. It is our thesis that the failure is a manifest result of racism; that racism has pervaded the development of the system of services; and that racism persists in its present operation.
>
> ... racism manifests itself in the present system of services in three major ways: (1) the kinds of services developed are not sufficient to the special situation of Black children; (2) within the system of services that has been developed, Black children are not treated equitably; and (3) efforts to change the system have been incomplete and abortive. (p. 3)

Billingsley and Giovannoni (1972) suggest that the overall quality of life of ethnic minority children and families in the child welfare system has not improved

because overt racism has been replaced with covert racism, evidenced by the maldistribution of services to families of color. They propose a multi-tiered system where African Americans control a portion of child welfare resources and take responsibility for designing and developing programs that meet cultural needs.

Chestang (1978) blames a combination of racism and poverty for the differential treatment of minority children and families by the child welfare system. He asserts that in many instances, when a minority child is removed from his/her home because of abuse and neglect, the real dysfunction stems from poverty and the problems associated with surviving with inadequate financial resources. A recent study of over 1,100 Black children in foster care, (Black Child Development Institute, 1989) suggests that in 25% of cases, poverty was the significant factor in placement. Inadequate housing was significant in another 40% of cases.

Other factors that might account for the differential treatment of minority families are personal racist attitudes and ignorance about ethnic family issues among individual practitioners in the child welfare system. Myths and stereotypes about minority cultures are plentiful, particularly regarding the family, drug use, sexual promiscuity and child-rearing practices. For example, many workers have myopic and preconceived notions about how families should look and behave in terms of lifestyles, values, beliefs and religious practices. The degree to which child welfare workers accept these unchallenged myths and stereotypes, or are unaware of cultural differences, will heavily influence decisions related to how families would be best served and whether children should be removed. This is especially disturbing given the number of practitioners who do not possess professional social work training and who have little supervision or in-service training, particularly in the area of culturally sensitive practice.

Unique Characteristics of Minority Families

Knowledge of different family structures, help-seeking behaviors, and the impact of acculturations may be essential for understanding how and why minority families experience social work interventions differently. More importantly, understanding these unique family structures and other minority family characteristics will affect how the worker plans services with client families of color. Family preservation offers a promising new practice technology for influencing the racist and culturally insensitive treatment of minority children in the child welfare system. All family preservation practitioners need to acquire such knowledge as part of their training and ongoing education.

Family Structure

Extended family networks, as opposed to nuclear family systems, are very common in all ethnic minority families. They serve important social support functions. According to Martin and Martin (1978), extended families are defined by their interdependence, multi-generations, dominant figure heads, central or base households, and geographical expanse. The Wilson family is an excellent illustration of interdependence, social support and fluidity of movement in extended families (Figure 1).

The Wilsons are an African American family living in Seattle, Washington. Larry (56), and Mary (52) are the parents. They have three children, John (29), Reggie (31), and Margaret (32). John is single and lives in Tacoma, Washington, approximately 30 miles south of Seattle. Reggie is divorced. He has resided in Los Angeles for six years.

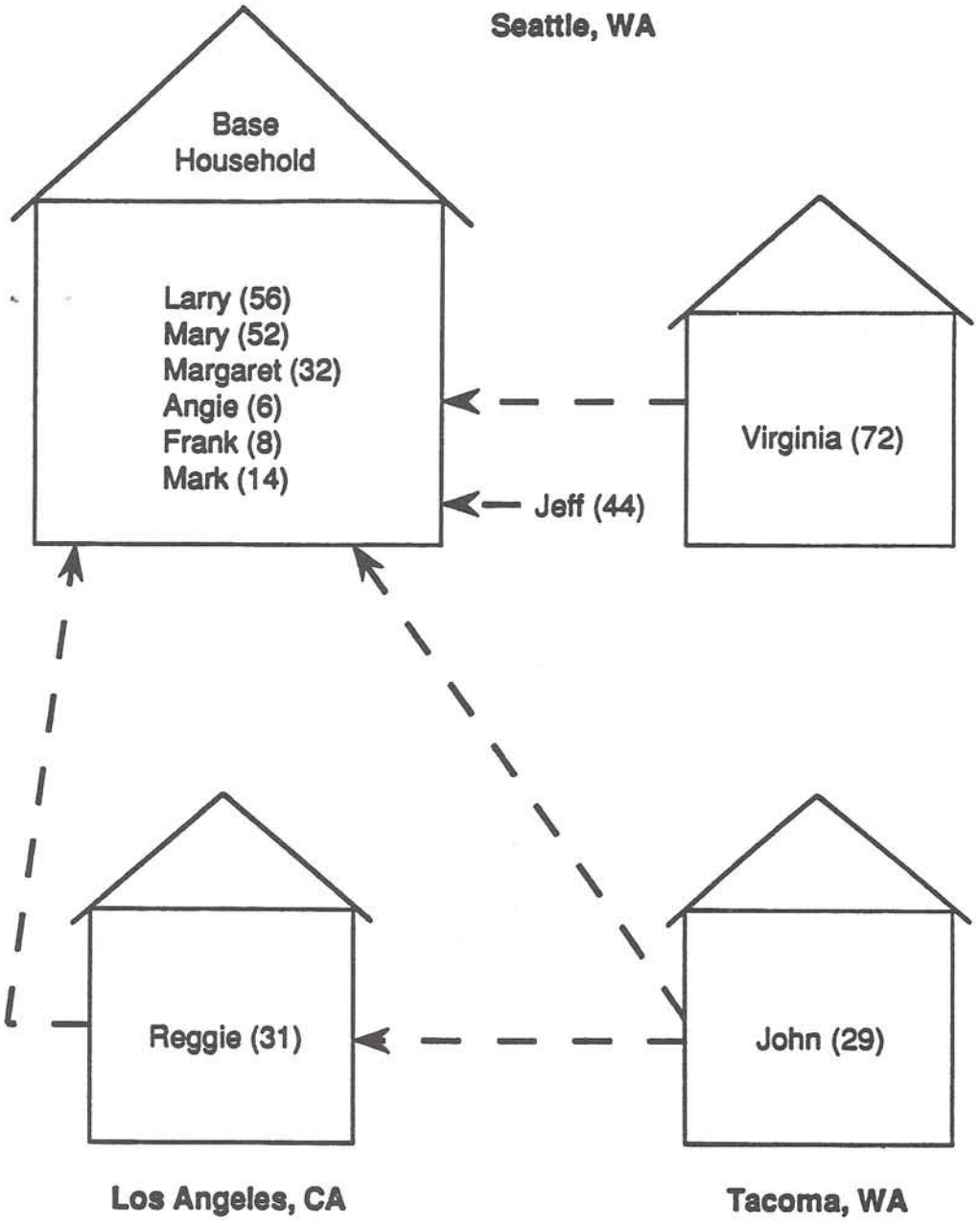
There are six persons living in the base household: Margaret, her children Angie and Frank, Reggie's son Mark, and Larry and Mary Wilson. However, the extended family consists of a host of relatives, neighbors, and friends that visit the base household frequently.

Margaret is divorced and has two children, Angie, (6) and Frank (8). Prior to her divorce, Margaret and her family lived about three miles away from her parents. However, when she separated, she moved back into her parents' home and has remained for the past three years. Her divorce was finalized six months ago. Margaret depends on her parents for shelter and child care. She works full time and contributes most of her income to household expenses.

Reggie is separated and lives in Los Angeles. His 14-year-old son, Mark, lives with his grandparents in Seattle. Reggie provides money for his son's clothing but is unable to provide additional assistance. Mark visits Reggie in Los Angeles during the summer months. Reggie sent Mark to live with his grandparents because of suspected gang involvement in Los Angeles.

John is single and moved to Tacoma two years ago. Over the past five years, John has lived with his brother in Los Angeles, his sister Margaret (prior to her separation/divorce) and his parents. Mary's mother, Virginia (72) lives next door. Larry's parents are dead.

FIGURE 1


Seattle, WA
Base Household
Larry (56)
Mary (52)
Margaret (32)
Angie (6)
Frank (8)
Mark (14)
Jeff (44)
Virginia (72)
Reggie (31)
John (29)
Los Angeles, CA
Tacoma, WA

Larry also has a brother, Jeff (44), who is transient and lives with Larry and other family members about three months each year.

The Wilson family reflects all of the characteristics of an extended family. They depend on each other for tangible resources (food, clothing, money, shelter) and emotional support beyond the scope of the traditional nuclear family and beyond the common emancipation age. Among other things, Larry and Mary provide shelter for Margaret and her children as well as for their grandson Mark. They undoubtedly perform various parenting functions for the children. Margaret contributes financially to the base household income, as well as performing maintenance and housekeeping chores. The family also provides meals, transportation, and home maintenance help to Mary's mother who lives next door.

Larry and Mary's home is the base household for this family. Members move in and out of the base as necessary, always with a sense that they can return if need arises. In fact, Larry's brother is very transient and moves into the base household for a couple of weeks, several times throughout the course of a year. Several of the Wilson children have left Seattle and are living elsewhere, illustrating the geographical expanse, yet they maintain strong connections to the base household.

Help-Seeking Behavior

Help-seeking behavior refers to the process that one uses to seek assistance with intrapersonal, interpersonal and environmental problems. There is considerable evidence that ethnic minority persons utilize health and mental health services at a lower rate than Caucasians (Smith, 1985; La Fromboise, 1985). Understanding the differential help-seeking behaviors of minority persons helps practitioners to develop more accurate intervention plans, design intake and referral procedures, and engage in outreach services that are culturally appropriate.

Help seeking can be influenced by a number of variables, including type and severity of problem(s), income level, gender, geographic proximity of helping network, and others. In general, however, minorities are distrustful of the formal welfare system and therefore are less likely to utilize formal services as the initial avenue of help seeking. This distrust is the result of a long history of racism and discrimination as well as the lack of relevance to minority populations. Lack of bilingual staff, inconvenient and inaccessible geographic location, inflexibility of administrative policies such as designated office hours, and a general insensitivity

to racial and ethnic issues has limited the use of formal social services by minority families (Rodriguez, 1987).

Minority persons are much more likely to reach out to family, friends, neighbors, church leaders, indigenous healers, and other less formalized community-based services. Familiarity and a sense of shared experiences makes approaching informal sources less threatening. In fact, requesting services from a formal social service agency is often the last resort for ethnic minority families. This is especially true when seeking counseling/therapeutic services as opposed to concrete services or financial assistance. The importance of understanding a family's help-seeking pattern can be illustrated in the following example.

An urban Native American family was referred to intensive family preservation services for suspected physical abuse. The IFPS worker believed that a parenting class would have been helpful in supplementing her parenting goals for the family. The practitioner referred the couple to a parenting class at the local community college by giving them information on registration and class meeting times. She asked the couple to be responsible for registering and enrolling in the class. After several subsequent inquiries, the worker learned that the couple had made no attempt to enroll in the community college class. The worker perceived this behavior as resistance and began to devise a plan to ensure better cooperation from the parents.

What the worker failed to realize was the couple's distrust of the "system" and lack of perceived similarities between themselves and the other participants at the community college parenting class. In this example, the worker failed to assess how the family usually solved problems. The couple's hierarchy of help seeking began on an individual level when they recognized, labeled, and utilized internal resources for problem solving. When the couple was unable to solve problems on their own, they would consult family members and tribal elders on the reservation. Their next level of assistance was Indian friends and neighbors. A fourth level of assistance was an Urban Indian Social Services Center. Only after these attempts were unsuccessful did they go outside of their community for problem solving, and then with great skepticism.

Two final thoughts on informal help seeking. While family, friends, and other informal support sources are important resource providers, family members might also be helpful in facilitating referral and follow-through to a formal agency, especially if the informal network is unable to absorb and resolve the problem. For example, a mother who experiences the sudden death of a child will undoubtedly turn to her family and friends for support and comfort. However, if after several months severe depression and possible neglect of other children persists, child protective services may intervene to protect the other children. One goal for this family might be individual or group grief counseling for the mother.

The intensive family preservation practitioner's success in connecting this mother with grief support might be aided by garnering support and encouragement from family and friends and asking them to encourage the mother to follow through with the referral.

The second point involves a cautionary note. It is easy to overburden the informal social support system because of the lack of existing formal services that are culturally relevant. Practitioners do minority families incredible disservice if they fail to advocate and facilitate social change in existing agencies to make them more culturally relevant. Informal networks are not and should not be replacements for formal services. However, until these agencies make efforts to become more relevant and accessible, they will probably go underutilized.

Level of Acculturation

Intensive family preservation services practitioners working with ethnic minority families should consider the impact that acculturation has on family functioning and the implications for case planning and service implementation. Acculturation refers to the integration of dominant-culture values, behaviors, and traditions with the associated values, behaviors, and traditions of the ethnic culture (Kumabe, Nishida, & Hepworth, 1985; Green, 1982; de Anda, 1984). Presumably, the longer a person lives in and interacts with the dominant culture, the more likely that person will integrate components of the dominant lifestyle.

Individual characteristics and quality of experiences with the dominant culture greatly influence the rate of acculturation. Other factors that influence one's level of acculturation include generation in the new country, income, length of residence in the new country, educational level, age and language. Acculturation is usually thought of as a continuum from totally traditional or integrating few, if any, of the dominant characteristics to totally assimilated or completely adopting dominant characteristics and abandoning one's ethnic heritage.

