If you have issues viewing or accessing this file contact us at NCJRS.gov.

Series on Community-Based Services for Children and Adolescents Who Are Severely Emotionally Disturbed

VOLUME I: HOME-BASED SERVICES

124578

Prepared By:
Beth A. Stroul, M.Ed.

CASSP Technical Assistance Center
Georgetown University Child Development Center
Funded by the National Institute of Mental Health
Child and Adolescent Service System Program (CASSP)

124578

U.S. Department of Justice
National Institute of Justice

This document has been reproduced exactly as received from the person or organization originating it. Points of view or opinions stated in this document are those of the authors and do not necessarily represent the official position or policies of the National Institute of Justice.

Permission to reproduce this [redacted] material has been granted by
Public Domain
Nat'l Institute of Mental Health
to the National Criminal Justice Reference Service (NCJRS).

Further reproduction outside of the NCJRS system requires permission of the [redacted] owner.

SERIES ON COMMUNITY-BASED SERVICES FOR CHILDREN & ADOLESCENTS WHO ARE SEVERELY EMOTIONALLY DISTURBED:

VOLUME I: HOME-BASED SERVICES

Prepared By:

Beth A. Stroul, M.Ed.

CASSP Technical Assistance Center
Georgetown University Child Development Center
3800 Reservoir Road, N.W.
Washington, D.C. 20007
202-687-8635

Funded by the National Institute of Mental Health
Child and Adolescent Service System Program (CASSP)

October 1988

ACKNOWLEDGMENTS

This series of monographs is the major product of a study of community-based services for children and adolescents who are severely emotionally disturbed. The study was conducted by Sybil K. Goldman, M.S.W., Beth A. Stroul, M.Ed., and Phyllis R. Magrab, Ph.D. of the CASSP Technical Assistance Center at the Georgetown University Child Development Center.

The following individuals contributed to the development of this document by serving on the Advisory Committee for the study. Their guidance throughout the project is acknowledged and appreciated:

Mareasa Isaacs, Ph.D., District of Columbia Commission on Mental Health
Judith Jacobs, Dr.P.H., National Institute of Mental Health
Ellen Kagen, M.S.W., CASSP Technical Assistance Center
Judith Katz-Leavy, M.Ed., National Institute of Mental Health
Roxane Kaufmann, Georgetown University Child Development Center
Jane Knitzer, Ed.D., Bank Street College of Education, New York
Ira Lourie, M.D., National Institute of Mental Health
Gary Macbeth, M.S.W., Virginia Department of Mental Health and Retardation
W. Douglas McCoard, M.S.W., Huckleberry House, Ohio
M.R. Newton, South Carolina Department of Mental Health
Ron Sharp, Ed.D., Alternative Rehabilitative Communities, Pennsylvania
Milton Shore, M.D., Independent Practice, Maryland

Thanks are due to the staff of the Florida Research and Training Center for Children's Mental Health for their review of this monograph series and for their insightful comments, Robert Friedman, Ph.D., Al Duchnowski, Ph.D., and Susan Yelton, M.S.W.

Special recognition and appreciation are given to Ira Lourie, M.D. and Judith Katz-Leavy, M.Ed. of the National Institute of Mental Health, Child and Adolescent Service System Program for their guidance and support throughout this project and for their continued national leadership in the effort to improve services for emotionally disturbed children and their families.

Finally, administrators and staff of the programs visited during the study provided a wealth of knowledge, information, and experience without which this monograph series would not have been possible. Youth, families, foster families, and staff from other community agencies also generously shared their unique perspectives with us. The willingness of these agencies and individuals to give of their time and expertise to assist in this project is gratefully acknowledged:

Child and Adolescent Emergency Service and Respite House
South Shore Mental Health Center
Quincy, MA

Children's Crisis Intervention Service
Transitional Residence Independence Service (TRIS)
Sicklerville, NJ

Family Advocate Project
Counseling Service of Addison County
Middlebury, VT

Family Network and Individual Residential Treatment
Lee Mental Health Center
Fort Myers, FL

Homebuilders
Behavioral Sciences Institute
Federal Way, WA

Huckleberry House
Columbus, OH

Pressley Ridge Youth Development Extension (PRYDE)
The Pressley Ridge Schools
Pittsburgh, PA

Satellite Family Outreach Program
Kaleidoscope
Chicago, IL

Ventura County Children's Mental Health Demonstration Project
Ventura County Mental Health Department
Ventura, CA

Wake County Juvenile Treatment System
Raleigh, NC

Family and Children's Services of the Kalamazoo Area
Kalamazoo County Community Mental Health Board
Kalamazoo, MI

TABLE OF CONTENTS

	PAGE NUMBER
PREFACE	i
INTRODUCTION	iii
I. A SYSTEM OF CARE FOR CHILDREN AND ADOLESCENTS WHO ARE EMOTIONALLY DISTURBED	1
II. HOME-BASED SERVICES	12
III. PROGRAM DESCRIPTIONS	69
IV. PROFILES OF HOME-BASED SERVICE PROGRAMS	121
APPENDIX: LIST OF PROGRAMS RESPONDING TO SURVEY	

PREFACE

The system of care for severely emotionally disturbed children and adolescents has been of great interest over the last several years. The conceptualization of this system has been a major focus in the advancement of the availability and appropriateness of services for this underserved population. In 1982, Jane Knitzer estimated in her seminal study, Unclaimed Children, that of the three million children with serious emotional disturbances in this country, two million were receiving no treatment whatsoever and countless others were receiving inappropriately restrictive care because of the lack of community-based service alternatives. Knitzer documented that only 21 states had a child and adolescent administrative unit within their departments of mental health and asserted that this dearth of leadership, lack of appropriate child mental health services, and fragmentation of systems has resulted in literally millions of children with serious emotional problems "falling through the cracks."

In 1986, Leonard Saxe performed a study for the Office of Technology Assessment (OTA) of the United States Congress, which confirmed Knitzer's findings. Saxe introduced this report, Children's Mental Health: Problems and Services, to Congress with the statement: "Mental health problems are a source of suffering for children, difficulties for their families, and great loss for society. Though such problems are sometimes tragic, an even greater tragedy may be that we currently know more about how to prevent and treat children's mental health problems than is reflected in the care available." Saxe presented three major conclusions:

- Many children do not receive the full range of necessary and appropriate services to treat their mental health problems effectively.
- A substantial theoretical and research base suggests that, in general, mental health interventions for children are helpful.
- Although there seem to be shortages in all forms of children's mental health care, there are particular shortages of community-based services, case management, and coordination across child service systems.

Even before the OTA study, Congress responded to these problems and to growing calls for change from the field, by funding, in 1984, an initiative to demonstrate the development of better functioning service systems. This effort led the National Institute of Mental Health to develop the Child and Adolescent Service System Program (CASSP). CASSP now supports 42 states in the development of interagency efforts to improve the systems under which the most troubled children and youth receive services. Through state and community level grants, the agencies that serve these youngsters -- mental health, health, social welfare, juvenile justice and special education -- are brought together to develop system change processes.

As states began struggling with system change, a number of critical questions evolved:

- What should a service system for children with serious emotional problems encompass?
- Toward what new configuration or ideal should service system change be directed?
- What are the components of the system?
- What is the ultimate goal of such systems change?

To provide a conceptual framework for the field and to answer these questions, CASSP supported the publishing of A System of Care for Severely Emotionally Disturbed Children and

Youth by Beth Stroul and Robert Friedman in 1986. This monograph has been called a blueprint for action in the child mental health field.

Stroul and Friedman described the various service options required by these youths and the need for continuums of care across all of the relevant child-serving agencies. From these components, they proposed a design for a greater "System of Care" encompassing both the full range of services and the mechanisms required for the assurance of their appropriate delivery.

The System of Care monograph describes a continuum of mental health services for severely emotionally disturbed children and adolescents. This continuum includes a group of important nonresidential service options that have been under-represented in states and communities. In order to assist states and communities that wish to develop a full system of care, CASSP initiated a major study on family-centered and community-based services for children and adolescents with serious emotional disturbance, which has resulted in this series of monographs.

This new series, which includes four volumes focusing on home-based services, crisis services, therapeutic foster care, and systems of care, complements the System of Care monograph as well as an earlier CASSP publication, Profiles of Residential and Day Treatment. Beth Stroul and Sybil Goldman have performed an extraordinary task in reviewing information on hundreds of community-based programs, in synthesizing this information, and in analyzing current treatment practices and service delivery strategies utilized within each of the three service modalities mentioned above. They have produced a truly "state-of-the-art" series on home-based services, crisis services, and therapeutic foster care. In addition, they have described in clear and direct prose three actual communities that have attempted to design and implement well-functioning systems of care for children with serious emotional problems and their families. This series constitutes a major contribution to the field and should be of great interest to program administrators at both the state and community levels, to service providers, to parents, and to advocates -- to all those interested in improving or developing community-based service options for these children and youth.

Ira S. Lourie, M.D.
Chief, Child and Family Support Branch
National Institute of Mental Health

Judith Katz-Leavy, M.Ed.
Assistant Chief, Child and Family Support Branch
National Institute of Mental Health

INTRODUCTION

This document is part of a series of monographs on community-based services for children and adolescents who are severely emotionally disturbed published by the Child and Adolescent Service System Program (CASSP) Technical Assistance Center at Georgetown University. This series is the product of an extensive national study of community-based service approaches for this population and includes the following volumes:

Volume I: Home-Based Services
Volume II: Crisis Services
Volume III: Therapeutic Foster Care
Volume IV: Systems of Care

There is broad agreement that comprehensive, community-based systems of care for youngsters who are severely emotionally disturbed and their families are needed, and the development of these systems has become a national goal. Many communities offer the more traditional components of the system of care, such as outpatient, inpatient, and residential treatment services. However, there are a growing number of promising and innovative treatment approaches emerging in the field, and there is a tremendous need for information about these service alternatives. The study of community-based services, funded by the National Institute of Mental Health Child and Adolescent Service System Program, was designed to identify and describe three types of services -- home-based services, crisis services, and therapeutic foster care.

The study was conducted from 1986 to 1988 and initially involved a survey of over 650 organizations and individuals requesting that they identify programs providing home-based services, crisis services, and therapeutic foster care to a population of severely emotionally disturbed children. The initial survey resulted in the identification of approximately 200 programs across the nation. An extensive questionnaire then was sent to all identified programs in order to gather detailed information about their organization, philosophy, services, client population, staffing patterns, costs, sources of financing, evaluation results, problems encountered, and other aspects of their programs. Responses were received from more than 80 programs in 36 states, and a one-page profile summarizing major characteristics was prepared for each respondent program.

With the assistance of an advisory committee, several programs in each category were selected for in-depth study through site visits. The programs were selected with the goal of maximizing variation along key dimensions, including different service approaches and treatment philosophies, geographic regions, types of communities, and age groups or minority populations served. Additionally, an attempt was made to select programs that exemplify the core values and guiding principles for the system of care described in Chapter I of this document. The programs selected for site visits were not necessarily considered "model" programs. Rather, they were selected to serve as examples of a variety of service delivery approaches. There are, of course, a great many other programs in the field which are also extremely effective in providing these types of services to troubled children and their families.

In addition to site visits to programs in each of the service categories, the advisory committee recommended visiting three communities that appeared to have a wide array of service components in place as well as effective mechanisms for linking and integrating these services into a coordinated system of care. Three-day site visits were conducted in order to become immersed in the programs in an attempt to determine what makes them successful. The site visits involved observation of program activities and extensive meetings and discussions with

program administrators, staff at all levels, staff from other community agencies, parents, foster parents, and children.

The analysis phase of the project involved synthesizing the information obtained from the survey, site visits, and literature review in each of the service categories. This monograph series represents the major study product, each volume providing a descriptive overview of the service approach, case studies of the programs visited, and profiles of the programs responding to the survey. The monographs are designed to provide information that will be helpful to state and community agencies, advocates, and others who are interested in developing these types of programs.

I. A SYSTEM OF CARE FOR CHILDREN AND ADOLESCENTS WHO ARE SEVERELY EMOTIONALLY DISTURBED

In her book Unclaimed Children, Knitzer (1982) reported that two-thirds of all children and youth who are severely emotionally disturbed do not receive the services they need. Many others receive inappropriate, often excessively restrictive, care. Recently, there has been increasing activity to improve services for children and adolescents who are severely emotionally disturbed. In 1984, with funding appropriated by Congress, the National Institute of Mental Health (NIMH) launched the Child and Adolescent Service System Program (CASSP) to assist states and communities to develop comprehensive, community-based systems of care for emotionally disturbed youth and their families. Coalitions of policymakers, providers, parents, and advocates currently are being forged across the nation to promote the development of such systems.

This chapter presents a model system of care along with principles for service delivery. The model and principles were developed through a project sponsored by CASSP with broad input from the field (Stroul & Friedman, 1986). The model offers a conceptual framework to provide direction to policymakers, planners, and providers. Individual service components, such as those described in this series, should be considered in the context of the overall system of care.

BACKGROUND

Nearly two decades ago, the Joint Commission on the Mental Health of Children (1969) found that millions of children and youth were not receiving needed mental health services and that many others received unnecessarily restrictive care, often in state mental hospitals. The President's Commission on Mental Health (1978) echoed the Joint Commission's conclusions, finding that few communities provided the volume or continuum of programs necessary to meet children's mental health needs. Both Commissions recommended that an integrated network of services be developed in communities to meet the needs of children and youth who are severely emotionally disturbed. Knitzer (1982) asserted that the needs of severely emotionally disturbed children have remained largely unaddressed. She considers these children to be "unclaimed" by the public agencies with responsibility to serve them. Most recently, the Office of Technology Assessment (OTA) of the United States Congress (1986) found that many children do not receive the full range of necessary and appropriate services to treat their mental health problems effectively. The OTA report stated that it is a tragedy that "we currently know more about how to prevent and treat children's mental health problems than is reflected in the care available."

These reports and others have made it apparent that the range of mental health and other services needed by children and adolescents who are severely emotionally disturbed is frequently unavailable. Many children are institutionalized when less restrictive, community-based services would be more effective. Additionally, there have been few attempts to get mental health, child welfare, juvenile justice, health, and education agencies to work together on behalf of disturbed children and youth. This has left children and youth who have serious and complex problems to receive services in an uncoordinated and piecemeal fashion, if at all.

Currently, there is broad agreement about the critical need to improve the range, appropriateness, and coordination of services delivered to severely emotionally disturbed children and their families. The development of comprehensive, coordinated, family-centered, and community-based "systems of care" for children and youth has become a national goal.

The term "continuum of care" has been used extensively in the field to describe the range of services needed by children and adolescents who are severely emotionally disturbed. Throughout this document, the term "system of care" is employed. "Continuum of care" generally denotes a range of services or program components at varying levels of intensity. These are the actual program elements and services needed by children and youth. "System of care" has a broader connotation. It not only includes the program and service components, but also encompasses mechanisms, arrangements, structures, or processes to insure that the services are provided in a coordinated, cohesive manner. Thus, the system of care is greater than the continuum, containing the components **and** provisions for service coordination and integration.

A system of care, therefore, is defined as follows:

> **A system of care is a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents who are severely emotionally disturbed and their families.**

This chapter describes how these systems of care might look and the values and philosophy that should guide service delivery.

PRINCIPLES FOR THE SYSTEM OF CARE

The system of care concept represents more than a network of service components. Rather, it represents a **philosophy** about the way in which services should be delivered to children and their families. The actual components and organizational configuration of the system of care may differ from state to state and from community to community. Despite such differences, all systems of care should be guided by a set of basic values and operational philosophies.

There is general agreement in the field as to the values and philosophy which should be embodied in a system of care for youth who are severely emotionally disturbed. With extensive consultation from the field, two core values and a set of ten principles have been developed to provide a philosophical framework for the system of care model.

The two core values are central to the system of care and its operation. The first value is that the system of care must be driven by the needs of the child and his or her family. In short, the system of care must be **child-centered**, with the needs of the child and family dictating the types and mix of services provided. This child-centered focus is seen as a commitment to adapt services to the child and family rather than expecting the child and family to conform to pre-existing service configurations. It is also seen as a commitment to provide services in an environment and a manner that enhances the personal dignity of children and families, respects their wishes and individual goals, and maximizes opportunities for involvement and self-determination in the planning and delivery of services.

Implicit in this value is that the system of care is also **family-focused.** In most cases, parents are the primary care givers for children with severe emotional disturbances, but efforts to work with and support families are frequently lacking. Parents often feel blamed, isolated, frustrated, disenfranchised, and shuffled from agency to agency, provider to provider. The system should be committed to supporting parents as care givers through services, support, education, respite, and more. There should also be a strong commitment to maintaining the integrity of the family whenever possible. Recent experience has confirmed that intensive services provided to the child and family can minimize the need for residential treatment, and that residential placements of all types are overutilized (Behar, 1984; Friedman & Street, 1985; Knitzer, 1982; Stroul & Friedman, 1986; United States Congress, 1986).

The second core value holds that the system of care for emotionally disturbed children should be **community-based**. Historically, services for this population have been limited to state hospitals, training schools, and other restrictive institutional facilities. There has been increasing interest and progress in serving such children in community-based programs which provide less restrictive, more normative environments. The system of care should embrace the philosophy of a community-based, family-centered network of services for emotionally disturbed youth. While "institutional" care may be indicated for certain children at various times, in many cases appropriate services can be provided in other, less restrictive settings within or close to the child's home community.

In addition to these two fundamental values for the system of care, ten principles have been identified which enunciate other basic beliefs about the optimal nature of the system of care. The values and principles are displayed on the following page.

SYSTEM OF CARE FRAMEWORK AND COMPONENTS

The system of care model presented in this chapter represents one approach to a system of care. No single approach as yet has been adequately implemented and tested to be considered the ideal model. The model presented is designed to be a guide and is based on the best available empirical data and clinical experience to date. It is offered as a starting point for states and communities as they seek to build their systems, as a baseline from which changes can be made as additional research, experience, and innovation dictate.

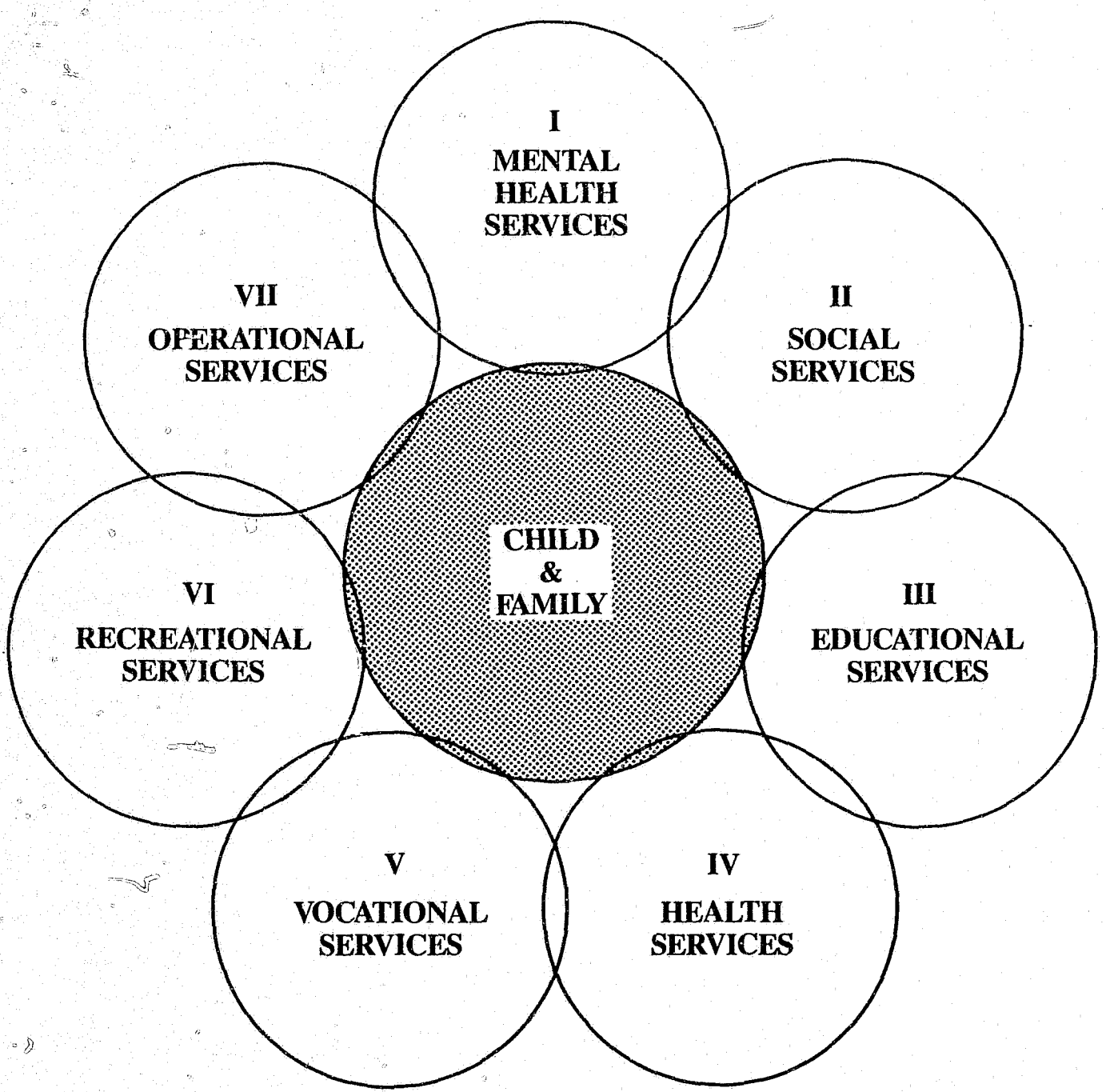
The system of care model is organized in a framework consisting of seven major dimensions of service, each dimension representing an area of need for children and their families. The framework is presented graphically on the following page and includes the following dimensions:

1. Mental health services
2. Social services
3. Educational services
4. Health services
5. Vocational services
6. Recreational services
7. Operational services

The system of care model is intended to be **function-specific** rather than agency-specific. Each service dimension addresses an area of need for children and families, a set of functions that must be fulfilled in order to provide comprehensive services to meet these needs. The model is **not** intended to specify which type of agency should fulfill any of the particular functions or needs. Certainly, particular agencies typically provide certain of these services. Educational services, for example, are provided most often by school systems, and social services generally are associated with child welfare or social welfare agencies. One might assume that the mental health services should be provided by mental health agencies. This, however, is often not the case.

All of the functions included in the system of care dimensions may be fulfilled by a variety of agencies or practitioners in both the public and private sectors. Therapeutic group care, a component in the mental health dimension, often is fulfilled by juvenile justice agencies and social service agencies as well as by mental health agencies. Day treatment is another mental health function that is frequently fulfilled by educational agencies, ideally in close collaboration with mental health providers.

SYSTEM OF CARE FRAMEWORK



CORE VALUES FOR THE SYSTEM OF CARE

1. The system of care should be child-centered, with the needs of the child and family dictating the types and mix of services provided.

2. The system of care should be community-based, with the locus of services as well as management and decision-making responsibility resting at the community level.

GUIDING PRINCIPLES FOR THE SYSTEM OF CARE

1. Emotionally disturbed children should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs.

2. Emotionally disturbed children should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.

3. Emotionally disturbed children should receive services within the least restrictive, most normative environment that is clinically appropriate.

4. The families and surrogate families of emotionally disturbed children should be full participants in all aspects of the planning and delivery of services.

5. Emotionally disturbed children should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing and coordinating services.

6. Emotionally disturbed children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.

7. Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

8. Emotionally disturbed children should be ensured smooth transitions to the adult service system as they reach maturity.

9. The rights of emotionally disturbed children should be protected, and effective advocacy efforts for emotionally disturbed children and youth should be promoted.