Second- and third-generation family members born in the United States differ considerably from their immigrant relatives. These intergenerational conflicts often are sources of tension and frustration between older and younger family members and are often the catalyst that brings the families to the attention of social service agencies. For example, the Nguyen family was referred for services by the school system for possible expulsion because of disruptive behavior and lack of educational achievement. The Nguyen family immigrated from Vietnam in 1970. The family includes father (50), mother (40), elder son (25),

elder daughter (19), daughter (15), and son (14). Both daughters and the youngest son were born in the United States. The father, mother and, to a lesser degree, the elder son continue to maintain very traditional Vietnamese values, including high value for family, respect for power and authority and loyalty (Tran, 1988). The American-born children are more acculturated and reject these values in an effort to gain "peer" acceptance. They experience a tremendous amount of stress trying to "fit in" in the American school while also trying to be faithful and true to their Vietnamese heritage. For the 14-year-old, stress is manifested as poor academic achievement, acting out in school, "wanna be" gang activity, and disrespect to parents. The parents are distressed by the uncharacteristically negative behaviors displayed by the son as well as by uncertainty about the health and welfare of relatives still in Vietnam or in refugee camps. Bicultural effectiveness training (BET) has helped to alleviate these types of intergenerational problems by refocusing conflict into discussions of positive characteristics of each of the cultures (Szapocznik, Rio, Perez-Vidal, Kurtines, Hervis, & Santisteban, 1986). BET helps parents and children understand and appreciate the other's position.

Chestang (1978) and Norton (1978) suggest a bicultural approach, where one neither totally rejects one's native culture nor totally adopts the dominant culture. Biculturalism, or the dual perspective, calls for people of color to learn two sets of behaviors. One set of behaviors is used primarily with the dominant culture in job or school settings, the market place, and when dealing with formal, white-dominated agencies and services. The other, or the "ethnic-cultural" set of behaviors, are utilized when interacting with family and friends in the ethnic community. The dual perspective allows people to maintain their ethnic identity and support while interacting successfully with the dominant culture.

Using the HOMEBUILDERS Practice Model With Ethnic Minority Families

The HOMEBUILDERS model is an empirically based approach to service delivery with client families. However, the model has been only preliminarily evaluated regarding its relevance for minority families. The following discussion will assess the underlying value base and the basic components of the model in terms of their appropriateness for use with ethnic minority families. These components include intensity, location and scheduling of services, and provision of concrete and counseling services.

Value Base

Having a compatible value base is the most basic ingredient for developing culturally sensitive interventions. At a minimum, interventions that are culturally sensitive must be developed on a value base that includes an appreciation and respect for differences, a respect for tradition and history, a belief in the goodness of people, and faith that people want to and are able to change.

The HOMEBUILDERS model is based on a set of values that supports the diversity that families of color bring to the practice context. These values influence how practitioners interact with clients as well as the types of interventions utilized. The primary value of HOMEBUILDERS practice is the importance of the family (Kinney, Haapala, Booth, & Leavitt, 1988). All other values support this fundamental belief that the family is the best place to rear a child. Other values include a belief that families want to change and have the power to change. It is the practitioner's job to offer hope and provide other resources and skills that will enable families to make changes. Another crucial value of IFPS involves regarding parents in the family as colleagues, partners in change. Practitioners do not assume that they know what is best for each family, nor do they try to impose their agenda on the family. Practitioners and parents work as partners as they jointly develop goals and interventions.

Intensity

A number of characteristics of the HOMEBUILDERS program reflect the intensity of the model. First of all, therapists and supervisors are available to families on a 24-hour basis. Family members are encouraged to contact their therapist whenever situations escalate to crises or when they feel like problems are getting out of control. Second, case loads are limited to two families, which allows for considerable face-to-face contact between therapist and family members. Finally, interventions are time limited; generally, therapist is in the home for four weeks. All of these factors contribute to the appropriateness of the HOMEBUILDERS model for practice with ethnic minority families. Often ethnic minority families experience therapy differently than majority culture families. Self-disclosures about family problems are very difficult in families of color. It takes a long time to develop trust in a person that you see once per week in an office setting. The intense nature of the HOMEBUILDERS therapy allows for more rapid development of relationships, as the therapist is able to spend several hours, if necessary, during the initial visit getting to know the family and assessing the

referral concerns. Furthermore, he/she is able to see the family frequently, with shorter amounts of time between sessions than with traditional office-based counseling.

While intensity is an asset, therapists must remember that the initial sustained contact does not allow them to become "informal" with families more rapidly than in traditional settings. Minority persons tend to be more formal in interactions than white families. For example, referring to parents and family elders by first names without having permission from them may be interpreted as disrespectful.

Location and Scheduling of Services

Perhaps the most compatible aspect of the HOMEBUILDERS model is that services are provided in the client's home and at the family's convenience. Assessments are made and interventions developed in the environment in which they will be used. This is very important for minority families. It is extremely difficult to design an effective intervention without having an opportunity to observe and participate in the home environment. Home-based practice allows, and perhaps forces, workers to learn and understand the culture and environment in which the family lives (Hodges & Blythe, 1990). Workers learn about values, family rules, relationships, language, style, etc. It is imperative that these cultural characteristics be incorporated into treatment programs; without them, the intervention is destined to be very temporary or fail completely.

Home-based services also allow workers to observe and assess the community environment in which the family lives. Interventions are often targeted at systems outside of the family (school, police, neighbors) that directly affect the family's functioning. These systems are more difficult to assess when most of the work is done in an office-based agency setting.

HOMEBUILDERS appointments also are negotiated to occur at a convenient time for the family. Many ethnic minority family members work at poor paying jobs and cannot afford to take time away from the job for an appointment with the counselor. This flexibility of scheduling not only shows respect for other obligations the family members must meet; it also is very empowering in that families have control over when these meetings will take place.

Provision of Concrete and Counseling Services

It is important that practice models for minority families be firmly established in empowerment philosophy. That is, intervention efforts are directed at helping families to identify and build on their strengths and resources and to gain increased power and control over the crisis situation, such that children are safe and no longer at risk of being placed out of the home (Pinderhuges, 1983; Solomon, 1976). Gutierrez (1990) outlines five techniques that are consistent with empowering practice: (1) accepting the client's definition of the problem, (2) identifying and building upon existing strengths, (3) engaging in a power analysis of the client's situation, (4) teaching specific skills, and (5) mobilizing resources and advocating for clients. The mixture of concrete and counseling services in the HOMEBUILDERS model enables practitioners to develop genuine empowering relationships with minority families.

HOMEBUILDERS commitment to empowerment practice is illustrated through the use of contracts, skills teaching, advocacy, and resource mobilization and linkage. HOMEBUILDERS interventions are highly individualized and begin with an in-depth assessment, from which family and therapist develop a mutual plan that includes goals and objectives, identified by the family, to be achieved during the four-week intervention. Goals and objectives are not limited by traditional social services worker roles. Therapists often provide concrete services such as transportation or occasional child care to facilitate the achievement of goals. The case-planning process is mutual in that the goals of the therapists, referring workers, and family members are represented. Family members are able to identify their own difficulties and are active in the development of intervention strategies to address these problems.

Another example of empowering practice is the HOMEBUILDERS commitment to skills building. Many family problems reach crisis status because family members lack sufficient skills to resolve their problems in a safe and socially acceptable manner. Whether training a family in communication, parenting, or mood management skills, HOMEBUILDERS therapists are committed to teaching alternative means of resolving problems.

Finally, advocacy and resource mobilization are important functions of the HOMEBUILDERS therapist, particularly with minority families. The flexibility to provide concrete services allows workers the opportunity to respond to the barriers that prevent minority families from effectively utilizing services. Most often these barriers include lack of resources which compounds normal parenting stress. Providing concrete services, as well as providing information, making referrals, and advocating for other services, fills resource gaps and frees family and worker to tackle the interpersonal difficulties that brought the family to the

attention of the public child welfare agency. For example, a mother may be prevented from discussing school problems with a child's teacher because of lack of transportation to the school. A HOMEBUILDERS therapist would have the flexibility to provide transportation for the mother to and from the school and, if appropriate, assume an advocacy role for the family.

Culturally Sensitive Practice Principles

No single chapter, article or book will adequately prepare practitioners for culturally sensitive intensive family preservation services practice. In fact, acquiring culturally sensitive skills is an ongoing process that will continue throughout one's life. This chapter concludes by offering practice principles and guidelines that facilitate the beginning journey towards providing culturally sensitive intensive family preservation services practice. These guidelines are not imperative and, therefore, should be carefully evaluated with each individual family. Practitioners are encouraged to continue their journey by reading about and exploring different cultures, remembering that the best lessons are learned from clients.

Practice Guidelines

1) Raise the issue of race and racial differences early in the relationship development phase. While practitioners may not have an issue with cross cultural work, clients are keenly aware of racial differences. Talking about racial differences conveys a sense of openness and a feeling that "anything can be discussed." Discussing racial issues also may facilitate the development of trust (Leigh, 1985; Boyd-Franklin, 1989).

2) Allow clients to define "family." Don't assume that only people living in the household are family members. In extended family systems, "family" will include kin and fictive kin. Allowing the family to define the unit increases the likelihood that all the critical players will be involved in the treatment plan.

3) Minority families are likely to have extended family members assisting in child rearing. Expect that some of the home visits will occur in the homes of extended family members.

4) Evaluate the family's level of acculturation. Determine if problems are the result of intergenerational conflict. Assist members in reframing conflict

and understanding the realities and stressors that each generation must endure with regards to value conflict.

5) Adopt an aggressive empowerment philosophy. A sense of powerlessness and anger may prevail, given the racist and oppressive experiences of minority persons. Empowerment requires the sharing of power and interventions directed at restoring responsibility and control to the parent.

6) Make referrals to resources and services within the ethnic community before exploring cross-cultural alternatives. Minority families are much more likely to utilize familiar services and agencies. Local support services offer the added advantage of being available after intensive family preservation services have closed the family's case.

7) Learn about the minority community. Spend time reading about and getting to know the community, neighborhoods, businesses, community leaders, and resources. Participate in community social change efforts.

8) Make a commitment to continue learning more about minority persons and practice issues with minority families. Advocate for personnel policies that aggressively recruit multicultural staff and provide regular training on multicultural issues.

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COMPARING INTENSIVE FAMILY PRESERVATION SERVICES WITH OTHER FAMILY-BASED SERVICE PROGRAMS

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Introduction

A variety of services designed to strengthen families and to prevent out-of-home placement of children have emerged in the field of child welfare. In the 1950s and 1960s, early forerunners of these services were developed as programs to treat the "multi-problem family" (see, for example, Brown, 1968; Geismar & Kreisberg, 1966; Wood & Geismar, 1989). Since that time, these services have been described as family-centered services, family-based services, home-based services, services to children in their own homes, and family preservation services. For example, many of the home-based programs share the following characteristics:

- A primary worker or case manager establishes and maintains a supportive, nurturing relationship with the family.
- A wide variety of helping options are used (e.g., concrete and clinical services).
- Small caseloads are maintained.
- Workers (or their back-up person) are available 24 hours a day for crisis calls or emergencies.
- One or more associates serve as team members or provide back-up with the primary worker.

- The home is the service setting and maximum utilization is made of natural helping resources, including the family, the extended family, the neighborhood and the community.
- The parents remain in charge of and responsible for their family as educators, nurturers and primary caregivers.
- The agency is willing to invest at least as much in a child's own family to prevent placement as society is willing to pay for out-of-home care for that child.
- Services are time-limited, usually 1-4 months (Bryce & Lloyd, 1980).

Some of these program components, however, are not included in other family-based programs. This paper will identify the major program components that should be examined when comparing various models of family-based services (FBS).

Intensive Family Preservation Services as One Model of Family-Based Services

As discussed above, family-based service programs have many different names as well as program characteristics. Within the broad framework of family-based services, wide variations exist across clinical methods, duration of treatment, caseload size, nature of concrete services provided and other program characteristics. The Edna McConnell Clark Foundation (1990) and other child welfare organizations active in this program arena have promoted the use of the term "intensive family preservation services" (IFPS) to denote a particular form of family-based services. The Child Welfare League of America, in its Standards for Service to Strengthen and Preserve Families with Children, has used a similar title "intensive family-centered crisis services," to discuss important features of a very specialized service model for children at extremely high risk for out-of-home placement and their families (Child Welfare League of America, 1989).

From another perspective, one could cluster services in this area into three categories: (1) Family-Based or Family-Centered Services (services broadly designed to strengthen and support families), (2) Home-Based Services (services to families in their home and community environment to improve family functioning and prevent child placement), and (3) Intensive Family Preservation Services (services which are home-based, intensive, and meet the criteria outlined

below and by Kinney et al., this volume) [Note 1]. The relationship among these three types of services is illustrated in Table 1.

Within the loosely-knit network of policy analysts, foundation representatives, administrators and therapists who fund, deliver and evaluate these services, there is growing agreement that IFPS programs must have certain characteristics. While many of these characteristics come from program experience, increasing recognition is given to the strategic importance of these program dimensions. For example, program staff members should deliver a variety of clinical and concrete services in the home setting, and be available 24 hours a day. Services should be tailored to meet each family's needs. In addition, services should be of short duration (four to six weeks) and should be intensive (a minimum of four hours of face-to-face client contact per week). To make this possible, therapists' caseloads are limited usually to two-to-four families at one time.

While working with families in the home, IFPS therapists focus on preventing child abuse and neglect, decreasing teenage runaways, reducing a child's oppositional behavior in the home and community and, to the extent that these are predictive of placement, reducing the need for placement in substitute care. Services are crisis oriented, intensive and brief. One of the oldest and most well-established IFPS programs is HOMEBUILDERS, which was founded in 1974 in Tacoma, Washington. This program model has been implemented in a number of states across the country (see Kinney et al., this volume).