10. Emotionally disturbed children should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

While the roles and responsibilities of specific agencies are acknowledged, many of the services can be, and are, provided by different agencies in different communities. Furthermore, many of these services are provided not through the efforts of any single agency but through multi-agency collaborative efforts. Such collaborations are important not only in identifying needs and planning services but also in developing, funding, and operating services. It should also be recognized that services are not always provided by agencies. Some functions within the system of care may be fulfilled by families, parent cooperatives, or other arrangements. In addition to public sector agencies and staff, private sector facilities and practitioners can play a pivotal role in the system of care, providing a wide range of services within each of the major dimensions. Additionally, juvenile justice agencies play an important role in the system of care by providing a wide range of services to children and adolescents who have broken the law (Shore, 1985).

An important aspect of the concept of a system of care is the notion that all components of the system are interrelated and that the effectiveness of any one component is related to the availability and effectiveness of all other components. For example, the same day treatment service may be more effective if embedded in a system that also includes good outpatient, crisis, and residential treatment than if placed in a system where the other services are lacking. Similarly, such a program will be more effective if social, health, and vocational services are also available in the community than if they are absent or of low quality. In a system of care, all of the components are interdependent -- not only the components within a service dimension such as mental health, but all of the seven service dimensions that comprise the model.

Within each of the seven service dimensions is a continuum of service components. These dimensions and the components within them are displayed on the following page. Of primary importance is the dimension of mental health services since these are critical services for all children who are severely emotionally disturbed. These services are divided into seven nonresidential categories and seven residential categories. When considering the individual services, it should be recalled that these are component parts of an overall system of care. The boundaries between the various dimensions and components are not always clear, and frequently there is overlap among them. While they are listed individually, the system of care dimensions and service components cannot be operated in isolation. Only when the services are enmeshed in a coherent, well-coordinated system will the needs of severely emotionally disturbed youngsters and their families be met in an appropriate and effective manner.

A critical characteristic of an effective system is an appropriate balance between the components, particularly between the more restrictive and less restrictive services. If such balance is not present, then youngsters and families will not have a chance to receive less restrictive services before moving to more restrictive services. If, for example, within a community there are no intensive home-based services, only 20 day treatment slots and 50 residential treatment slots, the system is not in balance. Most likely, youngsters and families will have no opportunity to participate in home-based or day treatment services because they are relatively unavailable, and the residential components of the system will be overloaded with youngsters, some of whom might have been diverted from residential treatment if there had been more nonresidential services available.

At the present time there are no clear, empirically-based guidelines about the appropriate capacity within each component of a system of care. Implicit within a model system of service, however, is the expectation that more youngsters will require the less restrictive services than the more restrictive ones, and that service capacity, therefore, should diminish as one proceeds through the system. As additional research and field experience are accumulated on systems of care for severely emotionally disturbed children, it may become

COMPONENTS OF THE SYSTEM OF CARE

1. MENTAL HEALTH SERVICES

Nonresidential Services:

Prevention
Early Identification & Intervention
Assessment
Outpatient Treatment
Home-Based Services
Day Treatment
Emergency Services

Residential Services:

Therapeutic Foster Care
Therapeutic Group Care
Therapeutic Camp Services
Independent Living Services
Residential Treatment Services
Crisis Residential Services
Inpatient Hospitalization

2. SOCIAL SERVICES

Protective Services
Financial Assistance
Home Aid Services
Respite Care
Shelter Services
Foster Care
Adoption

3. EDUCATIONAL SERVICES

Assessment & Planning
Resource Rooms
Self-Contained Special Education
Special Schools
Home-Bound Instruction
Residential Schools
Alternative Programs

4. HEALTH SERVICES

Health Education & Prevention
Screening & Assessment
Primary Care
Acute Care
Long-Term Care

5. VOCATIONAL SERVICES

Career Education
Vocational Assessment
Job Survival Skills Training
Vocational Skills Training
Work Experiences
Job Finding, Placement
& Retention Services
Supported Employment

6. RECREATIONAL SERVICES

Relationships with Significant Others
After School Programs
Summer Camps
Special Recreational Projects

7. OPERATIONAL SERVICES

Case Management
Self-Help & Support Groups
Advocacy
Transportation
Legal Services
Volunteer Programs

possible to define the optimal ratios of capacities in the different system components (Friedman, 1987).

The operational services dimension is somewhat different from the other system of care dimensions. This dimension includes a range of support services that can make the difference between an effective and an ineffective system of care but do not fall into a specific category. Instead, they cross the boundaries between different types of services. They are called "operational services" because of their importance to the overall effective operation of the system. The services included in this dimension are case management, self-help and support groups, advocacy, transportation, legal services, and volunteer programs.

Case management is a service within this dimension that can play a critical role in the system of care. Behar (1985) calls case management "perhaps the most essential unifying factor in service delivery." The important role that case management can play in a system of service has been increasingly recognized in recent years but has been operationalized in only a few states.

Case management can be provided to youngsters in both residential and nonresidential programs. It involves brokering services for individual youngsters, advocating on their behalf, insuring that an adequate treatment plan is developed and implemented, reviewing client progress, and coordinating services. Case management involves aggressive outreach to the child and family, and working with them and with numerous community agencies and resources to ensure that all needed services and supports are in place. One important trend in serving emotionally disturbed children is to combine specialized case management with the availability of flexible funds to secure the specific mix of services and supports needed by each individual child and family on a case-by-case basis (Update, 1986).

Advocacy can also play a critical role in the system of care. "Case" advocacy, or advocacy on behalf of the needs of individual children, is needed as well as "class" advocacy, or advocacy on behalf of a group of children. Class advocacy, if successful, can have a greater impact than case advocacy because it can produce changes that affect more children (Knitzer, 1984). Efforts to advocate for improved services are beginning to take the form of coalitions of parent, provider, professional, and voluntary advocacy organizations. These coalitions are forming at community, state, and national levels and are beginning to provide a much needed voice in support of system of care development.

The increased interest in advocacy is one of the more encouraging signs in the children's mental health field in recent years. A key issue affecting the degree to which effective systems of care will be developed is the extent to which strong, persistent, and well-targeted advocacy efforts can be developed.

SERVICE DEVELOPMENT

The model described in this chapter can be used as a guide in planning and policymaking and provides a framework for assessing present services and planning improvements. It can be conceptualized as a blueprint for a system of care which establishes directions and goals. States and communities should revise and adapt the model to conform with their needs, environments, and service systems. The model also must be regarded as flexible, with room for additions and revisions as experience and changing circumstances dictate.

Most important is the acknowledgement that conceptualizing a system of care represents only a **preliminary step** in the service system improvement process. Development of a system of care model is a planning task which must be followed by implementation activities. While

designing a system of care is an essential and challenging task, the real challenge for states and communities is to transform their system of care plans into reality.

Using the framework that the mental health dimension of this model provides, it is apparent that many communities are able to provide the more traditional services to emotionally disturbed children and their families, services such as outpatient services, inpatient services, and services in residential treatment centers. The service gaps generally include some of the more innovative service approaches such as home-based services, intensive day treatment, therapeutic foster care, crisis services, case management, and support services such as respite care.

Because these types of services frequently are lacking in communities, the study of community-based service approaches was initiated by the CASSP Technical Assistance Center at Georgetown University. The intent of the project was to develop and disseminate detailed information about specific service delivery approaches in order to assist states and communities in their efforts to implement similar programs. Thus, this series is designed to provide the tools for policymakers, planners, providers, parents, and advocates to translate their system of care plans into reality.

The three service components selected for study and described in the series are home-based services, crisis services, and therapeutic foster care. Home-based services are counseling, support, and case management services provided on an outreach basis to work intensively with severely emotionally disturbed children and their families in their homes. Many home-based service programs are crisis-oriented, intervening during crisis situations in which the child is in imminent danger of placement in an out-of-home setting. These programs work intensively with families on a relatively short-term basis with the goal of stabilizing the child and family and connecting them with ongoing services as needed. Other programs have developed longer term home-based interventions to work more extensively with families. Some of these programs are based on the assumption that families can benefit from a long and stable association with a professional. Some of the major characteristics of home-based services include the following:

- The intervention is delivered primarily in the family's home.
- The intervention is multifaceted and includes counseling, skill training, and helping the family to obtain and coordinate necessary services, resources, and supports.
- Staff have small caseloads to permit them to work actively and intensively with each family.
- The programs are committed to empowering families, instilling hope in families, allowing families to set their own goals and priorities and assisting them to achieve these.

Crisis services for children and adolescents involve numerous types of agencies, services, settings, and personnel that respond to crisis situations. The range of services includes crisis telephone lines, often specialized for particular types of problems such as suicide or substance abuse; walk-in and outpatient crisis intervention services; mobile crisis outreach services including home-based services and emergency medical teams; and crisis residential services including runaway shelters, crisis group homes, therapeutic foster homes used for short-term crisis placements, and crisis stabilization units. Inpatient hospitalization services of various types are seen as back-up to these other types of crisis services, to be used when other approaches are not adequate for responding to particular situations.

The underlying goals of virtually all of the crisis programs identified in the study were to assist children and adolescents and their families to resolve crises and to avert hospitalization. Despite diverse approaches and settings, there are many similarities among crisis programs for children with emotional disturbances:

- o They intervene immediately.
- o They provide brief and intensive treatment.
- o They focus treatment on problem solving and goal setting.
- o They involve families in treatment.
- o They link clients and families with other community services and supports.

Because crisis services provide brief, intense interventions, they generally are followed by other services. Thus, it is critical for crisis programs to maintain strong and effective linkages with all other components within the overall system of care.

Therapeutic foster care is considered the least restrictive, most normalizing of the residential options within the system of care. There is much controversy over what therapeutic foster care should be called -- foster family-based treatment, special foster care, individualized residential treatment, and other labels. The primary concern is differentiating therapeutic foster care, which is a form of **treatment** for troubled children, from regular foster care. Therapeutic foster home programs report that they successfully serve some of the most severely disturbed youngsters in home settings, some youngsters that could not be managed in the most restrictive, highly supervised institutional settings.

Therapeutic foster care usually involves:

- o Recruitment of treatment parents specifically to work with emotionally disturbed children. Treatment parents are seen as the primary therapeutic agents.
- o Provision of specialized training to the treatment parents to assist them in working with emotionally disturbed children and creation of a support system among the treatment parents.
- o Payment of a special stipend to the treatment parents significantly higher than the rate of payment for regular foster care.
- o Staff who work closely with each child and treatment family and usually assume both clinical and case management roles.
- o Counseling, support, and other forms of assistance to biological families.

Therapeutic foster care programs can be flexible and can easily individualize the treatment approach and program for each child. They can serve both sexes, children of different ages, and children with a wide variety of problems. Some therapeutic foster care programs offer more intensive versions for children with the most severe problems. These involve hiring a human service professional to serve as the treatment parent and provide full-time, one-on-one care for a severely disturbed child or utilizing rotating shifts of foster parent assistants to provide intensive, continuous care and supervision in the context of the therapeutic foster home.

While each volume of the series describes a particular service component, the interdependence of all system components should be kept in the forefront. No one service or program can meet the complex needs of emotionally disturbed children and their families. Thus, it may not be wise to devote all available resources to developing one or two services without considering the entire system. Each of the services described in this series must be part of a comprehensive, coordinated system of care which is dedicated to meeting the multiple and changing needs of severely emotionally disturbed youngsters and their families. Volume IV of this series describes the efforts of several communities to link a vareity of service components into well coordinated systems of care.

REFERENCES

Behar, L.B. (1984). An integrated system of services for seriously disturbed children. Paper presented at the ADAMHA/OJJDP "State of the Art Research Conference on Juvenile Offenders with Serious Alcohol, Drug Abuse, and Mental Health Problems," Rockville, MD.

Behar, L. B. (1985). Changing patterns of state responsibility: A case study of North Carolina. Journal of Clinical Child Psychology, 14, 188-195.

Friedman, R.M. (1987). Service capacity in a balanced system of services for seriously emotionally disturbed children. Unpublished manuscript. University of South Florida, Florida Mental Health Institute, Tampa.

Friedman, R.M., & Street, S. (1985). Admission and discharge criteria for children's mental health services: A review of the issues and options. Journal of Clinical Child Psychology, 14, 229-235.

Joint Commission on the Mental Health of Children (1969). Crisis in child mental health. New York: Harper & Row.

Knitzer, J. (1982). Unclaimed children. Washington, DC: Children's Defense Fund.

Knitzer, J. (1984). Developing systems of care for disturbed children: The role of advocacy. Rochester, NY: Institute for Child and Youth Policy Studies.