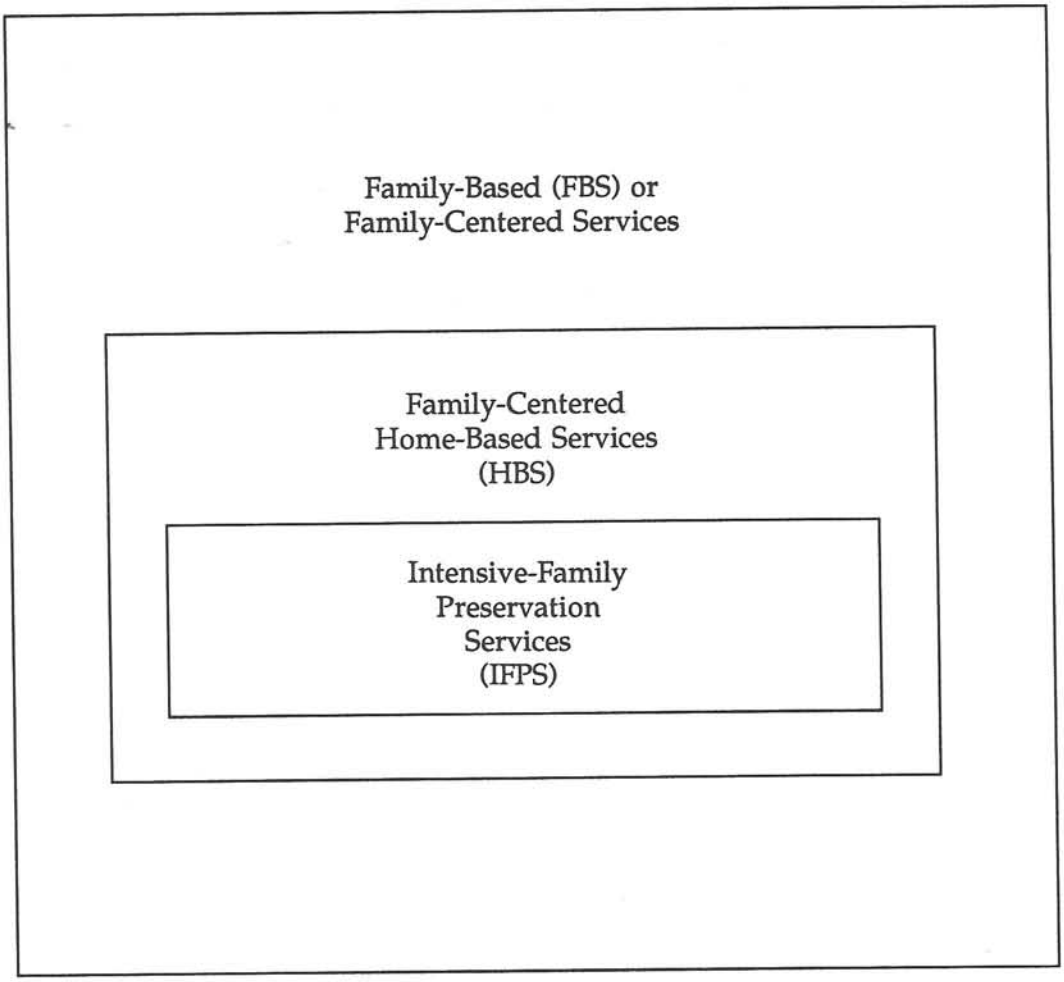
FBS Program Dimensions Need Clarification

While many family-based service (FBS) programs share some of the IFPS program features, the differences warrant careful examination. Across the nation, many child welfare administrators, policymakers and practitioners are being requested to develop FBS programs. Lacking information on the elements of service that distinguish one FBS model from another, they face making program decisions on the basis of personal knowledge, scant empirical literature, intuition and anecdote.

Having been forced to do this, many administrators, therapists, and researchers advocate that a typology of program models be developed so that there will be some consistency among programs across the nation, as well as comparability among evaluation studies. If a typology could be developed, it would assist child welfare and mental health professionals in answering such questions as: How many distinctive types of FBS programs exist? What are the key dimensions that distinguish certain FBS programs? With what types of clients (e.g., adolescents, chemically dependent parents, families experiencing chronic

Table 1

A Typology of Family-Based Service Programs



neglect) are specific FBS programs most effective?

In addition, effective program design and implementation require a clear understanding of the structural and other components necessary to deliver the service. Virtually all of these components need to be thought through carefully before purchase of service contracts are arranged or intra-agency service units are established. For example, the failure to specify required service elements clearly can lead to services that, while tacitly called intensive family preservation services, do not produce the outcomes that we are coming to expect from IFPS programs. Strategically, it is wise to replicate programs like HOMEBUILDERS because the clarity of program components, job expectations for staff and ease of quality assurance provisions increase the likelihood that new programs will start up within expected timeframes with fidelity.

Furthermore, there are tactical reasons for developing a well-articulated service model. From a public policy perspective, certain aspects of service delivery will push forward the goals of a public agency's mandate to protect children and support families, while others may not. For example, some excellent family-based services are less costly than a HBS program because they are office-based - the clients go to an agency office for service - thereby reducing staff member travel costs. However, from a tactical standpoint, the HBS program offers a service in the family's environment where the worker is more likely to see problems play out as they occur in real life. In addition, clients do not have to translate solutions from the office to the home. The HBS approach provides solutions to be tried and modified in the home context.

Program integrity is another issue; experienced child welfare and other family service administrators are familiar with the tendency for new and innovative programs to be modified over time so that innovation and effectiveness is lost. Clear program descriptions and procedures allow for careful program monitoring, evaluation, and replication. While these tasks are easy to list, the effort involved in carrying them out poses a tremendous challenge; so both service design and maintenance require clarity and focus in the program components that are chosen.

To facilitate discussion in this area and to help guide program design efforts, this chapter will draw upon the previous work of Greenblatt (1986), Kaplan (1986), and the National Resource Center on Family-Based Services (1986) to identify key dimensions in four major areas that need to be considered in designing a FBS or IFPS program: (1) client characteristics and case screening, (2) intervention model and services; (3) program structure; and (4) expected program outcomes (see Table 2).

Table 2
Major Program Components for Comparing Intensive Family Preservation Services with Other Models of Service

Client Characteristics and Case Screening

- Clients served in terms of such characteristics as:
  - primary caretaker and secondary caretaker age, marital status, education;
  - family household size and composition;
  - family income;
  - child age, ethnicity, gender, previous placement history, level of functioning, degree of truancy, delinquent behavior and substance abuse;
- Most common presenting problems or reasons for case referral;
- Referral source;
- Intake criteria;
- Screening procedures;

Intervention Model and Services

- Primary treatment approach;
- Primary treatment goals used;
- Clinical techniques and services most frequently provided;
- Concrete services provided or coordinated;
- Staff availability;
- Time elapsing between case referral and client contact;
- In-person and phone contact during first two weeks;
- Total amount of in-person and phone client contact;

Program Structure

- Proportion of interviews held in the family's home and community setting;
- Caseload size;
- Length of service;
- Staff qualifications;
- Staffing patterns (e.g., teaming, use of case aides);
- Therapist to supervisor ratio;

Outcome Criteria

- Improvements made in parent and family functioning, including communication, cohesion, adaptability, role clarity, parenting skills, and use of controlled substances;
- Improvements in child functioning, including school attendance, anger management, adherence to household rules, use of controlled substances, and delinquent behavior;
- Proportion of unnecessary child placements prevented;
- Proportion of families and children intact at case termination;
- Proportion of families and children intact 6 or 12 months after treatment;
- Number of potential child placement days used;
- Time elapsing between treatment termination and child placement;
- Reduction in projected placement restrictiveness;
- Cost-effectiveness.

Client Characteristics And Case Screening

If IFPS and other FBS programs are to be planned and compared in a consistent manner, the purpose, clients served, objectives, and service technology of each program must be clearly specified. For most programs, the purpose of the program is to reduce the risk for potential out-of-home placement by improving child and family functioning in a variety of areas, but some programs appear to serve children who are not at risk of imminent placement. Specifying the client population being served is necessary for selecting the types of clinical services and techniques.

Client Demographics, Presenting Problems and Family Strengths

Does the program serve a particular client group in terms of family structure, age, income, race, religion, geographic area (rural, suburban, urban), or other relevant demographic or socioeconomic characteristics? Certain aspects of social history are important, such as number or type of previous substitute-care placements and use of other social or psychiatric services because some studies are finding that children with these characteristics have a higher rate of placement (Fraser, Pecora & Haapala, in press; Nelson, Emlen, Landsman, & Hutchinson, 1988; Yuan, McDonald, Wheeler, Struckman-Johnson & Rivest, 1990).

In addition, it is important to identify the common reasons for referral to the program (i.e. what kinds of child or family problems are present to a degree that child placement is imminent?) Actually, the placement risk may be on a continuum from today to never. Any more than seven days until projected out-of-home placement may be a sign that placement is not immediate. Current child and family functioning should be carefully described, including family strengths and resources. These are important dimensions for comparing program models in relation to differential outcomes. For example, specifying client demographics and problems allows program analysts to determine which program models are most effective with certain types of children or families. Currently, it is difficult to compare many of the IFPS or FBS outcome studies because these dimensions are not specified. Some research studies equate office-based and home-based programs when the clients differ significantly on a number of important demographic characteristics.

Client Referral Sources and Screening Procedures

Who are the program staff and agencies that most frequently refer clients for IFPS and FBS services? What procedures must workers or agencies follow to refer clients to the program unit? For example, in Utah child welfare and allied professional workers complete an IFPS referral form that requests certain client demographic and problem situation data. The referral is then processed by the IFPS unit supervisor using the form and a brief interview with the referring worker. In Washington, referrals are telephoned directly to an intake coordinator in each office.

How are cases screened for acceptance into the FBS unit? For example, does the intake person, FBS supervisor, a placement screening committee, or the juvenile court screen cases? What written criteria or guidelines exist for screening referrals? In some states, a placement screening committee comprising child welfare, juvenile court, FBS and other staff members reviews cases. The program model should also specify under what conditions clients may be re-accepted into the program. For example, how much time must pass before clients are eligible for readmission (if at all)? Program acceptance criteria are typically among the most poorly specified components of most FBS programs. This is due, in part, to the difficulty of clearly specifying levels of client functioning and the lack of a clear definition of "risk of imminent placement" (Feldman, 1990a; Tracy, 1991).

In response to this issue, a recent California evaluation project tried to distinguish between how and where in the case-handling process the decision to place is being made (Yuan et al. 1990). In New Jersey, special placement screening committees are being used (Feldman, 1990b). For cases where child maltreatment is the presenting problem, a risk-assessment system and decision-making criteria developed by ACTION for Child Protection, the National Council on Crime and Delinquency, or others may be useful as these are tested and refined (Note 2). For other types of cases, such as emotionally disturbed adolescents or chronic runaways, new decision-making models need to be developed and tested.

A major part of the problem in case screening lies with the lack of valid risk-assessment systems for assisting staff members in judging which families have a high risk of future serious child maltreatment and other problems that place children at imminent risk of placement (Pecora, 1991; Wald & Woolverton, 1990). These systems would be helpful for improving the reliability and validity of worker judgment (Stein & Rzepnicki, 1984). In addition, what complicates the screening process is that placement decision-making is a process shaped by ecological factors that are not related to family conditions. These include:

- Juvenile court judge attitudes
- Worker training and caseload size
- Availability of community resources
- Availability of placement resources
- Recent media stories about child abuse-related injuries
- Worker and agency emphasis on considering family strengths and resources
- Use of sound risk-assessment approaches and placement criteria in a culturally sensitive manner
- Community standards and current placement incidence (Pecora, 1990).

A Special Note on the Strategic Importance of "Imminent Placement"

Practical problems aside for the moment, it is crucial from a public policy vantage point to target for special services those children who would be placed in foster care and other forms of out-of-home care in any child and family-serving public agency. Tremendous amounts of program funds are expended upon these children. If a reliable and safe alternative to placement could keep a large number of these children at home, then significant costs to the public might be reduced. But it is essential from this strategic perspective that a service program with this focus work only with those children who will be going into placement within a **short** period of time (e.g., one week). Some experts have argued that at this stage of program development, FBS programs should reduce child placements by isolating and serving only the highest risk children if we are to obtain the greatest benefit from the use of these services.

Thus, serving families at risk of imminent placement is a politically important goal that may be difficult to operationalize in practice. Recent controlled studies suggest that it is easy to underestimate the difficulty of implementing valid case screening and referral criteria. Criteria that are highly correlated with immediate placement (and these may vary with local conditions) should be carefully examined for use as part of a cautious approach to risk assessment.

Intervention Models And Services

In planning, adopting, or comparing the service interventions that will address the type of clients served, staff members are making choices among a

number of important program components. Dimensions helpful for describing the intervention model and services are discussed in these next sections.

Primary Treatment Theories, Case Goals and Clinical Services

What treatment theories and models are used to design intervention strategies? For example, many programs use a social learning approach that emphasizes teaching skills to clients in such areas as communication, child discipline, or household management. The HOMEBUILDERS program is based upon Rogerian, cognitive-behavioral, crisis intervention, and ecological theories, with the family and its social support system viewed as the focus of service. An emphasis is placed upon promoting client independence and psycho-social skill-building. HOMEBUILDERS therapists use a variety of clinical methods, including parenting training, active listening, contracting, values clarification, cognitive-behavioral strategies, and problem management techniques (Kinney, Haapala, & Booth, 1991).

Programs being developed in Arkansas, Ohio, and other areas are emphasizing a family systems perspective that may employ the use of genograms or ecomaps for family assessment. Other programs are using primarily strategic or structural family therapy techniques. While some similarity may exist across many of these treatment theories, the intervention model(s) and clinical services or techniques should be clearly specified. Program analysts should be able to describe the most common treatment goals established by workers and the families because these goals help identify the focus of the therapist's efforts.

In addition, one should be able to see actual behavioral demonstrations by workers indicating the clinical techniques espoused by the FBS program. Many FBS workers help families "reframe" situations in more positive, non-blaming ways. Other workers use Functional Family Therapy techniques to help parents attain "closeness" with children, and to help adolescents gain "distance" or independence in healthy ways (Alexander & Parsons, 1982; Lantz, 1985). In many programs, assertion, conflict management, child discipline, and other skills are taught (see AuClaire & Schwartz, 1986; Fraser et al. in press; Nelson et al. 1988).

Strategically, it makes sense to utilize those approaches that have the strongest empirical support for their efficacy. In general, research support for various HBS and IFPS programs is limited due to the lack of research funding and the recent development of these service models. However, the success of certain theory-based interventions in other contexts may be sufficient to justify the use of these interventions in a more natural family-based setting. The field should be emphasizing the use of the empirically-based methods that have shown the greatest potential for facilitating client behavior change.

Concrete Services

A variety of "concrete services" such as housecleaning, transportation, and shopping may be provided by some FBS workers. Other community resources that provide families with food stamps, medical care, day care and employment training may be coordinated by the worker as well. It is important to know who is providing the concrete services (therapist, case aide, other staff person) because staffing patterns affect the nature of the worker-family relationship, may alter treatment effectiveness, and have cost implications. For example, during the initial period of a Hennepin County project, concrete services were delivered by people other than the primary therapist teams (AuClaire & Schwartz, 1986).

In some FBS programs, concrete services are not emphasized as an intervention method. Yet, transportation, employment, recreation, house cleaning, and other services are widely recognized in the child welfare field as ancillary services that support working effectively with multi-problem families (e.g., Kaplan, 1986; Levine 1964; Polansky, Chalmers, Buttenweiser, & Williams, 1981). Only a few studies, however, have examined the effects of concrete services within the context of home-based services. Bryce (1982, as cited in Frankel, 1988, p. 150) found clients rated the provision of practical help (i.e. concrete services), providing services in the home, and therapist availability through flexible hours, as more helpful than the use of specific therapeutic techniques (teaching communication skills, help with expressing feelings, help with understanding behavior). The PACT program also reported provision of concrete services as essential for treatment effectiveness (Van Meter, 1986, pp. 80-81).

Studies of the HOMEBUILDERS program using multivariate analyses also found that child and mother reports of therapist offering or provision of concrete services were important for successful outcomes (Haapala, 1983). Fraser et al. (1991) found that teaching clients to meet their own concrete service needs was correlated with children avoiding out-of-home placement.

All of these studies underscore the importance of concrete services for effective treatment. And this service component is one of those that distinguishes some FBS programs from office-based family therapy programs where clinical treatment is the dominant or only mode of service. IFPS programs use concrete services as a tactic in four-pronged approach to: 1) address basic human needs, 2) teach clients the methods necessary to obtain basic necessities which will most likely foster greater independence, 3) establish rapport with a family through active involvement in the problems of concern to the client family, and 4) provide an ecologically based assessment of critical needs and a plan to address them (Haapala, 1983).

Response Time and Staff Availability

Depending upon the purpose of the program, the FBS unit's ability to process and respond to referrals within a certain time period is important. How much time elapses between the referral of a case to the unit and assignment of the case to a FBS worker? A related question focuses on how much time elapses between the assignment of a case to the worker and worker contact with the family by telephone or in-person. Quick worker response and availability is crucial to maintaining child safety, and these dimensions are central to the program design from a perspective of crisis theory. This theory posits that individuals and families are most amenable to change while they are in a state of crisis and when "normal" coping mechanisms for dysfunctional situations are not working (see, for example, Smith, 1986). According to this theory, programs should be less successful if case assignment or response requires a substantial amount of time. While this causal relationship has not yet been firmly established by research (see Barth, 1990), case response time is an important variable to be considered because of child protection concerns. From a policy perspective it is imperative that FBS programs provide immediate contact with many families at high risk for violence so that children may be allowed to remain at home without putting them at too high of a risk of maltreatment.

Related to this is the issue of client accessibility to staff members. More specifically, how are client telephone calls handled during evenings or on weekends? Some therapists carry pagers during periods when they are on call. Other programs use an answering service or a back-up worker strategy. While many FBS workers work evenings and some weekends, on-call coverage provided by another worker and backed by a supervisor is often arranged. This is often not as much of a problem with the more intensive IFPS models; clients are less likely to call at night or on weekends because the worker will be seeing them shortly and because the therapist may have taught them skills for avoiding or handling conflict situations (Kinney et al. 1991).

The issues of response time and worker availability underscore the importance of monitoring how much therapist contact clients receive during the first one or two weeks of service. Client contact data are important for determining the "intensity" of the services, particularly during the initial crisis period. In addition, total in-person and phone contact is useful for assessing the overall intensity of the service. Ideally, programs should track the amount of in-person, phone and collateral contact that clients receive from workers. These data enable IFPS programs in California, New Jersey, Michigan and Washington to document that their clients receive the face-to-face equivalent of nearly 3/4 of a year's worth of traditional weekly outpatient mental health treatment in four

weeks because of the intensity of the program. IFPS programs therefore, may provide the greatest monitoring for safety-oriented services in terms of the continuum of out-patient and home-based services. Low caseloads and a high level of client face-to-face and phone contact decrease the likelihood of further abuse or violence.

Program Structure

The following program dimensions relate primarily to the staffing and other organizational design aspects of a FBS program. These components to a great degree are structured by the type of clients served and the nature of the treatment model. But the program structure must complement the intervention models being used, or effective service delivery will be hindered or prevented.

Staff Qualifications

What therapist educational degrees, training, experience, skills, or attitudes are required for effective FBS practice? Some state-wide initiatives are hiring workers with bachelor's degrees (e.g., Michigan). Other states use primarily workers with graduate training (e.g., California, Washington). Many administrators and clinicians believe that not only is worker skill in a variety of treatment modalities essential for treatment success; but they believe that workers must have an attitude of genuine concern, optimism, and respect for the clients. For example, nonjudgmental attitudes and the formation of close supportive relationships with families are emphasized as important by many FBS agencies. Specifying what worker skills and attitudes are associated with effective practice is difficult because of a lack of empirical studies of IFPS or FBS programs focusing on therapist characteristics, but this information is essential for program replication and comparison.

Staffing Patterns

How are programs designed with respect to staff deployment? Are individual caseworkers, professional teams, paraprofessional-professional teams, paraprofessional aides or "trackers" used to deliver services? How often is co-therapy or multi-staff therapy, such as Multiple Impact Therapy, used? For example, the HOMEBUILDERS staff occasionally will use therapist teams to conduct a "multiple impact" or other type of family therapy session. The Hennepin County project used male-female teams of therapists (AuClaire &

Schwartz, 1986). The staffing pattern has important implications for how many clients can be served, family assessment, coordination of treatment, and prevention of worker burnout through mutual support.

One dimension related to staffing is the number of workers per supervisor/unit composition. The worker-to-supervisor ratio determines how much clinical consultation and support can be provided by the supervisor. Unit composition is also important: such as the extent to which the FBS unit also contains other types of child welfare staff, such as child protective services or foster care workers. In public agencies, integration of other program staff into the program units may lessen the isolation of the FBS staff. If, however, the FBS therapists are too widely dispersed, they may lose the collegial and administrative support that enables them to design effective interventions and to maintain demanding work schedules (Pecora, Kinney, Mitchell, & Tolley, 1990).

Costs are a major concern as services on the continuum become more intensive. IFPS programs, in general, may be a less costly service when only one line worker works with a family. In addition, with the IFPS program use of a primary therapist, coordination among worker teams and peer rivalry are less likely to result in wasted time and hard feelings.

Caseload Size and Treatment Duration

How many clients or families does a therapist serve, on average, at one time? Are any of these cases less intensive "follow-up" cases? How often does this caseload size fluctuate? Service intensity is, in part, determined by caseload size and treatment duration. (For example, a caseload size of six families who are served over a 90 day period results in less intensive service than working with two families for 30 days.) Yet roughly the same numbers of clients can be seen in a year's time by each therapist. Thus, caseload size, when combined with treatment duration statistics, can be used to calculate how many cases per year could be handled by a therapist. Annual caseload data often surprise program skeptics as a FBS worker handling two cases every month for 10 months, with a month for vacation time and a combined "month" for sick leave and holidays would serve approximately 20 cases a year, close to the equivalent of a "regular" child welfare caseload.

For program consistency, the length of treatment should be specified. The need for assessment periods or intensive follow-up phases, if any, should be thought through carefully as these may become problematic aspects of the program in terms of case screening or case termination. If implemented, these periods of time should be added or at least identified as related service periods. Is the length of the treatment flexible according to client needs? Programs vary

across the country with respect to these questions; and to some degree, length of treatment should vary with the treatment objectives of the program, types of client problems addressed, the availability of community supports, and the extent to which essential follow-up services are available in the community.

In terms of intensive crisis services, however, in informal research conducted over the past ten years, the HOMEBUILDERS program did not find significant differences in the treatment outcome of the clients served when they varied length of treatment. Yet HOMEBUILDERS therapists in the Bronx sometimes needed an additional 1-2 weeks with some families. So this program has retained a 30-day service period for most sites, with extensions granted in special cases. One of the advantages of such a time-limited approach is that it provides many clients with additional motivation because the service will end in 30 days (with less intensive follow-up services provided in some cases by other community agencies). A time-limited approach also encourages both the client and the therapist to focus their efforts on the most critical family needs. Finally, focused provision of services (if sufficient to meet family needs) will keep program costs down.

Program Outcomes

Criteria for measuring treatment success are essential for monitoring program outcomes, refining treatment strategies, and for comparing programs. Program outcome dimensions will vary by client demographics, treatment philosophy, administrative needs, and other factors. Certain types of outcome criteria and measurement methods should be used, however, if different FBS program models are to be compared. Examples of these criteria are discussed below.

Placement Prevention Measures

One of the most common (and over-emphasized) criteria for success is the percentage of families intact at case termination or at some follow-up point in time (e.g., two, six, or twelve months). Some programs track the placement situations utilized by degree of restrictiveness (e.g., foster home versus group care) and cost. The use of placement prevention as the sole outcome criterion is problematic, especially since many adolescents may experience one or more short placements before stabilizing at home (Rzepnicki, 1987).

One innovative approach used by the Hennepin County Project involves measuring the placement days used by clients divided by the total possible days

that the child could have been in placement (AuClaire and Schwartz 1986). Unfortunately, this measure is relatively insensitive to differences in the duration of placement prevention (e.g., families that do not experience placement for eleven months following treatment are considered statistically equivalent to families that do not experience placement for three months following treatment). Thus the Hennepin County project and other evaluation projects have conducted analyses based on other types of placement data to document program effectiveness.

One major problem with using placement prevention as an absolute measure of success is that child placement may be a positive case outcome according to the child, parents, and/or therapist. Measures of success need to be able to distinguish between those placements that are socially desirable and those that are not. FBS programs need to track why the placement occurred. "Greater attention should be paid to the post-treatment period to understand the dynamics of the family's living situation, interaction with community services, the nature of subsequent crises, and the family's response" (Gershenson, 1990, p. 7). With more information, it would be possible to specify more carefully what situations constitute IFPS treatment failure as opposed to problems in the larger child welfare system or community.

Definitions of what constitutes "placement" and follow-up periods differ among the studies. In addition, some evaluators rely only on one or two assessment methods (e.g., case records, caseworker interviews, agency management information system data) for determining how well a family is functioning and if the child has been placed. Methodological differences among these studies are important because, depending on the length of follow-up and the definition of placement, placement prevention rates will vary widely. The limitations of using only case records and management information systems (MIS) data are serious, as caseworkers are frequently not aware of what happens to children after they have closed or transferred the case.

Agency MIS systems only track publicly funded placements and this is adequate only when avoidance of publicly funded placements is the major criterion for effectiveness. Many state agencies are resisting the "dumping" of clients into their system by private psychiatric programs when the family's insurance coverage has been exhausted. For these agencies avoidance of both private and public placements is important. Finally, child runaway behavior places most children at risk of exploitation or maltreatment, so some programs consider this outcome to be important for assessing treatment effectiveness. Yet after treatment has ended, this is usually determined only by contacting the child's caretakers, so HBS and IFPS researchers need to contact primary caretakers for follow-up data, in addition to monitoring other sources of information.

While cost is a complicated concept to address, efforts to assess cost are crucial, because policymakers frequently make decisions relevant to service programs based upon fiscal considerations. Even though our methods and experience in assessing cost-benefit in family-based services may be primitive, we can not ignore these issues. For example, some studies have documented that the placements that occur during or after provision of IFPS are less restrictive and more short-term compared to control-group cases (e.g., AuClaire & Schwartz, 1986). Dichotomous measures of placement prevention miss these important outcomes, some of which have significant cost savings attached to them.

Child and Family Functioning

Proximal measures of child and family behavior change are fundamental in assessing the efficacy of FBS programs. A major assumption related to cost savings and family safety hinges on the improvement of family interactions, a decrease in violence, and the modification of other dysfunctional behavior patterns.

More specifically, some of the most important outcome criteria involve monitoring the target child's behavior, including school attendance, academic performance, delinquent behavior, cooperation with parents, and substance abuse. Measures of family functioning such as parental discipline, household sanitation, family cohesion, family adaptability, communication skills, or social supports can also be used as outcome indicators. More outcome measures that allow workers to identify child and family strengths or competencies need to be refined and used.

Measuring program outcomes in a valid, reliable manner remains a significant challenge for FBS program staff, in particular, and for the larger field of child welfare. A number of standardized scales and outcome measures, however, are available [Note 3].

One of the challenges is that, unless control-group designs are employed, the changes in assessment scale scores may not reflect the changes that some families and children are making while in the IFPS program, as distinct from the naturally occurring tendency for most families to progress towards a middle range of functioning if they scored in the extremely low or high ranges at intake (i.e. regression to the mean). Other programs have encountered difficulty when they have adopted outcome measures that do not reflect their treatment model or service philosophy. Finally, use of inferential statistics with control groups requires large sample sizes that are difficult to achieve in most agency settings (Gershenson, 1990).