President's Commission on Mental Health (1978). Report of the sub-task panel on infants, children and adolescents. Washington, DC: U.S. Government Printing Office.

Shore, M. (1985). Mental health and the juvenile justice system: A mental health perspective. Paper presented at the NASMHPD/NIMH Symposium "Addressing the Mental Health Needs of the Juvenile Justice Population: Policies and Programs," Washington, DC.

Stroul, B. & Friedman, R. M. (1986). A system of care for severely emotionally disturbed children and youth. Washington, DC: Georgetown University, CASSP Technical Assistance Center.

United States Congress, Office of Technology Assessment. (1986). Children's mental health: problems and services - A background paper. Washington, DC: U.S. Government Printing Office.

Update. (1986). Case management. Update, Newsletter of the Research & Training Center for Children's Mental Health, 2, 10-12, 15. Tampa, FL: Florida Mental Health Institute.

II. HOME-BASED SERVICES

HISTORY

Home-based services are interventions delivered to children and their families primarily in the family's home. Such services have been given multiple designations including in-home services, family-centered services, family-based services, intensive family services, family preservation services, and others. While there are distinctions among program characteristics, most home-based services represent an intensive method of service delivery which focuses on families rather than on individuals and is directed at strengthening families and preventing family dissolution (Hutchinson, Lloyd, Landsman, Nelson, & Bryce, 1983).

The concept of home-based services for persons with special needs is not a new one. Levenstein (1981) noted that school systems have provided home tutoring programs for physically and emotionally disabled students; visiting nurses have provided home health care since the end of the nineteenth century; and churches historically have ministered to the disabled in their homes. However, the use of intensive home-based services as social service and mental health interventions represents more recent trends.

In American society, family problems often are solved by placing disabled or troublesome family members in out-of-home care. Until recently, elderly, retarded, delinquent, and mentally ill persons typically were removed from their homes and treated in institutional settings. This policy has been fueled by the myth that specialized care and services must be provided outside of the home in specialized treatment settings. This myth has pervaded systems serving both adults and children. For example, Turitz (1961) pointed out the lingering but fallacious assumption in the child welfare field that only those services providing placement outside the home are "genuine" child welfare services. Removing a child from his or her family has been seen as the best means of protection. Accordingly, the most well-developed child welfare services are those involving the placement of children in substitute care and not those directed at strengthening and maintaining family life.

In the mental health arena, the myth that treatment must occur in a hospital or other residential setting also has created an overemphasis on out-of-home care. The Joint Commission on the Mental Health of Children (1969) found that families are unlikely to receive help until a child is badly disturbed or disruptive to the community and that resources most often are used to replace families rather than to support and maintain them.

Over the past decade, the profound problems associated with the out-of-home placement of children have become increasingly apparent. Some of the major concerns include the following:

- Increasing numbers of children in substitute care - Between one-quarter and one-half million children currently live away from their families in some form of substitute care (Edna McConnell Clark Foundation [Clark Foundation], 1985). According to the Clark Foundation, substitute care too often is used as a first response rather than as a last resort when a child or family is in trouble. Many feel that substitute care placements of all types are overutilized and that many placements could be avoided. In fact, most children in substitute care placements receive no services prior to placement.

- Lack of effectiveness of many out-of-home-placements - Increasing evidence has challenged the efficacy of foster care and institutional care for children. The Clark Foundation (1985) found that most children in substitute care are subjected to multiple placements; over one-fourth of all foster children live in three consecutive placements. The foster care system

has been called an "enormous, uncoordinated, and expensive holding tank for children." Many troubled children receive little treatment in foster care settings, and many children in residential treatment reenter the system within a year of discharge from a residential facility. Incarceration in institutional settings has proven equally ineffective for delinquents. The lack of positive outcomes in many types of settings has led to disillusionment with the effectiveness of substitute care.

- High costs of substitute care - Large sums of money are spent on substitute care placements for children. The cost of one foster placement has been estimated at $5,000 to $12,000 per year, and the average institutional placement ranges from $11,000 to $50,000 per year (Bryce & Lloyd, 1982). The high cost of out-of-home placements has contributed to the search for alternative service delivery approaches or ways to prevent placement.

- Social and psychological risks associated with out-of-home placement - Many experts have found that children crave continuity in their relationships with their parents (Clark Foundation, 1985). Even in severely dysfunctional families, both children and parents tend to show strong and enduring desires to maintain family bonds. Removing a child from his or her biological family, even temporarily, can be emotionally destructive for the child and parents. Children and parents experience feelings of loss, despair, guilt, anger, and inadequacy that may be difficult to overcome. Placement may offer relief and respite for families from a seemingly impossible situation, but, according to Cautley (1980), the pain, guilt, and sense of failure associated with separation are difficult for most families to bear. While out-of-home placement is clearly needed to protect children in danger or to provide highly specialized treatment, there are potential negative effects resulting from the separation.

For severely emotionally disturbed youngsters, there are additional problems associated with out-of-home placements. During the placement in a substitute care setting, the child may receive intensive treatment, and behavioral changes may be achieved. However, on return to the family, school, and community environment, the child's symptoms often recur (Heying, 1985). The Mendota Mental Health Institute, a residential treatment center in Wisconsin, found that treatment gains were not maintained once the child left the highly consistent milieu (Fahl & Morrissey, 1979). In addition, the parents' motivation to change diminished with the troubled child removed from the home, and parents generally were unprepared to take over as "mediators of change" for the child upon his or her return. Thus, changes in the child's functioning often could not be maintained or strengthened in the natural environment. While the ultimate goal was to improve the child's functioning within the family, school, and community, the program succeeded only in training children to function within an institution. These observations led to the initiation of a home-based treatment program, the Home and Community Treatment Program, to minimize the need for residential treatment.

It has become evident that there are effective ways to help troubled children and families without removing children from their homes. As early as the 1950s, the St. Paul Family-Centered Project in Minnesota experimented with home-based services and found that 65 percent of the most dysfunctional, multiproblem families improved (Lloyd & Bryce, 1984). By the 1970s, a number of similar programs began to emerge and to provide data which indicated high rates of success in preventing out-of-home placement at costs that were significantly lower than the costs of substitute care. One such program is Homebuilders, which was first implemented in Tacoma, Washington, in 1974. The Homebuilders program was based on the premise that alternative approaches should be tried before removing a child from the home, and the program designed a strategy of intensive, time-limited intervention to prevent family dissolution (Kinney, Madsen, Fleming, & Haapala, 1977).

Home-based programs have continued to develop since the demonstrated success of the early programs. Currently, such programs are gaining wider recognition, and there appears to be an upsurge of interest in home-based approaches. This increased interest and activity appears related to efforts to reform both the child welfare and mental health systems.

In the child welfare system, the concept of "permanency planning" has become the guiding philosophy to ensure that children remain in their own homes if at all possible, or are adopted, or, at minimum, remain in a stable foster placement. Public Law 96-272, the Adoption Assistance and Child Welfare Act of 1980, creates financial and other incentives for efforts to prevent out-of-home placement and reunify families. Legislation in many states has provided further impetus to develop home-based services to help children remain with their families. As a result, there is a clear trend toward the development of home-based, family-focused services within the child welfare system.

Within the mental health system, calls for reform have focused on the need for comprehensive "systems of care" for emotionally disturbed children and adolescents (Stroul & Friedman, 1986). As noted by Heying (1985), there have been a limited number of options for treating severely emotionally disturbed children. Available services are often limited to outpatient care which provides one or two treatment hours per week and residential or institutional care. Mental health professionals may refer children for residential treatment because they have no other way to prevent further deterioration in the child's and family's situation. Home-based services represent one of the needed components in a system of care to provide intensive, family-focused services, which could substantially reduce the need for residential placement. Thus, home-based service programs are beginning to develop to serve emotionally disturbed children and their families.

PHILOSOPHY AND GOALS

Home-based services are based upon the tenet that the family is the most powerful social institution and that families should be supported and maintained whenever possible. The primacy of the family is the basis for home-based services and represents the core philosophy of home-based programs. Home-based programs reflect the principle that the first and greatest investment should be made in the care and treatment of children and families in their own homes. Accordingly, society should invest as much effort and money in working with a child's own family to prevent placement as it invests in out-of-home care.

Home-based service programs regard the decision to remove a child from his or her family as monumental -- a decision that should be made only after great consideration. Out-of-home placement may damage whatever continuity the child has experienced, may introduce new emotional risks, and may undermine family relationships and bonds. Further, Lloyd and Bryce (1984) emphasize that social and mental health services are not advanced enough to predict which families are "hopeless," "unmotivated," or otherwise unlikely to benefit from intensive home-based services. Thus, home-based services are based on the premise that an investment in the family should precede placement.

The principle of the primacy of the family is also reflected in the emphasis among home-based programs on family empowerment. Programs express the belief that parents are in charge of their families and that home-based services are provided to support, encourage, and assist them in the parenting role. Service providers often underestimate both the strengths of families and the power of family attachments (Lloyd & Bryce, 1984). Parents of emotionally disturbed children often feel tired and beleaguered and may feel guilt, fear, and blame for the problems of the child and family (Heying, 1985). Home-based services aim to counter these feelings by attempting to recognize, respect, and build upon the strengths of the family. Further, home-based programs consciously avoid regarding parents as inept and in need of

"treatment." Rather, programs are based upon the premise that even the most troubled families are not totally incapacitated and have strengths that can be enhanced and developed. The underlying philosophy of home-based services, therefore, involves empowering families rather than supplanting them, upholding rather than undermining family integrity, and building upon the strengths of the family.

The perspective of most home-based service programs can be described best as an "ecological family systems" orientation. A "systems" approach is the essential foundation for home-based services. Rather than focus on an individual troubled child, these programs focus on the complex interdependence of the child, the family, and the broader community environment.

Family systems theory considers the forces of the entire family system on the behavior of an individual family member. The client and recipient of treatment is the family as a unit rather than the individual family member, even though the problems of the individual family member led to the referral for services. However, viewing the family system as the client may not be sufficient for treatment effectiveness (Stephens, 1979). There are many environmental forces which impact on the child and family and which are considered within the purview of home-based services. Thus, in addition to attending to the child within the context of the family system, home-based services consider variables including peers, schools, physical environment, social support networks, and community agencies and institutions. In effect, the family, teachers, agency personnel, and other significant, involved persons become the "client" for home-based interventions and are viewed as potential change agents by providers of home-based services. In addition, the approach addresses the family's practical and material problems together with their psychological or mental health treatment needs.

The goals of home-based services are consistent with the principles of family primacy and family empowerment and with the ecological family systems orientation of most programs. Despite differences in specific service delivery approaches, most home-based service programs strive to achieve three primary goals:

- To preserve the integrity of the family and to prevent unnecessary out-of-home placement.
- To link the child and family with appropriate community agencies and individuals to create an ongoing community support system.
- To strengthen the family's coping skills and capacity to function effectively in the community.

The first goal, almost universal among home-based service programs, is to preserve the integrity of the family and, if at all possible, prevent the out-of-home placement of children. In order to prevent family dissolution, programs attempt to engage the family in taking the actions, making the changes, and learning the skills needed to make it possible for the child to remain at home. Many families are referred to home-based service programs in a crisis situation, when the child is in imminent danger of removal. Thus, addressing this goal frequently involves providing intensive services to defuse the immediate crisis, stabilize the family situation, and thereby prevent the out-of-home placement. Teaching new skills and problem resolution techniques is an integral part of the intervention to reduce the likelihood of crisis recurrence.

This goal of family preservation is tempered by home-based programs with an equally important goal -- that of assuring the safety of the child. Programs must be sufficiently vigilant and include sufficient safeguards to ensure that the goal of family preservation is always balanced against the child's safety and well-being. If the child's safety or treatment

needs are compromised by the child's remaining within the home, home-based programs work to facilitate an appropriate placement and treatment plan.

The second goal involves creating links between the family and needed community services and resources. It is expected that these links will endure after the home-based intervention is completed and that these services and resources will support the child and family's ongoing functioning. The arrangements for ongoing services may address ongoing mental health treatment needs for the child and family as well as needs for educational, economic, vocational, health, social, or legal services, or any other type of service or resource.