Cost Effectiveness

As has been stressed throughout this chapter, the average cost and cost savings per family served by the FBS program is important data for both administrators and policymakers. Per-client cost is a difficult dimension to measure in that a decision must be made regarding which costs are to be included. For example, therapist and supervisor salary costs are sometimes used to calculate the numerator in a cost-benefit ratio when administrative overhead and the costs of ancillary support services provided by the **community** should be included as well. Some FBS evaluations have documented significant cost savings (see, for example, Kinney et al., this volume; Halper & Jones, 1981). Other benefit-cost analyses have determined that an effective FBS program may cost as much as or more than traditional services (Hayes & Joseph, 1985; Rosenberg, McTate, & Robinson, 1982; Yuan et al. 1990). The benefits of family preservation in terms of the quality of life or prevention of future child dysfunction are often not fully measured in these types of analyses, and improved methods need exploration. Creative approaches that improve upon cost-effectiveness analysis, which describes program costs as well as outcome effects in strictly physical terms, may need to be developed (Armstrong, 1982; Barnett, 1986; Levin, 1985).

In calculating cost savings, agencies need to take into account the costs associated with various types of placement and average length of stay for particular types of cases. With this information, the costs of the projected placement can be compared with follow-up data to calculate the savings resulting from the provision of IFPS or FBS treatment (see, for example, Haugaard, Hokanson, & National Resource Center on Family-Based Services, 1983). While these types of analyses are complex, they are essential for promotion of FBS programs and fiscal planning. Strategically, those forms of family-based services that offer special characteristics that ensure safety or by design keep costs down are most attractive to funding agencies.

Larger System Impact

With the large-scale implementation of IFPS and other types of FBS programs in Illinois, Michigan and other states, the field may be able to identify some of the impacts that these programs will have on the larger child welfare, mental health, and/or juvenile justice systems. If early reports of placement-rate reduction are verified by these large-scale experiments, the investment in IFPS or other types of FBS program technology is likely to be increased substantially.

Summary and Conclusions

In comparing various types of FBS programs, a thorough comparative analysis of the client demographics, services provided, and problem situations is necessary to compare differential program outcomes by type of client and service. Client demographic information, presenting problems, and case goals provide insights into what types of clients each program is serving. Intervention theory and services often distinguish one program from another. While case demographics and intervention characteristics are important, many administrators and legislators are most interested in the last set of dimensions: program outcome and cost-effectiveness data. It is difficult to compare outcome data for many programs because of use of different definitions of placement and non-standardized outcome measures. Control-group studies and similar outcome measures are necessary in order to assess the differential effectiveness of these programs for certain types of clients. In addition, the design and responsiveness of certain types of family-based services are crucial dimensions to be considered as they are assessed in terms of their ability to meet the public demand for child safety and cost effectiveness.

Out-of-home placement continues to serve as a major mechanism to protect children and society in this country. In 1984, more than 275,000 children resided in foster care on any given day (Rosen, Fanshel, & Lutz, 1987) and close to 49,000 were in public security facilities (Bureau of Justice Statistics, 1986). Additional thousands of children were placed in group homes, detention, and private residential facilities. These numbers are increasing at a disturbing rate (Pelton, 1990). Fortunately, while out-of-home placements continue to be a common solution in dealing with severe multi-problem families, there appears to be a growing trend across the nation towards the utilization of IFPS and other forms of FBS programs to work with these difficult family problems. But significant financing shifts to support these programs have not occurred in most states.

On balance, however, the growing popularity of IFPS and other FBS interventions may be advantageous for numerous reasons. The use of some of these programs will likely result in significant cost savings for the taxpayer, and they will stabilize the home lives of many children who might otherwise have been placed in foster or group care. For example, families who have received some types of family-based services avoid placing their children and report less of a need to contact their social service worker for follow-up services. But there is a danger that the value or applicability of FBS treatment methods will be exaggerated or extended to populations for whom these services may not be appropriate. This may be a problem despite the growing use of IFPS technology

in fields of practice other than child welfare (see Leavitt & McGowan, this volume).

The purpose of this chapter has been to identify dimensions useful for comparing various types of FBS programs and to illustrate some key features of IFPS programs that have garnered some empirical support. In comparing services across various FBS programs, information about some of the dimensions may not be available for particular programs. Notwithstanding, using many of these dimensions for comparison may promote collection of data to monitor better the referral and service delivery processes, as well as encourage the use of standardized measures and outcome criteria for program evaluation. If IFPS and other types of FBS programs are to sustain the effects that have catapulted these intervention models into prominence in the fields of child welfare, mental health, and juvenile justice, careful attention must be given to the structural characteristics of services as they are developed in agencies across the nation. These programs are young enough and sufficiently complicated that continued formative and summative evaluations are our best tools for empirically determining program components, supportive services, and other factors that account for successful family treatment.

Reference Notes

[1] For more information regarding the types of family-centered programs and this typology, see Child Welfare League of America (1989); Fraser, Pecora, & Haapala, 1991, this volume; and Kinney, Haapala, & Booth, 1991.

[2] For example, see Baird et al. (1988); Holder and Corey (1986); and Miller, Williams, English, & Olmstead (1987). For further information about the ACTION decision-making model, contact ACTION for Child Protection, 4724 Park Road, Suite C, Charlotte, NC 28209.

[3] For scales and checklists that may be useful for evaluating FBS programs, see Achenbach and Edelbrock (1983); Hudson, Acklin, and Bartosh, 1980; Magura and Moses (1986); Magura, Moses, and Jones (1987); McCroskey & Nelson (1989); McCroskey, Nishimoto, & Subramanian (1991); Milardo (1983); Olsen, Portner, and Lavee (1985). Note that a new version of the FACES IV may be released soon, along with other measures of family functioning.

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UNDERSTANDING INTENSIVE FAMILY PRESERVATION SERVICES IN THE CONTEXT OF THE TOTAL SERVICE CONTINUUM

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Intensive family preservation services (IFPS) are best understood in the context of an overall continuum of child and family helping.* This continuum begins with primary prevention strategies designed to "inoculate" a population against known risk factors that predispose to adverse developmental outcomes and extends all the way to secure placement services for some children, for example, children with severe emotional disturbances. The idea, to paraphrase a social work pioneer, Homer Folks, is to provide the right thing, for the right child (and family) at the right time. All services share the common characteristic of "responsiveness," defined by Peter Bell (1987), President of the Edna Clark Foundation as follows:

> In our experience, social programs that work have a common core of characteristics. They understand, respect and respond to the people being served. Effective programs increase their clients' sense of self-esteem, enlarge their capacities for self-help, connect them with a broader community and deepen their stake in the community. These programs are usually "family-like" in that they are personal and caring. They keep track of their clients; they do not lose them in a bureaucratic maze. Nor do they give up easily on people. They keep coming back at clients out of the conviction that the people they serve matter.

Intensive family preservation services are representative of a major paradigmatic shift in the human services field. The knowledge, value and skill elements of this shift are identified in the present volume in several papers, including those by Maluccio, Krieger and Pine, and Leavitt and McGowan. This present, brief paper will:

(1) Trace the origin of family-focused service as a new paradigm;

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*The initial section of this chapter is abridged from Whittaker, J.K. (1991). The leadership challenge for family based services: Implications for policy, research and practice. Families in Society, in press.

(2) Locate intensive family preservation services in relation to early intervention, family support and placement services;

(3) Identify a framework for critically comparing intensive family preservation services with other services on the continuum; and

(4) Identify practical suggestions for helping students think about intensive family preservation services as a more significant component of an overall continuum of care and helping.

From Child-Centered to Family-Focused Helping

As noted, intensive family preservation services are emblematic of a substantial shift in values and in the services field. This shift may perhaps be illustrated best by contrasting "old" and "new" approaches to family and child helping. Several unmistakable features distinguish each approach. The "old" model, for example, consisted of:

(1) Categorical services (foster care, residential care, in-home) with professional allegiances tied to each and no apparent connections between the parts, i.e., no continuum of care.

(2) A child rescue philosophy. Saving children from the evil influence of "pathogenic" environments, including (often) family, peer groups and neighborhood was a primary aim. Separation through placement services, not surprisingly, was a key element in treatment.

(3) An unswerving faith in a personalistic psychology as the key to diagnosis and treatment. This psychology (Freudian in the main) provided a framework for differential diagnosis, classification and treatment. Judging by emphasis alone, accurate diagnosis was of enormous importance (there seems to have been an unstated conviction that proper diagnosis was 95% of treatment) and clinical intervention was based on one or another variant of "talk" (or play) therapy with the goal of insight and understanding as a necessary requisite for behavior change.

(4) A "hands off," or at least segregated approach to work with families--in particular parents. There were many reasons for this:

some structural, such as the geographic distance between needed services and the family's home; some financial, i.e., a placement economy tends to direct dollars to client child care rather than family work; and some ideological, i.e., if the primary source of child psychopathology lay in disturbed familial relationships, then separation from those relationships could be a key to successful treatment. This "family etiology" hypothesis (Whittaker, 1976) could take on extreme forms, as in the twelve-month prohibition on parental visiting in place at perhaps the most famous residential treatment center for severely disturbed children during the 1950s and 1960s.

Other factors, such as scarcity of resources, affected the development of child and family services, including child mental health services, as well. But I submit that this condition will nearly always be in effect. The point is that these "old" ideas, some from theory and some from the "conventional wisdom of practice," have a great deal to do with how available resources were spent on such services as they were created.

Then, as the novelist Joseph Heller said, Something Happened: a new set of ideas began to emerge--sometimes explosively and with great fanfare (as with "permanency planning"), sometimes more slowly and imperceptibly (as in the gradual accumulation of evidence on the criticality of social and environmental factors as a correlate of successful child and family treatment outcomes) (Tracy & Whittaker, 1987; Dumas & Wahler, 1983)--that offered a series of counterpoints to the old model. These include:

(1) The notion of a service continuum--from preclusive prevention to secure treatment--with expanded capacity for individualized case planning through flexible funding and service eligibility.

(2) The idea of promoting competence and meeting basic developmental needs of children and families in "normalized" settings by teaching practical "life-skills" and providing environmental supports as opposed to uncovering and treating underlying pathology. Evidence of this trend is apparent in the explosion of educational or "life-skills" approaches (Danish & D'Augelli, 1982), the move away from presumptive labeling and towards more developmentally focused, competence-oriented assessment and by the move in many fields towards

"normalization" of both the loci and foci of treatment (Wolfensberger, 1972).

(3) The notion of services, not as "child saving," but as family supportive and family strengthening. The rapid expansion of crisis oriented family support services (Whittaker, Kinney, Tracy, & Booth, 1989), the "family support movement" (Zigler & Black, 1989) and the renewed emphasis on family involvement in child placement services (Jenson & Whittaker, 1987) all offer partial evidence of the strength of this idea.

(4) The re-emergence of a "person-in environment" perspective in theory, empirical research and clinical practice as a foundation for intervention design. Bronfenbrenner's "ecology of human development" (1979), the empirical work of Garbarino and others on the environmental correlates of child maltreatment and the rapid growth of preventive-remedial intervention in mental health designed to enhance social support (Gottlieb, 1988; Biegel, Farkas, Abell, Goodin, & Friedman, 1988) are all indications of what is, essentially, a return to the most traditional of social work paradigms for helping (Tracy & Whittaker, 1987; Brieland, 1987).

As noted, the effects of these ideas continue to be uneven, though their influence (as well as the influence of other facets of what might be thought of as a new paradigm for service design) is clearly evident in current state-of-the-art thinking in family-based services. But one example is the notion of "ecological validity," i.e., that understanding of the psycho-social environment as experienced by the client ought to inform practice and research underpins much of the current emphasis on identification of culturally and socially relevant services to meet the special needs of ethnic/minority children and their families. Full understanding of this new value/theory base--What it encapsulates and what it replaces--is, I submit, a necessary requisite for understanding the design characteristics and components of an integrated responsive service system. How well we communicate these "new ideas," which include values and philosophy as well as human behavior theory and research, constitutes a formidable initial challenge to social work educators.

Early Intervention, Family Support and Placement Services in Relation to Intensive Family Preservation Services Programs

Intensive family preservation services programs share much in common with early intervention programs and family support programs (Kagan, Powell, Weissbourd, & Zigler, 1987; Lazar & Darlington, 1982). This is particularly true in the assumptions underlying intervention. For example, the Family Resource Coalition, a national association of family support programs, identifies the following as "defining assumptions":

- Parenting is not completely instinctive.
- Parenting is a tough and demanding job.
- Parents desire and try to do the best for their children.
- Parents want and need support, information and reinforcement in the parenting role.
- Parents are also people with their own needs as adults.
- Programs should focus on and work with family strengths, not deficits.
- Programs should empower families, not create dependence on professionals.

Heather Weiss, a leading spokesperson for family support program evaluation, suggests that these assumptions reflect a subtle but powerful change in the relationship between parents and professionals. Parents are no longer seen as "empty vessels" ready to be filled with knowledge about child development; nor is the professional to be the dominant authority, but instead a partner seeking to enhance child and family development (Programs to Strengthen Families, 1983).

Definitional problems plague the family support movement, since at some level any program that touches the lives of families could be construed as family supportive. More typically, family support is thought to include preventive service programs such as:

Prenatal and infant development
Child abuse and neglect prevention
Early childhood education
Parent education and support
Home, school and community linkages
Families with special needs
Neighborhood-based, mutual help and informal support
Family-oriented day care

Many such programs trace their origins to parent education efforts early in the 20th century and to more recent initiatives stimulated by the War on Poverty in the 1960s. Most stress an ecological and competency oriented approach to practice, as described by Maluccio in this volume and elsewhere; and many make a concerted attempt to involve informal helpers as well as professionals in service provision. Points of contrast with IFPS programs may include client eligibility (particularly with respect to imminent risk of placement), duration of service, intensity, locus and success criteria. Points of fruitful collaboration include development of common evaluation technology and transfer of promising intervention strategies. The framework for program analysis described later in this paper will be useful for comparing and contrasting specific program examples of family support and intensive family preservation services models.