The third goal focuses on developing or improving the ability of parents to care for their children in their own homes. Most home-based programs work to teach parents effective parenting skills along with coping and problem-solving skills and techniques. These interventions are directed at strengthening the family's capacity to function effectively. For families of emotionally disturbed children, this goal seeks to strengthen parents' ability to manage and cope with their children's emotional and behavioral disorders and to assume the role of change agent for their children.

It is important to note that in addition to intervening to prevent out-of-home placement, many home-based programs are used to assist children already in placements to reunify with their families. Emotionally disturbed children who have been in foster care, group homes, residential treatment, or hospital settings often are expected to return home as different people, without problems, and perhaps "cured" (Heying, 1985). Additionally, the level of family stress that was relieved with temporary removal of the child may escalate on the child's return. As a result, intensive, home-based services can be directed at providing the child and parents the high levels of services and supports needed to reintegrate as a family. The intervention can include facilitating and monitoring increasingly frequent home visits leading up to reunification as well as monitoring and addressing any adjustment problems that may occur when the child returns home from care. For many programs, assisting in the reunification of children with their families is an added goal.

CHARACTERISTICS

Home-based services are provided under the auspices of both public and private agencies through a variety of different arrangements. Public agencies may establish specialized units to provide intensive home-based services or may purchase these services from a variety of types of private providers (Hutchinson & Nelson, 1985). Child welfare agencies, mental health centers and other mental health agencies, hospitals and residential treatment centers, juvenile justice agencies, and other human service organizations may all be involved in providing home-based services. Despite the different auspices and organizational contexts, most home-based programs share similar characteristics. The major characteristics of home-based service programs have been described by the Clark Foundation (1985), Lloyd and Bryce (1984), Kaplan (1986), the Family Empowerment Resource Network (1987), Ginsberg (1986) and others. Based upon the literature and observations from the field, a set of characteristics were developed to describe the major features of home-based services.

1. The intervention is delivered primarily in the family's home.

Traditionally, emotionally disturbed children and their parents have been seen in offices located in some type of mental health facility. In home-based programs, the majority of the direct contact between counselors and family occurs in the family's home. Contacts may also occur in other community settings. For example, counselors may meet with family members and other involved persons at schools, courts, and a wide variety of community agencies. Additionally, counselors may accompany family members to doctor's appointments, on shopping

trips, and to recreational or other outings which provide more informal opportunities for counseling and teaching.

There are numerous advantages to using home visits as the primary mechanism for service delivery. Most obviously, home visits overcome barriers related to service accessibility. Particularly for rural or isolated families or for those without transportation, home visits offer a viable service delivery approach. In addition to enhancing accessibility, services delivered on the family's own "turf" tend to be less intimidating, less threatening, less stigmatizing, and, therefore, more acceptable. Home visits also provide an opportunity to engage the entire family in the service delivery process; family members who may be reluctant or unwilling to come to a traditional office setting might be reached and involved at home.

Assessment of a child and family's problems and progress is more accurate when based upon direct observation in their own environment. The counselor can recognize and understand the family's dynamics, problem areas, and strengths more easily and accurately through first-hand, on-site observation. Further, families can learn and practice skills more effectively within their own environment. Families are not expected to learn skills in the counselor's office and then try to apply them at home. Rather, they can practice in the environment in which they will need to use the skills, with the counselor present to model, coach, and provide feedback.

2. Home-based services have a family focus, and the family unit is viewed as the client.

As noted, home-based services are family-oriented. Rather than focusing solely on the emotionally disturbed child, the child is considered in the context of the family. Programs attempt to involve as many members of the family and extended family as possible, and the entire family's needs are considered in developing the service plan (Hinckley & Ellis, 1985). The families of emotionally disturbed children frequently have been overlooked in the service delivery process, whether the child is at home or in a residential setting. Parents most often are the primary care givers for emotionally disturbed children, and may lack the specialized parenting and coping skills and other resources and supports needed to fulfill their role effectively. Home-based services offer an opportunity to observe and intervene in the entire family system, helping the family to become the change agent for the child.

3. The services have an "ecological" perspective and involve working with the community system to access and coordinate needed services and supports.

Home-based services look beyond the family to the community as part of the service delivery process. Families often are involved with a number of different helping agencies and systems, and they generally require multiple services and supports in order to meet their needs. The ecological perspective enables home-based service providers to recognize the interdependence of the family with its environment and to expand their intervention accordingly. Thus, most home-based programs go beyond traditional "mental health treatment" to address the whole range of needs the family may experience. They work to obtain services and resources from various community agencies; they attempt to identify and utilize natural social support networks where possible; and they work to coordinate the various services and supports needed by a child and family.

4. Home-based service programs are committed to family preservation and reunification unless there is clear evidence that this is not in the child's best interest.

As noted, home-based services operate from the premise that the family is of primary importance and that efforts should be made to support and assist the family unit in order to avert out-of-home placement. While family preservation is the first and foremost goal of

home-based services, this goal is not pursued at the expense of the child's safety and best interests. Home-based service providers emphasize that the safety and well-being of the child is a primary consideration. In fact, providers assert that the nature of home-based services actually allows more careful supervision and observation of potentially dangerous situations due to either the child's or parents' behavior. Supervision and assessment are enhanced because workers visit families frequently, spend many hours in the home, and are available 24 hours a day to respond to crises. As a result, home-based services can help to ensure that family circumstances are assessed accurately and that dangerous situations are diagnosed.

Families involved in home-based programs are made aware that staff must report abusive behavior and that, if a child is in clear danger, staff will advocate for out-of-home placement. Additionally, if the treatment needs of an emotionally disturbed youngster cannot be adequately addressed in the context of the home, staff will explore appropriate out-of-home placements. Thus, home-based providers consistently strive to maintain a balance between their zeal to maintain and preserve family integrity and their goal to ensure that the safety and treatment needs of the child are met. If out-of-home placement proves necessary, home-based services provide a ready means for the family to be involved in the decision-making process as well as to prepare and plan for the child's eventual return home (Bryce & Lloyd, 1982).

5. The hours of service delivery are flexible in order to meet the needs of families, and 24-hour crisis intervention is provided.

Home-based services are generally provided at times that are convenient to the family, including evenings and weekends. Most traditional mental health services are offered during working hours, requiring families to adjust work schedules and the schedules and demands of other children to participate. The flexibility of home-based services eliminates this problem since workers are available at a time and location to suit the family's needs.

Generally, there are few time limits placed on meetings with families. If a family is in crisis, the worker can remain in the home for as long as is needed to stabilize the situation and develop plans. The worker can visit the family daily, if needed, for a period of time. As a result of this flexibility, home-based providers are able to adjust the timing and the intensity of service delivery based upon the changing needs of the child and family.

Nearly all home-based programs offer 24-hour crisis intervention to involved families. Round-the-clock availability enables families to feel that they are not left to cope with difficult and painful problems on their own; they know that help and support are available whenever a crisis arises.

6. Home-based services are multifaceted and include counseling, skill training, and helping the family to obtain and coordinate necessary services, resources, and supports.

The interventions provided by home-based programs typically are highly flexible and are tailored creatively to the needs of each client family. Services are generally as complete and comprehensive as is needed to strengthen the family and bring about needed changes. Bryce (1982) characterized home-based services as providing help with any problem presented. If workers do not have the expertise or resources needed to address particular problems, they arrange for or create resources in order to achieve the goal of stabilizing and improving family functioning.

This flexibility and mix of services is one of the distinctive characteristics of home-based services. While more traditional service delivery approaches tend to concentrate on counseling needs, home-based approaches provide "concrete" services or "hard" services along with

counseling and support. These include teaching child management and problem solving skills and providing or brokering any resources, services, and supports that the family might need.

7. Services are offered along a continuum of intensity and duration based upon the goals of the program and the needs of the family.

The most significant variants among home-based programs are the duration and intensity of the services provided. Some programs define themselves as crisis intervention efforts. They tend to provide highly intensive services (as much as 20 hours per week) for a brief period of time, ranging from approximately four to twelve weeks. These short-term, time-limited interventions are not intended to address all of the families problems. Rather, like most crisis intervention programs, they attempt to stabilize the immediate crisis and link the child and family with other services and supports to meet their longer-term needs.

Other home-based programs provide services for longer periods of time. While highly intensive services may be provided at the outset, service intensity may decrease to a lower level as the intervention progresses. These programs extend their focus beyond crisis intervention, and utilize the home-based approach to work with families on a longer-term basis. Some home-based programs work with highly dysfunctional, multiproblem families for a period of a year or more. These programs are based upon the assumption that a dysfunctional family can benefit from a long and stable association with a single worker.

Generally, the specific goals of the program determine the targets for service duration and intensity. Within certain boundaries, many programs allow flexibility in both intensity and duration of services in order to meet the needs of the particular family.

8. Staff have small caseloads to permit them to work actively and intensively with each family.

Mental health professionals and social workers often are responsible for large caseloads. Under these circumstances, it is difficult, if not impossible, for them to work in a highly active and intensive manner with any one case (Clark Foundation, 1985). To do so would compromise other cases that also demand time and attention. Home-based service programs are characterized by small caseloads. By assigning a limited number of families to each worker, the programs ensure that workers can work intensively with each family and can provide services that are realistically matched to needs of the family. Some home-based programs limit caseloads to two families per worker; others allow caseloads as high as twelve.

9. The relationship between the home-based worker and the family is uniquely close, intense, and personal.

The small caseloads, intensive levels of service, and home visit approach all contribute to the uniquely close relationship that develops between the worker and the family. The worker spends a great deal of time with the family, visits evenings and weekends, is available during crises, and does whatever is needed to help the family in addition to counseling. Additionally, workers generally dress and behave in a relaxed, informal manner and interact with the family under relatively informal circumstances such as around the kitchen table. As a result, very intense and personal relationships tend to develop. Both staff and families report that the home-based service approach allows them to overcome the "professional distance barrier" so common in traditional service settings. Improved trust and motivation often are the results of the close worker-family relationship.

10. The programs are committed to empowering families, instilling hope in families, and helping families to set and achieve their own goals and priorities.

Home-based service programs are dedicated to "empowering" families rather than taking over their role or responsibilities. Lloyd & Bryce (1984) emphasize that parents remain in charge of their families as educators, nurturers, and primary care providers and that workers attempt to offer the encouragement, support, and resources that parents need to fulfill their role effectively. Throughout the service delivery process, families are actively involved in setting goals and priorities, planning, and decision making. The service delivery process generally starts by addressing those problem areas identified as priorities by the family. Additionally, home-based services focus and build upon families' strengths and not just on their problems. Recognition of strengths as well as problems provides a more hopeful, positive framework for service delivery. Many families have a long and frustrating history of attempting to cope with their problems; they are distrustful of service providers and have often lost hope. Home-based services attempt to overcome these barriers by encouraging optimism and hope, focusing on strengths, respecting the family, and teaching the family the skills needed to accomplish the goals they set for their children and themselves.

MAJOR VARIABLES - SERVICE INTENSITY AND DURATION

According to Hutchinson (1986), there is much debate among leaders in the field of home-based services regarding many aspects of service delivery. Debate centers around what to call it, what types of staff should do it, what types of agencies should provide it, what types of families should receive it, and how long it should take. While there are variations in the labels, characteristics of staff, agency auspices, and the types of client families served by home-based programs, the most significant variables among home-based programs are service intensity and duration. Among the programs responding to this survey, the reported duration of services ranged from an average of four weeks to three years, and service intensity ranged from 2 to between 20 and 30 hours of direct contact per week with family members.

As noted, some home-based programs subscribe to the short-term, crisis intervention model of service provision. These programs were pioneered by the Homebuilders program which provides four to six weeks of intensive intervention. The goals of the crisis-oriented programs are to stabilize the family and reduce the risk of out-of-home placement, teach the family new coping skills, and connect the family with appropriate community resources for ongoing service needs. The short-term programs tend to provide intensive services (10 to 20 or more hours per week) to families, and often provide the equivalent of two years of traditional outpatient counseling in less than two months. Due to the highly intensive nature of these services, workers carry extremely small caseloads, often working with no more than two or three families at a time. These short-term, intensive interventions represent a dramatic departure from traditional service delivery approaches.