The relationship between IFPS programs and placement services has, to a degree, been characterized by polarization. The abuses and excessive costs associated with out-of-home placement have often provided a foil or counterpoint to family preservation efforts. Sometimes lost in the debate was the important distinction made in PL 96-272 and elsewhere between "placement," per se, and the avoidance of unnecessary placement. Recent thinking has focused more on the development of a variety of placement options, including long- and short-term planned foster care, therapeutic foster care and community-based group-home treatment and a range of guardianship options as necessary, but not sufficient elements in an overall continuum of care and treatment (Barth & Berry, 1987). Intensive family preservation services have much to offer placement services and vice versa. For example, the defining characteristics of IFPS programs, as described in this volume and elsewhere, should constitute a threshold intake criterion for placement, i.e., were preventive services of a sufficient intensity and duration offered to families in a timely manner to forestall placement?

For those youngsters headed into placement, the technology of IFPS intervention contains useful strategies for maintaining contact and continuity with the family and preparing for successful reunification. The lessons learned in nearly 20 years of IFPS work can provide useful models for reunification, family involvement, aftercare, parent education and family treatment programs for children in placement. Similarly, as argued earlier, there exists a wealth of useful technology among therapeutic care staff and foster parents--on behavior management, structuring routines, planning activities and managing self-care--which, properly communicated, could be enormously helpful to parents struggling to manage a difficult child while dealing with a host of other difficulties. As yet, there are no clearly identified pathways by which such information can readily be transferred from placement services to in-home preventive services. One useful vehicle for exploring such potential transfers is to

encourage student assignments that compare and contrast innovative models of service from a number of different points along the continuum. This approach has the virtue of exposing students to exemplary "whole cloth" models which may be very different in their client selection, intervention, organization evaluation components. Moreover, it is a corrective to the trend in clinical social work education to separate the technologies of intervention and evaluation from their organizational requisites. One framework that has proved useful for organizing such a comparative seminar is adapted from Whittaker and Tracy (1989). For each model of service, the following questions are asked:

(1) Value base. What core values underpin the interventions? How are these manifest in policy and procedure? Are there fundamental assumptions about human behavior? Are these consistent with intervention strategies and organizational behavior?

(2) Client selection. What are the threshold criteria for exclusion/ inclusion? To what extent does the program control intake? How diverse is the client mix with respect to race, gender and ethnicity? Is there evidence of "creaming"?

(3) Cultural sensitivity. To what extent does the intervention manifest ethnically and culturally sensitive practice? What percentage of staff are minority? Are training opportunities available to enhance ethnically competent practice? How are "typical" families described?

(4) Training. What is the duration, focus and quality of the training? Is there pre-service training? Is it criterion based and skill focused or primarily based on cognitive understanding and participation? What is the empirical base of the training and is it in any way tied to on-going evaluation and career advancement?

(5) Purpose. To what end is this helping approach designed--behavior change, insight, alteration of the client's self-image, moral conversion, adjustment, other?

(6) Knowledge base. From what theories, empirical research, or other sources does this approach draw--psychoanalytic theory, social learning theory, existential philosophy, communications theory, ecological theory, other?

(7) Setting. Where is this service typically practiced--clinic or hospital, social agency, correctional facility, school, residential treatment center, the client's own home, community center, other?

(8) Composition. Who are the *dramatis personae* in the treatment encounter--client, worker, client's family, spouse, peer group, relevant others? How is the composition decided--by the client, by the worker, by client and worker, by the agency, other?

(9) Role of therapist or worker. What part does the worker play in the treatment encounter--counselor, therapist, teacher, behavior monitor, discussion leader, other? What are the requisite skills necessary to carry out this role--verbal, listening, group discussion, group activities, other? To what extent is working with and through the environment part of the helping approach? Are informal support systems utilized?

(10) Role of client. What part does the client play in the treatment encounter--active participant, co-director of treatment, student-learner, group member, other? What are the requisite client skills: cognitive, behavioral, affective?

(11) Strategies and techniques of helping. What actually occurs in the treatment encounter: confrontation, clarification, teaching, role playing and simulation, group discussion, values clarification, behavior shaping, mystical experience, other?

(12) Indications. With whom does this helping approach appear to work best--married couples, adolescents, children, developmentally disabled, acting-out delinquents, depressed clients, clients with limited verbal skills, whole families, psychotic clients, others?

(13) Contraindications. Under what circumstances and for what type of client is this helping approach inappropriate or ineffective: e.g., How relevant for various ethnic minority groups? For sexual minorities?

(14) Empirical validation. To that extent has this approach been rigorously tested in experimental field studies or in single case

designs? Were significant results achieved? What are the implications of this research for the individual practitioner?

(15) Implementation. What special forms of training or professional education are required by the method? Does the helping approach make special demands on the organizational (agency) environment? Are requirements for data keeping simple or complex? How costly is the intervention compared to others? Are aspects of the intervention controversial and likely to evoke community response?

Some of these questions are easily answered from program reports and brochures. Others will require much more extensive searching and some may be unanswerable. At the University of Washington, we have found this and similar analyses useful in teasing out key distinctions between different approaches to "family based" practice and between disparate models of intervention that occupy different points on the service continuum.

Final Suggestions

1. Encourage thinking about the total service continuum. Perhaps one of the best ways of exploring the potential as well as the limits of intensive family preservation services is to stimulate students to think about the initial design and re-focusing of an entire spectrum of services for families and children: what relative emphases on placement vs. in-home services? What guiding assumptions? What fiscal incentives? What stimuli for innovation? What knowledge base and state of maturity for practice technology? What impediments to change?

2. Encourage "blank slate" analyses. An idea closely related to the above, is to stimulate discussion about novel solutions, including "non-service" solutions, to the complex problems families and children face. A recent *New York Times* article by the noted pediatrician T. Barry Brazleton offers excellent examples of the interplay between social and medical service strategies and other forms of needed assistance for meeting the needs of children of drug involved and homeless parents. The policy development model developed at the Bush Center for Child and Family Policy at the University of North Carolina, Chapel Hill offers a useful framework for organizing such an exercise--highlighting costs/benefits and differential value bases (Haskins & Gallagher, 1981). A fundamental issue here

involves helping students tease out the limits and potential for service and income strategies in addressing various problems in family preservation and child protection.

3. Identify multiple indicators of success. For various services on the continuum--intensive family preservation, therapeutic foster care, parent outreach programs, for example--what are basic indicators of success? How are they best measured? In what ways would these services need to change in order to accommodate additional goals? Is there a "statute of limitations" on services, i.e., a reasonable period after which we no longer credit them with success or hold them accountable for "failures"? Helping students see the effects of altering success criteria within a service area--like intensive family preservation services--can help students to appreciate the conflicts between basic values and identify the incremental costs to policy implementation as goals are made more complex.

4. Understand service integrity and quality assurance. Students will benefit from understanding what, for any given service on the continuum, are hallmarks of exemplary practice: are these solely value derived or do they have an empirical base as well? Given their salience as necessary elements in a service design, what supportive mechanisms--training, administrative review, citizen review--are needed to insure the integrity of the service in an individual case? What are the threats to service integrity and how can we maintain intensity? How can services become "watered down"? At the level of the service system, how is exemplary practice preserved as programs extend to a region, state or the entire country? What can we reasonably expect from promising pilot programs, for example? How is organizational maturity assessed in terms of a program's readiness for broad dissemination? Such exercises will aid students in making the distinction between design and development issues in promising new programs and insuring that clients have access to the most effective service options at any particular point in time.

5. Avoid polarization between services and look for the potential negatives in currently fashionable reform agendas. Kahn's point about one generation's "solution" becoming the "problem" in the next bears repeating. Rather than seeing "placement" as the enemy, how can students be helped to see the logic and rationale that advanced foster care as a solution to child dependence in the first place? What were the assumptions? The valuational and evidentiary base? The expectations? What, ultimately,

went wrong? One sensitizing exercise is to take a current reform goal--the elimination of juvenile institutions in favor of community-based alternatives--and ask what vaccine will immunize the new service organizations against the same disease processes that infected the old: better trained professionals? Clearer values? Better review processes? The following quote from Robert Maynard Hutchins, late president of the University of Chicago and leader in the juvenile reform movement in the first quarter of this century, will perhaps give pause to some who believe that they who espouse the current reform position occupy, as it were, a pinnacle of moral high ground:

> When I graduated from law school some fifty years ago, the aspiring liberals among us thought we knew what was the trouble with the law. It was too narrow and too formalistic: from Pleading, Evidence, and Criminal Law to the new subjects like Administrative Law and Trade Regulation, we hailed those developments which emphasized the differences in "fact situations," which required the interposition of the social sciences, and which sought to temper the wind to the shorn lamb by the exercise of discretion.
>
> In those far-off days the word *bureaucracy* was never heard; perhaps it had not been invented. The liberal hope was in the agents and agencies of government. The juvenile court, then only twenty-five years old, reflected the responsibility of the state as *parens patriae*, which could rescue children from the law, and from those agents of government whom we did not trust, like policemen, prosecutors, judges in criminal courts, and wardens of jails and penitentiaries. It could even rescue children from their parents. To us the juvenile court, with which few of us had any experience, looked like the fulfillment of our dreams. It had come into existence through the efforts of persons whose ideals we shared. It was packed with discretion from stem to stern. It relied on social workers. It aimed at "saving the child," not punishing him. If it had not existed, we would have tried to invent it...how wrong we were. (1976, p. VII)

In sum, intensive family preservation services are best understood in the context of an overall service continuum for children and families. At any particular point on the continuum and between different services (like placement and in-home options), it is useful to compare and contrast diverse approaches by asking a set of common questions. Finally, it is helpful for students to see our present reform agenda in some measure of cultural and historical context--not for the purpose of forestalling change, but for the purpose of better predicting its consequences.

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MOVING CHILD FOCUSED RESIDENTIAL PROGRAMS TO FAMILY-BASED SERVICES

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Since the advent of the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272), public policy has favored and funded more family-focused programs that use brief but intensive services to strengthen child and parent functioning. As a consequence of this policy shift, directors of "privately funded" residential treatment programs for children have experienced increased pressure to shift from child and adolescent centered practice to a practice that is more family based and pays more attention to the community environment to which children will return. Consequently, managers of social service agencies are struggling to change the context and form of agency practice. This paper will explore the managerial practice principles involved in effecting such a shift in program emphasis.

Although the focus of this paper is on managers of residential programs, the exploration has expanded importance because it identifies knowledge and skills that are useful to managers who are involved in moving social service agencies towards family-based services, home-based family services or intensive family preservation services. Therefore, the knowledge and skills that are essential to program development or agency change must be part of the discussion to disseminate intensive family preservation services (IFPS).

Changing Program Emphases in Residential Treatment and Group Care

There are a number of "drivers" beyond the aforementioned policy shift that has caused the directors of more traditional residential programs to move towards family-based services. An examination of practice research that evaluated the long-term community adjustment of youngsters who completed residential care pointed to three factors that were associated with positive outcomes: (1) continued connection with family and community while in residential care, (2) continued work with the family and child after the child leaves the residential facility, and (3) social skills teaching with parents and child. Research that

examines the conditions of the families who have children in care points to the necessity of helping families build positive social supports if they and the children are to survive together (Jenson & Whittaker, 1987: Whittaker, Overstreet, Grasso, Tripodi, & Boylan, 1988). The children who come into care are most difficult to live with and each child's personal condition has large elements of chronicity.

The parents of difficult children require help and support. If they are not provided with appropriate resources, their children often place an unmanageable burden on the families who are contracted to care for them. Traditional residential practitioners have always known that the best child-focused work often was unsuccessful when biological parents, extended family members, and foster or adoptive parents struggled to raise their program graduates with insufficient support. Furthermore, parents were frequently blamed for the failures. Research has shown that attention given to birth families at the outset can maximize treatment success after residential care.

In conversations with directors who are currently involved in changing their agencies, we asked them "Why are you changing your agency to be more family focused?" Another factor emerged: the desire for their programs to be among the best and an unwillingness to be associated with program that did not make sense. They stated that this factor provided the primary motivation to direct programs of which they were proud. As one director stated, "I'm not going to be associated with a crummy program." To be "amongst the best" demanded that agency practice reflect what is known to be the best practice.

Thus, directors of "privately funded," traditional and residential child-focused agencies are confronted with two related challenges: shifting to family-focused or family-based practice while diversifying and strengthening their sources of program funding. The two challenges are created by a shift in program funding and a rethinking of what constitutes good practice. Although the two are related, this issues paper will focus on identifying and managing nine issues involved in shifting a program to a new practice model, in this case, family-based or IFPS services.

General Factors and Concerns

What are some general factors or concerns that must be addressed before the change-oriented director enters the program modification process? We have identified five factors that we believe warrant careful thought before the director really moves down the path of change. The first is agency tradition and culture. This factor relates to how long the agency has been around, any prior history of change and what happened, how long the practice-to-be-changed has been in place, the "sunk costs" associated with the program, the number of adherents

affiliated with the practice, and where the internal support for change originates (Patti, 1974).

The second factor is tolerance for conflict. How much can the director stand? How much can the staff stand, and how much will the Board tolerate? The third is the issue of access and pathways. Simply stated, "Who has access to whom and for what?" Which staff have access to which Board members? Which community supporters of what staff factions have important political connections and which staff have what connections with each other? The fourth is the necessity of conducting a thorough analysis of the formal and informal communication patterns inside the agency. The directors we spoke with emphasized the importance of understanding and utilizing existing communication patterns to guide the change process, whether that guidance was provided through a rigorous formal planned change process or the dropping of a pointed verbal message at a staff meeting or as part of a conversation with a key staff member.

The fifth and last factor is to understand and counteract the tendency of human service practitioners to be short term and "ought-to" rather than persevering, organized, ethical and pragmatic change agents. This involves articulating a clear rationale for the change and identifying staff supports and rewards for program refinement. An examination of these five factors will provide the director with ideas related to choosing tactics and anticipating the pace of change.