Many have noted the benefits of the time-limited, crisis intervention approach to providing home-based services. In times of crisis, families are particularly motivated to change, and home-based workers can capitalize on the family's increased willingness to accept help as well as the material provided by the crisis (Caplan, 1964). Time limits can be used constructively to further increase motivation. The pressure of the limited treatment time frame often can induce changes more quickly than they would occur otherwise. Families are made aware from the outset that services will be limited to a specific time period and that the counselor will be available to help as much as possible during that time only. Initial misgivings among Homebuilders' founders about the brief treatment period proved groundless. According to Kinney (1978), the Homebuilders program has shown that four weeks is indeed a sufficient time for most families to initiate lasting changes. In fact, the Homebuilders program gradually

decreased its intervention from eight to four weeks as a result of pressure to serve more families. This reduction in duration did not affect the program's overall success rate.

Short-term programs, however, do not expect to solve all of the family's problems. Generally, they target three or four selected goals as immediate priorities and expect the family to continue working on problems when the intervention is completed, perhaps with help from another community resource. Hinckley compared the short-term, home-based approach to emergency road service rather than major repairs (Polsky, 1986).

Many professionals regard very short-term intervention as "second rate," with effects that are likely to be merely "palliative and temporary." However, support for the use of the time-limited, crisis intervention approach is provided by a study conducted by Fisher (1980; 1984). Families referred to 6-session, 12-session, and unlimited treatment groups showed no significant differences in outcome at termination or at follow-up. The study concluded that time limits can, in fact, shorten the length of therapy without diminishing its effectiveness or the durability of outcomes. Additionally, completion of a short-term, home-based program does not necessarily mark the end of services. Many short-term programs attempt to refer families to other community resources for longer-term services.

Other providers advocate for longer-term approaches to the delivery of home-based services. For example, Goldstein (1973) stated that, for many families, long-term treatment is inevitable. Crisis intervention services have been provided time and time again by many agencies, and the families continue to be crisis-prone. He argued that once an immediate crisis situation is stabilized, it seems unwise to withdraw the service only to wait for the child and family's next crisis. Rather, longer-term services and supports are more likely to help the child and family to remain stable and the family to remain intact.

The value of a long-term, continuous, supportive relationship with a single service provider also has been emphasized, particularly for dysfunctional, multiproblem families (Kagen, Schlosberg, & Reid, 1986; Tannen, 1986a, 1986b). Many families have long-standing, multiple problems which require intensive and lengthy efforts to improve. They may have had negative experiences with a series of more traditional treatment programs and may have dropped out, failed to respond, or refused treatment on previous occasions. For these families, it takes a long time to build trust and an effective counseling relationship. Home-based services offer a service delivery approach that frequently is effective in reaching, engaging, and overcoming mistrust in families that have not responded to other, more traditional approaches. Terminating the services, and the relationship that has been established with the provider, after a brief period of time may be counterproductive in these cases. The longer-term programs offer the opportunity for both crisis intervention and continued family work on an outreach basis.

Thus, longer-term home-based programs extend their focus and goals beyond crisis intervention. They attempt to change dysfunctional family patterns and improve the family's ability to cope as well as to prevent out-of-home placement. Rather than refer families to other programs for ongoing assistance, these programs actually provide the ongoing assistance to families following resolution of the initial crisis situation. The capacity to provide longer-term home-based assistance may be particularly important for those families who are unwilling or unable to use traditional service delivery approaches and in areas where there is a lack of services to provide care following crisis resolution.

Based upon descriptions of programs in the field, three categories of home-based programs have been identified. While the boundaries are by no means absolute, the framework helps to distinguish programs of different combinations of service intensity and duration. The three types of program include:

- Short-term, crisis programs - up to three months duration,

- Mid-range, brief treatment programs - three to six months duration, and

- Long-term intervention programs - more than six months duration.

Of the 32 home-based programs responding to the survey, 41 percent can be characterized as short-term programs which provide services for up to three months. In this category are the programs modeled after Homebuilders, offering interventions for four to six weeks. Some programs in this category limit their interventions to 90 days. Thirty-four percent of the programs are in the mid-range category, and 25 percent of the responding programs are long-term programs, providing services for extended periods of time. Some long-term programs report average durations of nine months, one year, or eighteen months; others report durations as long as three years or more. Several programs within this category place no limitations on the duration of service, contending that long-term, continuous, home-based intervention is still cost-effective if substitute care placements for one or more children are avoided.

As a general rule, the short-term, crisis programs tend to provide highly intensive services for the limited period of service delivery. The mid-range and long-term programs tend to provide more intensive services initially, and decrease service intensity over time to a level consistent with the needs of the family. Across all programs, regardless of duration, the average level of service intensity is over seven hours of direct contact with families per week.

In addition to reflecting programmatic philosophy, decisions about the intensity and duration of services often are a reflection of caseload demands and budget restrictions. Programs establish time limits in order to serve the most families possible within the constraints of limited resources. While there may be temptations to lengthen the intervention, it should be recognized that when duration is lengthened, service intensity is usually reduced in order for the program to remain cost-effective. Thus, the duration/intensity variables are often juggled to achieve optimal service quality and cost-effectiveness and to enable a program to help as many families as possible.

Tannen (1986a) noted the controversy concerning the most effective combination of service intensity and duration for home-based services. She advocates flexibility in the delivery of home-based services, avoiding arbitrary cut-off dates, and tailoring the intensity and duration of the services to the needs of each individual family. In order to respond to the varying needs of families, the Family Advocate Project of the Counseling Service of Addison County, Vermont, expanded its focus to offer a continuum of home-based services. Short-term, crisis intervention is provided when appropriate; mid-range services are provided for situational crises or for families with fairly adequate coping skills; and long-term services are provided for highly dysfunctional families.

Environmental considerations may also play a role in determining the most appropriate time frame for home-based services. Short-term crisis intervention approaches may be more effective in communities with relatively comprehensive systems of care which can provide a range of follow-up resources for ongoing services. If a community has limited resources for ongoing services and support, then brief, time-limited approaches may be insufficient to meet the needs of many families with emotionally disturbed children.

Additional experience and research may be needed to determine the optimal length of home-based interventions or the optimal mix of intensity and duration for particular types of families. Currently, programs tend to base their decisions about the duration and intensity of services largely on their own programmatic focus coupled with the requirements of their

funding sources, particularly whether they define themselves as a crisis intervention program or as a broader alternative to traditional mental health service approaches.

SERVICES

Referrals to home-based service programs generally originate from a variety of child-serving agencies. In most cases, families are referred for home-based services when a child is about to be removed from the home or is at high risk for out-of-home placement. The most frequent referral source for home-based programs tends to be the social service or child welfare agency. Other frequent referral sources include courts and juvenile justice agencies, mental health agencies, and schools, all of which are likely to become aware of emotionally disturbed children and families needing help.

An intake worker or a program supervisor commonly has the responsibility for reviewing all relevant information about a child and family and determining the appropriateness of the referral. This may involve reviewing information on a referral form, reviewing written materials and reports, and talking with involved workers from other agencies. Some programs, such as the Community-Based Service Program of the Baird Center for Children and Families in Vermont, require a screening visit to a family's home prior to final acceptance into the program. Regardless of the process, most programs require that the child be at high risk for out-of-home placement and that at least one parent be willing or motivated to participate in the program in order to prevent placement (or to assist in the child's return from placement). Some programs, such as the Satellite Family Outreach Program of Kaleidoscope, have an "inclusive" admissions policy. This means that if there is a service slot available, the program will accept and attempt to work with virtually any family that is referred, regardless of the severity of their problems. Participation in most home-based programs is voluntary. However, some families may participate knowing that it is the last resort prior to placing a child out-of-home, and in some home-based programs, such as those in Maine, families may be required by court order to participate.

Most of the short-term home-based programs do not keep waiting lists. If there is a worker available, the case is accepted; if there is no service slot available, it generally is recommended that the family be referred elsewhere. These programs maintain that if a family remains on a waiting list for several weeks or months, the crisis often is resolved in some way. The "no wait list" policy is an effort to preserve the crisis focus of the programs. Under these circumstances, some referring agencies may find the referral process frustrating and discouraging. For example, persons making referrals to the Homebuilders program reported that they must be persistent and call daily at 8:00 A.M. in hopes of securing an open service slot for their clients. While referring individuals understand the importance of working with families at the point of crisis, they also wish that there were greater staff availability to ease the difficulty of obtaining services.

More than half of the programs responding to the survey do report waiting lists for services. The waiting period for services ranges from one week to as long as six to eight months. The average waiting period for services in programs with wait lists appears to be between two and eight weeks.

When a worker becomes available, a family deemed appropriate for the program is assigned to the worker's caseload. There may be an attempt, in some programs, to match particular workers with families based on characteristics such as sex or race. In most programs, however, it is a luxury to match families with workers since generally there is only one service slot open at a given time.

It is at this point that the "intervention" begins. The intervention or service delivery process for home-based programs can be divided into three phases: Phase I encompasses engagement, assessment, and planning; Phase II encompasses the actual interventions of counseling, skill teaching, and brokering resources; and Phase III includes the termination and follow-up aspects of service delivery. These phases are not discrete, nor do they have clear boundaries. Rather, they may overlap considerably with several processes occurring simultaneously. Each general phase of home-based service delivery is described below.

Phase I - Engagement and Assessment

The worker initiates the service delivery process by reviewing relevant materials and contacting the family to arrange the initial visit. In some programs, workers do not read the large volume of available materials, evaluations, and reports concerning the child and family prior to the initial visit. This minimizes the potential for the worker to see the situation as overwhelmingly negative or hopeless and, therefore, become discouraged at the outset.

The initial meeting, held in the family's home, is used to further explain the program, clarify expectations and goals, and complete necessary forms and releases. Workers emphasize the anticipated intensity of services, the time limitations, confidentiality policies, policies regarding communication with other agencies, and any ground rules. Family members have the opportunity to ask questions about the program or their participation. Particularly with the short-term programs, the initial meeting is used to ensure that families understand the limited duration of the intervention. While some programs require all family members to be present for the first meeting, most programs are flexible in this regard and will move ahead even if a key family member is unable or unwilling to participate initially. The initial meeting may last from one to seven or more hours depending upon the family's situation and may involve meeting with individual family members as well as with the family as a group. After the initial meeting, families are given the opportunity to decide whether or not they wish to participate.

The first meeting with the worker present in the family's home potentially can arouse strong feelings (Brown, Miller, Dean, Carrasco, & Thompson, 1987). Some families may feel comfortable with the worker and relieved to have help, while others may view the process as intrusive or even degrading. With some families, the worker must use a variety of "ice breaker" techniques to encourage the family to participate, while other families may burst forth with their problems when given the opportunity. Thus, the worker must be alert to the family's reactions and must be prepared to acknowledge and address these feelings. Regardless of any initial negative reactions, according to home-based providers, very few families choose not to participate following the initial meeting.

When the decision is made to proceed with home-based services, several processes are begun simultaneously. Defusing and stabilizing crisis situations, engaging the family in the home-based intervention process, building a relationship between the family and worker, assessment of the child and family's problems and strengths, establishing service goals and priorities, and planning the interventions are all integral parts of the first service delivery phase.

A strong relationship between the worker and family is central to the success of home-based services. As noted, some families initially may be resistant, hostile, disgruntled, or distrustful based upon their past experiences with insensitive or unresponsive service systems (Horejsi, 1981; Lloyd & Bryce, 1984). Home-based workers must have excellent relationships building skills in order to engage families in the service delivery process and to secure a "treatment alliance."

The nature of home-based services facilitates the joining process and the development of an especially close worker-family relationship. Services take place on the family's turf, eliminating much of the threat and stigma of other types of services. Workers generally interact with families in a relaxed, natural, and informal manner which minimizes professional distance. Programs report a number of techniques used to facilitate the engagement or relationship building process (AuClaire & Schwartz, 1986; Weitzman, 1985; Horejsi, 1981):

- Relating to families in a warm, direct, open, nonjudgmental manner, and accepting their gestures of hospitality.
- Demonstrating interest, concern, and respect for families.
- Identifying the family's strengths in addition to its problems.
- Allowing the family to define its own problems and directing the intervention toward goals decided upon by the family.
- Providing practical and tangible help to address a specific and urgent need as the first step.
- Remaining consistently available and accessible to the family on a regular basis and for crises.
- Providing high levels of support and encouragement.
- Conveying positive expectations and hope.

These methods coupled with the home setting and the intensity of services all contribute to the development of a uniquely close and personal relationship between the worker and family. It is important for the worker to be aware of potential problems that may result from this intense working relationship. For example, workers take care not to encourage excessive dependency. They attempt to avoid doing things for families but instead concentrate on teaching families how to do things for themselves. Workers also are alert to potential invasion of privacy or excessive intrusiveness into the family's life and adjust the relationship and intervention accordingly.

When a family is in crisis, one of the first priorities of the home-based intervention process is to defuse the crisis and take steps to halt further disintegration of the family's situation. This may be facilitated by separating family members and allowing each family member to talk with a worker at length about his or her feelings and perceptions of the problems (Kinney et al., 1977). Workers use active listening and other techniques to elicit information until feelings are clarified and tension is released. Often, family members express relief when they feel that they have been heard and understood. Workers may help to structure the situation to minimize the chances for violence or uncontrolled emotional outbursts. Keeping family members in separate rooms and bringing co-workers to talk with each out-of-control person are methods used by workers to begin to defuse a crisis. Contracts, contingency plans, crisis cards which specify behavioral actions to be taken in various situations, scheduling activities, and other methods for relieving stress and gaining control are used frequently by home-based workers (Lloyd & Bryce, 1984). In the FamiliesFirst Program in Davies, California, the therapist may stay with a child and family for up to 48 hours to help to stabilize a crisis situation or may talk with a family on the telephone as often as every hour. Both the therapist and family must feel comfortable with alternative plans for averting explosive situations. Lloyd and Bryce (1984) note that hope and motivation can be developed by helping the family to take one initial action that makes an immediate difference or relieves at least

one source of stress. Once the initial crisis is "defused," families generally are ready to begin defining problems and goals.

Identifying problems and establishing goals is under the rubric of assessment and planning. Several factors distinguish assessment and planning in home-based programs from these processes in other types of programs (Lloyd & Bryce, 1984). First, assessment and planning in home-based services is not a distinct and separate process as it may be in other types of service delivery. Because of the crises faced in many families, assessment generally occurs concurrently with the early stages of service delivery. Further, assessment and planning are not one-time exercises but are ongoing processes used to adapt the intervention to the changing needs and priorities of involved families. In most programs, assessment is pragmatic and is used specifically to gather the information needed for planning service delivery. Finally, home-based programs tend to involve the family as "colleagues and consultants" in the assessment and planning process, relying on the family to clarify problems, consider options, and establish goals.

Assessment information is gathered through many avenues. The home setting offers an opportunity for first-hand observation of the environment, the child's behavior, family interactions, and the family's relationships with the larger community. Beyond observation, the home-based worker may gather information through interviews with the child and family, reports from other professionals, consultation with other professionals who are involved with the family, forms or checklists completed by the family and worker, and standardized instruments or psychological tests when appropriate.

The culmination of the information gathering process is the development of a service plan. Many home-based programs indicate that the service plan is a working document, used to outline specific problems to be addressed and specific actions that will be taken. The service plan generally includes the assets and strengths of the family, the priorities and needs of the family, a precise clarification of what needs to be changed and what new skills need to be developed, the identification of community forces which impact on the families, the goals of the referring agency, and the agency and community resources needed to implement the service plan. The service plan is reviewed and updated regularly (weekly in the short-term programs, monthly in the longer-term programs) and is used as a worksheet to monitor service provision and progress.

Many of the families involved in home-based services have been involved with numerous other providers in the past. Emotionally disturbed children and their families commonly have undergone numerous evaluations and assessments, many of which are negative and pessimistic. Most home-based programs attempt to be more positive and stress using the assessment process to identify strengths as well as problems. Kinney, Haapala, & Gast (1981) provide a series of guidelines for assessment in home-based programs. For example, they stress that the assessment and service plan must give the client hope by setting goals small enough to minimize the chance of failure. They also note that the assessment should conceptualize problems as skill deficits in order to avoid blame and increase hope and motivation for change. An attempt is made to frame the problem as something everyone in the family must work together to solve rather than focusing exclusively on the disturbed child within the family. Further, the priorities of the assessment and plan must match the family's priorities and hierarchy of needs. It may be difficult for parents to concentrate on enhancing their child management skills when they face serious unmet needs for such basics as shelter, food, or income. Home-based programs report that they attempt to start "where the family is at," with the most pressing problems identified by the family. This begins the process of "empowering" families and helps to engage families in the service delivery process.

Phase II - Intervention

As noted, the interventions provided by home-based service programs are multi-faceted. Most programs are committed philosophically to responding to the needs of the child and family. Thus, programs tend to use a combination of approaches that vary according to the specific problems and needs of each family. The nature of the approaches and services used by the short-term and the longer-term programs are remarkably similar, with the distribution, emphasis, and intensity of services varying among programs of different types.

As a general rule, home-based programs strive to select two or three goal areas to work on. The assessment and planning process, as a first stage of service delivery, involves clarifying issues of concern to the family and prioritizing these issues in order to focus the service delivery process. Home-based programs do not attempt to solve all of a family's problems but rather to set limited and specific goals that can be achieved within the anticipated time frame for service delivery. In addition, service delivery is guided by the two principles of "starting where the family is at" and emphasizing the achievement of small changes so that families can experience success. Workers in the Homebuilders program often ask both children and parents, "What one thing would you be willing to change?" as a way to begin focusing service delivery.

In order to emphasize this notion of goal-directed services, some programs require all family members to sign a contract for participation. The Families Work program in Schenectady, New York, for example, negotiates with each family a six-week contract which identifies specific goals and tasks for families to address. At the end of the six-week cycle, the family can recontract for an additional six-week cycle if there are additional goals to address. Not only does this procedure serve to engage the family in clearly defined tasks, but it communicates the expectation that change can occur in a relatively short period of time (Tavantzis, Tavantzis, Brown, & Rohrbaugh, 1986).

Similarly, most home-based programs are careful to establish a realistic mindset about the intervention with families. Workers do not portray themselves as "miracle workers," capable of helping the family with every problem they face. Instead, workers are vigilant about presenting the program as a vehicle to help the family address certain specific problems within a specified time frame and teach them certain skills that they can enrich on their own. Families often are grateful for the honesty and for the realistic expectations about the services.

Services in home-based programs are not always delivered to the entire family at once. Home-based workers may work with the parents individually or as a couple, with children individually, with the entire family as a unit, or with any combination of family members. Additionally, workers spend a great deal of time working with other agencies and individuals who are involved with the child and family. Just as home-based workers may work with varied combinations of family members and others, the types of services delivered are equally flexible. In general, services provided by home-based programs fall within the three broad categories of counseling, skill teaching, and brokering and coordinating resources. While these three types of interventions are discussed separately, it is important to recognize that they generally are delivered by the same workers and, more often than not, overlap. The optimal mix of these services is determined for each family involved in home-based services.

- **Counseling** - Counseling of various types is a major aspect of most home-based service programs. Individual, marital, and family counseling are all options available to the home-based workers to address a particular family's problems. Somewhat "formal" counseling sessions might be structured for a family if appropriate. For example, a family counseling session might be held at the same time each week with the entire family, and an individual

counseling session might be held weekly with a child. Such sessions often are held in the kitchen or living room. A wide variety of techniques appropriate to traditional counseling situations are applicable to home-based services, including structured exercises, family therapy techniques, behavior therapy, and approaches to deal with depression, anxiety, and anger (Lloyd & Bryce, 1984).

In home-based services, much counseling occurs on an informal basis while workers share tasks or coffee in the kitchen, accompany family members to job interviews or other types of appointments, or participate in a variety of outings and activities with family members. Workers report that some of the most effective and significant counseling occurs during these informal activities and situations.

- **Skill Teaching** - A major goal of home-based services is to achieve learning-induced behavior change that will improve the child and family's ability to function. As a result, skill teaching represents an essential aspect of most home-based interventions. Programs work with families to improve parenting and child management skills, communication and relationship skills, anger management and conflict resolution skills, problem solving skills, constructive coping skills, assertiveness and self-advocacy skills, skills needed to use community resources, household management skills, and so forth (Lloyd & Bryce, 1984).

  Home-based services provide an excellent opportunity for teaching and applying new skills to real life situations. According to Fahl (1981), it is very difficult for clients to take discussions or explanations of techniques provided in an office interview and translate these into new or revised behavior. Modeling, role playing, coaching, cuing, practice, feedback, support, and reinforcement must accompany didactic teaching in order for families to learn new skills efficiently. The Home and Community Treatment Program of the Mendota Mental Health Institute in Madison, Wisconsin, uses these methods to work with families of emotionally disturbed children. In the context of their own home, parents are taught behavior management skills and have the benefit of the worker's assistance in applying, practicing, and refining these skills. The program has developed a manual outlining its behavioral approach along with many instructional aides for use with families to teach child management skills such as positive reinforcement, removal of reinforcers, contingency management, and techniques such as "time out" and "stop the world."

  Many other home-based programs also combine didactic approaches with approaches including modeling, practicing, coaching, and reinforcement to teach new skills. Some programs, such as Homebuilders, enhance their skill teaching efforts by providing readings, lecturettes, audiotapes, videotapes, or materials developed specifically for the particular family (such as cards specifying "what Andy can do when angry at Mom"). The Homebuilders program also stresses looking for "teachable moments," times which offer naturally occurring opportunities to learn and practice a new skill. For example, anger management and relaxation techniques might be taught to an increasingly agitated mother waiting with a worker at the welfare office.

- **Brokering and Coordinating Resources** - Emotionally disturbed children and their families invariably have multiple needs for services and supports. Most of these resources are not under the direct command of the agency providing home-based services but are provided by other agencies and systems. Special education, vocational services, substance abuse treatment, income maintenance, housing assistance, health care, recreational services, respite care, and more are resources that may be needed by the child and family and that must be brokered from appropriate agencies and programs in the community. A major aspect of home-based services involves identifying the needs of the family and assisting the family to procure needed resources and services. Further, programs attempt to help families link with informal or natural support systems in the community to alleviate the

sense of isolation and hopelessness that many families face. Self-help groups are among the natural supports that might be considered.

Home-based workers help families to make contact with appropriate agencies and programs, accompany them to the first appointment, and remain in contact with the agencies to coordinate and monitor service provision. Most home-based programs indicate that the resource brokering function does not focus merely on obtaining resources for the family, but rather attempts to teach families how to locate and utilize community resources. Teaching families the basic ingredients of "case management" helps families to grow in feelings of competence and autonomy (Heying, 1985). The success of the home-based intervention may depend, to a significant extent, on the degree of success in accessing needed services and supports for the child and family.

In addition to the resource brokering role, home-based services also involve a resource coordination function. Due to their multiple needs, emotionally disturbed children and their families become involved with many agencies and systems. In many cases, these agencies do not communicate effectively with each other and may be working at cross purposes. The home-based worker often becomes the focal point for coordination due to the intense relationship with the family and the holistic approach to service delivery. The goals of coordination are to develop joint treatment plans which delineate the roles and functions of all involved agencies; to assure that the efforts of all agencies are directed toward common goals; and to assure that the various methods used by different agencies do not conflict or confuse family members (Lloyd & Bryce, 1984). The school generally is a priority for coordination efforts. Home-based workers in many programs play an active liaison and advocacy role with the school, attempting to coordinate home and school efforts and to ensure that the child receives any necessary special education services and supports.

In effect, the home-based worker assumes a case management role for the duration of the intervention. The worker has both the time and the mandate to perform both clinical and "networking" functions. For most home-based programs, the "official" case manager is the child welfare worker involved with the case. In Florida's Intensive Crisis Counseling Programs, for example, the case manager from the Department of Health and Rehabilitative Services retains overall responsibility for the case. The home-based worker must contact the case manager regarding any referrals for additional community services as well as to report progress or problems. Nevertheless, the home-based worker fulfills most case management functions (brokering, monitoring, and coordinating resources) **temporarily** during the time period of the home-based intervention. Similarly, home-based workers in other programs generally do not assume the title of case manager but assume case management roles and functions for the duration of the intervention.