Choosing a sound strategy is not sufficient. The director must desire change because a different practice makes sense and recognize that change requires a long-term commitment. The experience of the authors is that at least five years of stressful work is required to alter the practice of settled residential focused agencies in order to implement a major shift in treatment technology.

Administrator Personality Traits as a Factor in the Change Process

Does the personality of the director make a difference in the selection of the tools for change? We believe that the answer to this question is a decided "Yes." In a recent review of the practice of two directors it was clear that their selection of change strategies was idiosyncratic, in that the choice of strategy flowed from certain personality characteristics. The first person was patient and cautious. He assumed responsibility for details, had limited tolerance for conflict, and was a guarded risk taker. The second was impatient and "action-oriented." He delegated responsibility for details, relished conflict and lauded risk-taking. The first selected a planned change process and obtained initial guidance through an external consultant. The work was carefully managed by the director but

involved staff and Board in an orderly fashion. The initial effort in this case involved refining the five-year corporate goals and objectives. The second director defined his vision for staff and Board, clarified that vision through external consultants, hired an associate director to manage the change process, issued program proclamations and assertively pushed for change.

Neither director used much of the other's tactics. It is interesting to note that both lost many staff during their change efforts. The "cautious" director lost staff primarily due to resignations and certain program unit eliminations. The "action-oriented" director lost staff through resignations and firings. It also is interesting to note that the pace of change in both agencies has been about the same.

Board Support

How important is it to involve and receive support directly from the agency's Board of Directors in the change process? Board support is critical to successful change efforts. If you lose either board involvement or support, the director is at an immediate risk of having to look for a new job. Involvement and support from the Board are central to successful program change. Again, it was interesting to discuss this issue with the two directors. There were similarities and differences in their approaches to this issue.

When hired, both were clear with their boards about their goals to refine agency practice to make it more family focused. Both continually invested considerable energy in educating their Boards about the differences between "good" practice and current agency practice, and both worked to keep their respective boards abreast of change activities and consequences. The "cautious" director further cemented Board support by facilitating Board members' strategic involvement in ongoing goal setting and in selected agency operations. In contrast, the "action-oriented" director focused on expanding and solidifying diversified and discretionary funding as the key to Board backing.

The authors are familiar with several recent situations where directors lost their jobs as part of a program change process. The primary factors associated with their terminations were misjudging the tolerance of the Board for conflict, aggrieved staff and others having immediate access to Board members without prompt opportunities for the director and key staff to present their cases, and not enough Board involvement in goal setting and change.

Supportive Management Structure is Essential

During the change process, the agency must have a management structure that provides support for the director's change activities. How can such a structure be developed? It is imperative that the director obtain respect and support from key management personnel, particularly when the change activities of the director are creating a lot of discomfort for agency staff. The organizational change process can be isolating as well as stressful; the core management staff must be cohesive and willing to provide support to each other.

When using the word "support," we are referring to personal and programmatic activities. Outside consultants must provide support or be terminated. If key management staff are not supportive of the proposed changes the process is hampered from the beginning. One of the directors interviewed told us that he will not begin change activities until he has key managers who like and support him. The other reported that he was "stalled" until he replaced a key manager.

In examining management structures, at least seven areas require scrutiny. First, the personnel policies and procedures of the agency require attention. Which practice forms do they support? How is practice defined? How are people hired, promoted or fired in relationship to those definitions? Second, which key management staff can be relied upon and for what? What are their respective power bases? Where is current liking and support for the director? Who is educable and who will have to change or leave?

Third, assuming that management roles are currently structured to support existing practice, what restructuring will be necessary to change the practice form? For example, if the primary role of social workers in the residential units is to provide individual treatment to children and supervision to child care workers, and if the supervision of those social workers is provided through an outpatient department that places high value on individual therapy, it would be difficult to change the practice behaviors of those workers to emphasize more work with the children and their families in the home and community settings. Different definitions of practice and organizational arrangements would need to be developed. Because the primary clinical role would be redefined to emphasize work with families, a different supervisory or support structure would need to be developed.

Fourth, what are the current patterns of supervision, training and consultation? Who is teaching and reinforcing what and with whom? If the patterns do not fit with the change goals, shifts will need to be made. Fifth, management information systems should be designed to support specific forms of practice (Bronson, Pelz, & Trzcinski, 1988; Caputo, 1988). In examining the MIS

system, does the information being provided support current practice? If not, what changes are needed and how will the changes be made? Sixth, it is imperative that the director monitor all employment decisions while change is in process. Each decision regarding the hiring or promotion of a staff person is critical. Either all employment decisions go through the director or they are delegated to key managers where respect and support are ensured. Finally, the director needs outside support. As agency changes are discussed and implemented, agency life is characterized by conflict. The director is under constant stress and there is a tendency to become caught up in the battle of the moment. Personal and professional supports are necessary. The supports may be personal friends, key consultants, mentors, and/or an external management support group. In any case, the supports have to be identified and utilized.

We cannot overemphasize the importance of attending to managers or staff members who like, respect and provide professional support to the director. It is common practice to attend disproportionately to those who provide neither. Directors tend to focus on those who initially resist or continue to resist change, a focus that results in souring the mental health of the director and his/her critical supporters. Attending to supporters requires focused attention and suggests activities such as supportive memos, dropping by to talk, pulling staff members together for lunch, making rewarding speaking assignments, and advocating for salary increases for those implementing innovative practice strategies.

Encouraging the Adoption of New Practice Technology

How does the director help the staff to practice in new ways, reinforce risk taking and reduce staff anxiety, indifference and hard resistance? This is the core of the organizational change: changing the practice behaviors of staff and what is done with clients. After family-focused agency goals are in place and the management structure is largely supportive, staff have to be assisted to change how they practice. Staff will not change unless the management structure provides leadership. It also is recognized that this is not a linear process; all management staff will not be supportive at one time or another, and staff will support and resist.

The aforementioned "cautious" director tried to involve staff in goal setting and in determining the "outline" of new practice forms. The "action-oriented" director told them where he was heading and what form he expected agency practice to take. Both made extensive use of staff training after new practice technology and change goals were defined.

Before training occurs, it is important that the director or key managers answer a number of questions so that training can be targeted and the practice outcomes monitored. For example, what is the substance of the practice that must change if the agency is to move to family-focused practice? Who has formal or organizational control and with whom and what is the practice substance of that control? Specifically, who are the key first-level supervisors who must provide clinical guidance, supervision and follow-through if the new approach is to be used successfully? Either the controlling persons or the practice definitions must change.

In addition, it is important to consider who has informal or personal power with whom, and what practice forms are reinforced by that power. Once again, which staff are to be targeted for new practice learning and monitoring? Similarly, what mentor networks exist inside and outside the agency? Who are the key staff, consultants or associations that can be influenced by the director? Is there an internal agency "guru"? Is there a highly popular consultant? Is there a professional association or an educational setting which can be influenced? Associations of child care workers and schools of social work might become allies. What will be the strategy for influencing the change process?

Finally, the practice behaviors and nomenclature being reinforced by existing job descriptions and the structural relationships between them must be modified. The role of social workers and existing supervisory patterns are codified in agency job descriptions. When practice is redefined, job descriptions must be rewritten, supervisory relationships are altered and program components are renamed. Child-centered practice becomes family based, social workers work with families instead of exclusively with individual children, outpatient programs for residential treatment institutions are called family services, and line staff and supervisors are retrained. Program descriptions also must be rewritten and Board personnel committees must be involved in the rewriting.

Again, it is critical to attend to staff who are making changes in how they practice and staff who are excited about change. Too often, managers overly attend to those who are saying "No," with the attendant reinforcement of the wrong practice behaviors and the souring of the manager's mental health. Attending to staff who are making shifts requires focused attention because these staff may not demand attention. Such attending involves activities such as public praise, written and verbal "Thank you's," positive informal communications, and the assignment of important tasks, promotions and salary increases.

Dealing With Entrenched Resistance

In terms of the bottom line, if managers or staff continue to quarrel about change, what is the director to do? This issue is difficult for human service practitioners to confront as our professional training typically does not prepare us to handle conflict (Coser, 1956; Fisher & Ury, 1983). We suggest that a difficult issue can be made more manageable by attending to the following five factors.

First, the director is not making program shifts for the sake of making shifts. There should be a clear rationale that is based on providing the best known service to clients; this is an ethical and empirical matter. The director must be absolutely clear about this rationale. Second, the performance of staff and managers must be evaluated against clear performance standards. The practice behaviors required by new services must be clear and codified. Required practice behaviors must be behaviorally specific and stated in job descriptions. Third, staff who are having difficulty making the necessary changes require assistance. If the difficulty is a function of not knowing how to do something, then training is needed. If training is provided, then a strategy for monitoring and evaluating changes in staff practice performance must be implemented. If the difficulty is a function of being unable to practice in the required fashion or refusing to do so, then that staff person must be assisted to leave.

There are ethical, personal and financial considerations involved in terminating managers or staff. Clients should be attended to and service should be minimally disrupted. Clients and therapists must be helped to terminate in ways that maintain client gains. Applicable formal statements of professional ethics must be followed. Many professional organizations (e.g., NASW) have published personnel standards that address the basic principles and procedures for the termination of employees. If the procedures are not followed the director and agency may be vulnerable to formal proceedings on behalf of discharged employees. Persons in this situation also require support. Terminated employees may require personal support, career planning or personal counseling. The director may assist in the identification and provision of the necessary services. Directors often partially attend to the financial difficulties of terminated employees through the mechanism of severance pay. Agency personnel practices and all applicable laws must be strictly adhered to (Coulson, 1981; Morin & Yorks, 1982) if the agency is to avoid costly litigation. Hopefully the necessary legal expertise and direction can come from members of the agency's board.

Fourth, it is important to understand that the discomfort of employee termination and its aftermath is followed by relief for all concerned. The relief for the director is most often immediate. The relief for remaining managers and staff is almost immediate but is more likely to be affected by existing personal

relationships. Even those persons who are terminated eventually experience considerable relief as they find work in settings where they feel more valued. A residue of tension will linger in the agency and all staff will wonder if they ever again want to be part of a change process. Lastly, it is not unusual for persons who voluntarily leave or those who are terminated to take legal action against the agency. The wise director anticipates such activity with the Board and is absolutely clear about and in compliance with relevant legal guidelines.

Helping managers or staff to change or leave is not a favorite pastime of human service professionals. But it is necessary to carry out this function in a caring and professional manner if we are to discharge our primary ethical responsibility and provide the best possible service to clients currently known.

How Case Planning Influences Clinical Practice

How do the case planning procedures in the agency influence how staff practice together? How an agency manages the work of intake, case planning, case monitoring (including data collection) and client termination reflects and affects practice at every point. Changes in agency practice require changes in case planning procedures. If the focus is to be on families, then case management procedures must be responsive to a number of factors. The professional responsible for "managing" the case will be the person responsible for working with the child's family. The primary institutional identification of the person managing the case should be to an agency entity which is committed to providing primary support to family services. In addition, the intake conference must involve all who will be working with the child and family; and the conference should be chaired by the assigned family worker. Furthermore, codified questions and forms should guide the development of treatment goals and objectives so that all are directly related to family and community functioning, and treatment activity is viewed as beginning with intake.

The individual treatment programs of the children in residence are determined by the family-focused plan and are monitored by the person who works with the child's family. Residential data collection must focus on describing child progress in relationship to the family plan and residential workers must systematically be involved in family work. Such involvement may be as parent coaches, parent-agency liaison persons or through direct participation in family sessions. Finally, the agency management information system will be revamped to collect and maintain a data base related to family-focused practice.

Agency Physical Setting Affects Practice

How can the agency's physical plant support or undercut new practice initiatives? Although many family-based services are provided in the home setting, the nature and utilization of agency physical space for practice is important and should be attended to from the beginning of a change process (Maier, 1987). What practice is supported by the current use of space in a residential facility for children? Where will the family workers' offices be located? Does the agency have a space for parents to meet, a space parents can "own"? How self-contained is the agency campus? What are the physical incentives for youngsters and staff to get involved in community activities? Is current therapy space suited for family work? In examining the current space and its utilization, what changes will need to be made? Agencies need to be comfortable for families and staff. Directors must make changes in physical space in anticipation of practice shifts. Examples of such changes would be family meeting rooms in cottages, a parent- rather than child-oriented waiting room, a parent "owned" and managed room in the administration building, counselling facilities that are built and equipped for family meetings, and a decor that states that parents are partners.

Community Support

What needs to be done to maintain and develop the support of various communities? The directors we interviewed were working to change "stable" agencies. The reputation of the agencies was set in their communities and there were supporters and detractors. During the change process supporters often became detractors and detractors often became supporters. Both directors stated that it was important to constantly communicate changing goals and shifting practice in their agencies to their practice communities (e.g., NASW), to persons who were influential and supportive of the change (e.g., key persons in ethnic communities), to supportive funding sources (e.g., county and state officials), to critical neighborhood entities (e.g., neighbors, schools), to current and potential referring agencies (e.g., public child welfare services or mental health agencies) and to adjacent professional schools (e.g., schools of social work).

In our introduction we stated that we would not discuss in detail the issue of agency finance, but community support expressed through fiscal incentives constitutes an important factor. Shrinking funding and the increase in the amount of family-focused requests for proposals (RFPs) from government agencies provide a primary push for change as agencies struggle to assume a more

competitive practice posture. Both directors we interviewed stressed the importance of positioning the agency to receive third-party payments, attracting private-pay families, and program diversification to pursue new funding sources.

Conclusion

Our purpose was to identify and discuss nine issues that must be addressed to assist "residential-based" agencies to move from child-focused practice to one that is more family and community centered. We suspect that many issues and strategies for organizational change are relevant to child-focused social service programs. Both public policy, clinical research, and evolving practice wisdom are placing an increasing emphasis on focusing on the family and community as important practice arenas in addition to the child. Although the issues and strategies presented were discussed with particular reference to residential agencies, these are knowledge and skill areas that can be utilized in program development or change efforts in other programs as agencies struggle to serve families better.

Reference Note

[1] For additional research and practice strategies related to the organizational change principles discussed in this paper, see Brager & Holloway (1978), Kettner, Daly, & Nichols (1985), Munson & Pelz (1987), Resnick & Patti (1980), and Rothman, Erlich, & Teresa, (1981).

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SUPERVISION IN INTENSIVE FAMILY PRESERVATION SERVICES

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The role of the supervisor has always been viewed as important in human service agencies (Munson, 1983). Supervision has been described as an educational process, an administrative process or a combination of both (Kadushin, 1976). In intensive family preservation services (IFPS), supervision clearly involves both processes. As the link between the professional community and the workers, supervisors play a key role in defining intensive family preservation services and in maintaining that definition for both groups. As in other human service organizations, supervisors are responsible for the overall day-to-day functioning of their programs. IFPS program supervisors must ensure that program integrity is maintained, that workers are supported in their efforts and, ultimately, that families are safe. In new IFPS programs, supervisors often shape the program through their screening of families referred for services, their influence over the workers delivering services and their interactions with the larger professional community in which the program operates. All of these responsibilities take on increased importance, given that families are in a state of crisis and that IFPS workers are trying to give families one more chance to stay together, all in a brief period of time. Yet there is a void in the professional literature on intensive family preservation services with regard to the nature of supervision, the roles and responsibilities of supervisors and the needs of supervisors.

This issue paper describes a structure for providing formal and peer supervision in intensive family preservation services programs. Parallels between IFPS work and supervision, as well as some significant differences, will be noted. Formats for carrying out supervision will be discussed, and the importance of providing supports for IFPS workers and of securing supports for supervisors will be addressed. Finally, issues surrounding supervision in intensive family preservation services will be identified.

The Structure of Supervision

Supervisors, along with program administrators, are responsible for the safety of workers and the families being served. Thus, supervisors must be

knowledgeable about the client families and about significant, new developments in their treatment. Moreover, workers must be able to secure consultation on cases from their supervisor or someone else 24 hours a day, seven days a week. To allow for close supervision of IFPS workers, it is generally recommended by HOMEBUILDERS that supervisors provide clinical supervision for an average of six full-time family preservation workers, sometimes referred to as a treatment team.

Augmenting formal supervision, peer supervision also is a frequent form of supervision in IFPS work. Peer supervision involves peers supervising each other, either to supplement or to supplant traditional, individual supervisory sessions led by the supervisor (Tizdale, 1958). In intensive family preservation services, peer supervision can occur in both formal, structured meetings and in informal meetings of co-workers. Peer supervision can foster creativity in helping families overcome difficulties. It also builds a sense of esprit de corps among staff and can be an important morale booster. Therefore, it is important that supervisors foster peer supervision, rather than feel threatened by it. Careful monitoring of peer supervision and its outcomes by supervisors should maintain their confidence in this form of supervision.

Two types of staff meetings allow formal supervisory work and peer supervision to occur. Weekly family service reviews for each treatment team allow time for case consultations from team members (peer supervision) and the supervisor. New cases are introduced and goals for new and ongoing cases are presented. Here, the supervisor must ensure that only goals essential to keeping a family together are developed, and that all work with a family is reflected in goal statements. Significant developments in ongoing cases are reported, which facilitates staff rotation and coverage of on-call services. Difficult treatment issues with specific families also are discussed, using a problem-solving focus. Finally, workers receive public praise from their co-workers for their accomplishments with families. Through these family service review meetings, the supervisor and other members of the treatment team are informed about the status of each family being served by the team, and workers receive general and specific feedback on their work with families. Moreover, such monitoring by supervisors helps to maintain IFPS programs of sufficient intensity and brevity, while preventing treatment drift (McMahon, 1987).

Staff meetings, which can be weekly or less frequent, allow time for the discussion of business and program policy issues. Agenda items can come from supervisors or workers and can range from methods for reducing paperwork to larger concerns about a component of the program. These meetings serve dual functions of dealing with the issues at hand, while building cohesion and support among team members.

Parallels Between Workers' and Supervisors' Roles and Activities in Family Preservation

The previous overview of the structure of supervision in intensive family preservation services suggests some parallels between workers' and supervisors' roles and activities. One such role shared by supervisors and IFPS workers is that of resource person or resource broker. Workers are resource persons for the families they serve, and supervisors provide the same function for their staff. Supervisors should continually develop their resources, including knowledge, informative consultants, good community programs and helpful written materials, so that they have new forms of assistance to offer to their staff.

Another shared role is that of role model. Just as workers may act as role models for client families, supervisors may serve as models to their workers. When supervisors are simultaneously assessing, supporting and problem-solving with their staff, they also are modeling a role that workers must play with families. This is not to suggest that modeling alone is sufficient for supervision, as supervisors also must provide clear feedback and must carefully monitor workers' activities with families. Just as workers strive to give families greater power and control, supervisors strive to give IFPS workers more power by increasing their options for intervention and by helping them develop realistic expectations for families.

The role of advocate is shared by workers and supervisors. Much of workers' time is spent in advocating on behalf of families with school personnel, landlords, other service providers, friends and others. Similarly, supervisors need to advocate for workers and for the IFPS program within the agency, with other community agencies and with funding sources. Other shared roles, including supporter, counselor, teacher and evaluator, are important in the work of supervisors and intensive family preservation workers.

In addition to the similarity in roles, the important tasks and activities of supervisors in IFPS programs are similar to the tasks their workers are completing with families. Assessment of workers is critical and must be ongoing, just as workers must continually assess their families. Supervisors assess workers to determine if they are asking for help when they are stuck, which is viewed as a strength, not a weakness. Supervisors also assess workers' needs, such as a need for informal support or for specialized training and their adherence to program standards.

Just as workers must organize themselves to be available to families 24 hours per day, seven days per week, supervisors also must be available to workers. Often the decisions workers must make are extremely difficult, as they balance the joint goals of keeping families together and keeping family members

safe. Workers need to know that they have access to consultation and backup at all times. Effective time management skills are critical for family preservation workers and supervisors.

Workers should be viewed as colleagues by supervisors, just as family members are viewed as colleagues by IFPS workers. This implies a mutual respect for each other and recognition of the important knowledge that each brings to the problem-solving process.

There also are some important differences between the ways in which IFPS workers help families and supervisors help IFPS workers. The administrative role, which involves such activities as formal appraisal of staff performance, dictates these differences (Pecora, 1990). In addition, supervisors are more likely to "push" workers than workers are to "push" families. Supervisors expect that staff will work to the best of their abilities and within reason. Workers, on the other hand, must find a balance between holding high expectations for families and letting families set the pace. Moreover, a family's "pace" must fit the framework of established time limits and the contractual agreement that certain goals must be accomplished to keep children at home.

Supports for Workers

Because IFPS work is intensive and challenging, workers need a variety of tangible and intangible supports from supervisors. In addition to more typical forms of support, such as training (Meyer, 1983), IFPS supervisors employ many types of informal support that range from recognition for accomplishments with families (such as a round of applause at a staff meeting when a worker gets a child to attend school after a long period of school refusal) to help in reducing stress and frustration (such as listening to the worker "blow off steam"). Periodic group activities for teams of IFPS workers, such as attending a baseball game or honoring a staff member's birthday, also provide opportunities for informal exchanges of support. Noting workers' accomplishments in other public forums also are effective forms of informal support. Posting excerpts from client satisfaction feedback from closed cases on bulletin boards, and awards given at agency or board meetings are examples. While such supports clearly can be found in other human service programs, the task of providing support is a job expectation of supervisors in the HOMEBUILDERS model.

Supervisors may need to attend to stressed relationships among team members, particularly if workers see families in pairs or when several families are having difficulties at the same time (which often occurs at holiday times, for example). Because workers need to feel that they can rely on team members for backup, support and peer supervision, strained relationships can be especially

harmful. Supervisors must monitor their teams for any indicators of stress, and act quickly to defuse tension and help mend strained relationships so that the team can continue to function smoothly.

Support for Supervisors

While much has been said about the need for supervisors to support their staff, supervisors also need to muster sources of informal and formal support for themselves. These sources can take several forms, but every supervisor should have a wide variety at his or her disposal. To begin, supervisors need administrators' support for the program philosophy and interventions. In particular, this may be an issue when intensive family preservation services are housed in public child welfare agencies, and adopt a set of values and interventive methods that differ from protective services or foster care departments.

Caseload management becomes an issue not only for workers but for supervisors as well. Supervisors can support themselves by not taking on too much responsibility beyond the supervisory role. All too often in smaller, new intensive family services preservation programs, supervisors also perform program administrator roles and/or supervise other programs. It is critical that the staffing guidelines mentioned above be adhered to by program administrators, whenever possible, so that supervisors are not stretched too far and are able to devote sufficient time and attention to their supervisory activities. It is extremely difficult to do a competent job of supervising a staff of six family preservation workers, and then to shift one's focus to a different program or to problems of securing additional funding for the IFPS program, for example.

Consultation is another possible support for supervisors and should be available from a variety of individuals with expertise in working with children and families, preferably within a family preservation framework. Like their staff, supervisors should attend workshops, conferences and other continuing education programs to increase their knowledge base. Organizations of professionals involved in intensive family preservation or home-based services can provide formal and informal support to supervisors. Supervisors also need to have access to other IFPS supervisors within the agency or to a program administrator who can provide consultation on difficult decisions and backup when the supervisor cannot be available to staff. Finally, supervisors need to follow the same advice they give to their workers about taking a break from thinking about families, finding outlets for stress and tension and the like. While this may be difficult to implement, supervisors may find it easier to do so if they realize they are modeling these behaviors for their workers.

Issues and Remaining Questions in Supervision in Family Preservation

As noted at the outset of this paper, little has been written about supervision in intensive family preservation services programs. Because these services are organized and delivered so differently from other forms of practice, supervision also must be organized differently. Unsurprisingly, there are several outstanding issues and questions.

One such issue is that intensive family preservation services are relatively new and not fully articulated, particularly when services are offered to certain specialized client populations such as juvenile delinquents or parents with substance abuse problems. Thus, as supervisors respond to and support workers making difficult decisions regarding a specific case or make a decision about whether to accept a certain referral, they often are simultaneously determining program policy. For example, a worker may feel that a single mother with seven children is overloaded. If the worker supports the mother in having two of the older children live with their grandparents in another state for the summer, is this consistent with the program goal of maintaining families? The central question here is whether this type of decision making is in the best interest of the program. Does such a method result in a good, coherent program policy? If not, how can this method of determining policy be avoided or improved?

Another issue relates to the way in which supervisory and administrative activities are organized. Some programs have an outside consultant with intensive family preservation services experience provide the clinical supervision, since it is difficult to locate supervisors with this type of experience. In these instances, the "supervisor" performs more administrative activities along with supervisory activities. Is this a good solution to the person-power problem? Is it harmful to a program when the supervisor does not possess a good understanding of the clinical issues in family preservation? While these are not ideal solutions, they may be necessary in certain situations. Consideration of such questions also might result in proposals for other ways of organizing staff and accomplishing supervisory tasks.

Because little is written about supervision in intensive family preservation services, we have few guidelines that articulate the requisite or even desirable skills for performing as a supervisor in this field. The QUEST program standards developed by HOMEBUILDERS can provide valuable help. QUEST provides a description and means of evaluating core program standards for family preservation programs following the HOMEBUILDERS model, and includes a specification of standards for supervisors.

For programs that cannot fully meet these standards, it would be helpful to have guidelines that speak to the importance of having experience as an IFPS worker before taking on supervisory activities. Often it is not possible to hire supervisors with previous intensive family preservation services experience. In these instances, albeit less than ideal, what types of experience are most helpful? Should supervisors be required to carry IFPS cases for a period of time, to acquire this experience? Some states already have such a requirement. Is it useful?

Along these same lines, another unanswered question relates to the differences and similarities between supervision in intensive family preservation services and in other fields of practice. A thoughtful analysis of the similarities and differences would shed light on the advisability of supervisors acquiring training in traditional methods of supervision in human services and would further define supervisory functions, tasks and requirements.

A more specific supervisory question relates to the ways that supervisors can best understand what is happening when a worker helps a family. How can a supervisor know if the worker is asking for help when needed, or is asking for the right kind of help? Because services are not given in the office, the supervisor has limited opportunity to see how a worker conducts him/herself with families. Is it sufficient to rely on a worker's verbal report and case notes? Should supervisors be required to accompany workers periodically on home visits? Should supervisors request audiotaped or videotaped sessions? If not, what critical clues suggest that the worker is on the right track or that the worker needs help but has not yet recognized the need? Whatever the method of getting information, the supervisor must not be too intrusive and must be respectful of the worker and the family.

Teaching Suggestions

1. Regarding assessment of requisite competencies for a supervisor, the instructor might first have the class generate a list of knowledge, skills and values, and then students would develop and try out (through role play) means of assessing these competencies in job interviews.

2. Have class members role play a team meeting in which cases are discussed. Using a case example from this book or the Edna McConnell Clark Foundation Press Packet, identify what might have been a difficult point in treatment. Have class members take on roles of workers and supervisor as they provide consultation to the worker carrying the case. The supervisor's job is to help the team stay focused on the consultation

question, foster peer supervision, and offer suggestions and support to the worker.

3. Have class members generate a list of ways in which supervisors can provide sources of informal support for intensive family preservation services workers. Begin the discussion by giving them some suggestions, such as a bulletin board in the office that highlights specific staff members' accomplishments with families. Send the class's suggestions to a local IFPS program and invite their comments and reactions to the ideas.

4. Assign class members, working in small groups, the task of contacting local IFPS programs to determine staffing patterns, how supervision is delivered and demographic information on the programs. In one class session, develop the specific questions to be asked so that standard information is collected across programs. In the subsequent class session, compare notes across IFPS programs.

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