In addition to these three major categories of interventions, some home-based programs offer other services. The Homebuilders program provides an education consultant who works on a volunteer basis with school systems. The consultant functions as an advocate for special education and support services when needed. Other programs also provide specialized staff to serve as liaison with the schools and to coordinate home and school efforts. Some programs provide health care services as an integral part of their home-based interventions. The SCAN Program in Philadelphia includes a nursing unit comprised of a nursing coordinator and four outreach nurses who function as a team with the family workers. This adds a special health care dimension to the program (Tatara, Morgan, & Portner, 1986). The Satellite Family Outreach Program of Kaleidoscope includes a nurse who is available to work with families as needed. Kaleidoscope also provides recreational activities for children involved in any of the agency's programs such as a basketball team and recreational evening activities.

Of considerable usefulness are the flexible funds available to many home-based workers to use in a variety of ways for each family. The Family Advocate Project provides $25 per family to take them to a restaurant, make a small purchase, or support some other type of recreational activity, and the Satellite Family Outreach Program provides $100 per month for each team to purchase incidentals for families. The Homebuilders program has "reinforcement funds" available to purchase concrete services or items for families as part of the treatment program (e.g., purchasing an inexpensive watch for a youngster with a history of wandering off and then requiring the child to check in at regular intervals). The Maryland Intensive Family Service Program provides $600 per family for any emergency need such as housing, food, heating fuel, medical treatment, or even for car repairs or the purchase of a job training opportunity. Workers report that the flexible funds are extremely beneficial in the service delivery process and that home-based programs would profit from increased amounts of such funds.

It should be recalled that many of the above services take place in the context of other types of activities and interactions with families. Counseling and skill teaching may occur while taking the mother out for coffee or lunch; taking the children on an outing to the park; involving the family in a picnic or other recreational activity; accompanying a family member to a job interview, school meeting or appointment with a community agency; or even in the car. Additionally, workers frequently help family members with everyday tasks around the house as a vehicle for strengthening the relationship as well as assisting the family with sometimes overwhelming demands. In fact, Goldstein (1973) stresses that in home-based services, counseling is frequently secondary to "living it out" with the family. Active involvement and assistance with daily living problems, help obtaining services and resources, availability in times of crisis, and persistence in the face of difficult problems are all essential ingredients of home-based interventions.

Round-the-clock availability to respond to crises is a nearly universal feature of home-based programs. In some programs, workers give their home telephone numbers to families so that they can be reached directly at any time. The Homebuilders program also provides families with the home telephone number of the supervisor who is also familiar with the case. As a third option, a beeper is rotated among other staff members so that someone is always available to respond to crises. If the family's own worker cannot be located to handle the situation, the staff member with the beeper assumes responsibility. Many other programs decline to give out workers' home telephone numbers. The Homebuilders program reports, however, that most crises can be anticipated due to the large amount of time workers spend with the family and that families do not call excessively. Families also are encouraged to call workers to share good news as well as problems. Programs that do not provide families with workers' home telephone numbers generally operate some type of rotating on-call system. The Satellite Family Outreach Program rotates crisis coverage among staff members and reports that more crisis calls occur in the early stages of the intervention when families may be testing the availability and commitment of the program.

Most programs have clearly defined policies for handling crises, particularly those involving danger of any type. Workers generally are required to consult with their supervisors whenever danger is involved. Programs reported that they attempt to provide high levels of support and supervision to keep children within the home. For example, the Homebuilders program has provided 24-hour in-home supervision for a suicidal child. However, when the child's behavior or symptoms are no longer manageable within the home setting, programs refer them for hospitalization. The Homebuilders program, for example, contacts the crisis staff from the local mental health center to assess the child and determine if he or she meets the criteria for hospitalization. Should a child require inpatient care, the home-based program typically continues working with the family, child, and other involved persons to plan for the child's eventual discharge and return home. If a child is judged to be in danger of physical,

sexual, or emotional abuse, the worker also would recommend removal from the home. In some cases where danger is imminent, the worker may have to call the police to intervene in order to ensure the safety of all involved.

Some programs have other types of placement resources available for use in crisis situations. The Eastern Nebraska Community Office of Mental Health operates a home support program for families with severely emotionally disturbed and autistic children (Eyde & Willig, 1981). Short-term placements in family crisis care homes are provided for short-term crisis placements. The program has found that, in some situations, removing the child for a brief period of time (even for 24 hours) can help to defuse tension and relieve stress in the family, allowing time to marshall needed services and resources. The Family Advocate Project also has professional parent homes to provide youth with emergency, temporary shelter along with intensive efforts to work with the child and family.

As noted, the intensity and duration of services are highly variable among home-based programs. In many programs, intensity is highest in the early phases of service delivery due to the initial crisis and/or the high level of need. Florida's Intensive Crisis Counseling Programs require at least three face to face visits per week with the family for the first two weeks of service delivery, with telephone contact on the days that visits are not made. Additional visits might be made if the family has no phone. After the first two weeks, at least two visits per week are required. The Homebuilders program may visit the family four or five times during the first week and then decrease to three visits per week, depending upon the needs of the family. The intensity of services provided by the programs responding to the survey ranges from an average of 2 hours to more than 20 hours per week of direct contact with families.

The duration of services reported by home-based programs ranges from an average of four weeks to three years. The short-term crisis intervention programs report that they must be extremely conscious of the time limits throughout the intervention. Workers stress the time limits from the outset of the intervention and may reinforce this by such strategies as providing calendars for families to show the projected termination date. Referrals for ongoing services are initiated as early as possible in the service delivery process, and progress is reviewed as often as weekly to determine which goals have been accomplished and which tasks are left to address. Providers of the short-term crisis models compare their services to microwave cooking -- brief but so intense that they are equivalent to a longer period of more traditional services.

The Homebuilders program began by providing an intervention of approximately eight weeks in duration. As the program has evolved, the intervention period was reduced to six weeks and ultimately to four weeks with the possibility of a two week extension if needed. The average duration of services currently provided by the Homebuilders program is four and a half weeks. The program reported, however, that the average duration of services is somewhat longer for cases involving severely emotionally disturbed children. This conclusion is based upon a demonstration project focused solely on children who were referred in lieu of residential treatment or hospitalization. While the population for this project was very small, the results suggest that it may be more difficult to engage severely emotionally disturbed children and their families in services and that it may take a longer period of time to search for and link families with the resources needed for ongoing treatment and support.

Some of the longer-term programs suggest that such highly intensive services are intrusive, and that joining and building a trusting relationship with a family takes time. These programs believe that it is disruptive to give so much and withdraw so quickly, and, therefore, they offer less intensive interventions of a longer duration. The Satellite Family Outreach Program and the Family Advocate Project provide longer-term interventions, averaging 18 months and

13.5 months respectively. These programs tend to proceed more slowly with the engagement and intervention processes, and they adjust the time frame of services based on the needs of each child and family. Further, these programs have broader goals than the short-term crisis programs and attempt to provide a longer-term service delivery alternative. Some programs provide home-based support for many years to families that would be likely to disintegrate without such extended support. They argue that long-term, in-home support is preferable to and more cost-effective than the long-term, out-of-home placement of a child.

Home-based workers have pointed out that work with families tends to expand to fill whatever time frame a program allows. Everyone (including referral sources, families, and workers) wants more time for the intervention as there is always more to be accomplished with a family. Still, it must be recognized that, as the intervention is lengthened, the intensity generally is reduced and worker caseloads are increased to remain cost-effective. This has implications for worker availability to families as well as for the number of families that can be served by a program.

Phase III - Termination and Follow-Up

Planning for the termination of home-based services commonly begins when the case is opened. Particularly in the programs of short duration, planning for termination and for meeting ongoing support needs is an integral part of service delivery. The Family Advocate Project refers to this phase as "transition" rather than termination because it is not seen as the end of services. Use of this term emphasizes that children and families may not be "cured" and that they may have many remaining problems. They have, however, met their primary treatment goals with the program and are ready to move on. Lloyd and Bryce (1984) indicate that the decision to terminate services often is complex and difficult. They provide a set of general guidelines to assist programs in judging when termination is appropriate:

- The family is coping reasonably well.
- The family has reached acceptable attainment of service goals.
- The family's basic needs are being met.
- The child is no longer at risk of placement or has returned home from placement and made a positive adjustment.
- The family is receiving necessary services from other agencies.
- The family has developed a support system (extended family, friends, other agencies, or groups) which is likely to remain accessible.

Of course, termination may occur under other, less positive circumstances such as when the family refuses to participate any further or the child is placed out-of-home.

In many programs, termination is a gradual weaning process. As the family makes progress, the worker naturally may visit less frequently. The Family Advocate Project, for example, makes brief, monthly, supportive visits to a family for a period of time prior to completing the transition. As termination approaches, some programs develop specific termination plans. These plans are negotiated with the family and may include the number and frequency of visits, plans for handling any remaining unresolved issues, and plans for handling crises which may arise (Lloyd & Bryce, 1984). Other programs handle the discharge process more informally. The steps taken by most programs to ease the termination or transition process involve planning for termination from the earliest phases of the intervention, regularly

reviewing progress and remaining issues, setting a time frame for termination with the family, discussing impending termination with the family, and ensuring that needed ongoing services and supports are in place. Some workers and families arrange a special party or dinner to celebrate progress and the end of services, and, in some cases, families give the worker a tangible gift of gratitude.

Many home-based programs remain a resource for the family following the termination of services. If a problem or crisis occurs, families are encouraged to call the programs for additional assistance. Under these circumstances, workers may provide needed support or assistance via telephone or may offer one or two home visits to review skills and address current problems. The Homebuilders program refers to these additional sessions as "booster shots" (Kinney et al., 1977). Families also may be re-referred to Homebuilders for a second episode of intervention, if appropriate, after a 90-day period has elapsed. Other programs also remain available to assist families following termination of services. Kaleidoscope, for example, may provide crisis intervention services to families or may reinvolve families for longer-term services if a slot is available and if everyone agrees that reinvolvement is necessary and appropriate. Families inevitably will experience crises and ongoing difficulties in their attempt to cope with the demands of a severely emotionally disturbed child. Most programs offer some type of crisis intervention or "refresher course" for families to reinforce previous skill building and provide support when families request additional help. Workers do not want families to feel deserted when setbacks occur, nor do they see it as a failure if families require help again at a later time. Families know that there are periods of time during which they can function on their own but that, when they experience a crisis, they can ask for and receive additional help.

Follow-up is a difficult and frustrating aspect of service delivery for many programs. Some programs have formal procedures for follow-up. The Families Work program has a standard follow-up procedure involving planned meetings at six weeks, three months, and one year after termination. The follow-up meetings are used to review the child and family's progress, assess current level of functioning, and reinforce the family's gains. The follow-up visits also allow the worker to note any signs of increasing stress or impending crisis and to provide any needed support or intervention before the situation further deteriorates. Thus, the follow-up sessions often serve a crisis prevention function whereby problems can be anticipated and coping strategies devised.

Most programs, however, do not have such formal or organized follow-up procedures built into the program design. Rather, workers and families remain in touch on an informal basis, primarily by telephone. Follow-up contacts generally are at the initiative of the worker and/or the family. Many workers expressed the desire for a follow-up period of approximately six months during which they could maintain phone contact and periodically visit to ensure the family's stability prior to withdrawing completely. However, the demands of current and new cases often interfere with their ability to follow-up on former clients. Many programs are struggling to find effective ways of supporting and monitoring families following the termination of services without compromising their current caseload responsibilities.

Theoretically, families involved in home-based services will receive needed ongoing services and supports from other agencies. Programs report, however, that linking families with appropriate resources also can be frustrating. The short-term, crisis programs may find that the time period is too short to make all the necessary arrangements for ongoing services. For example, the process of developing an Individual Educational Plan (IEP) and arranging for special education can be cumbersome and may not be completed by the end of the intervention. Thus, there may be "loose ends" at the closure of the crisis intervention time frame. In some cases, workers continue to monitor and assist in completing referral arrangements even though services have been terminated.

In many areas, resources to provide ongoing services and supports simply do not exist. A severely emotionally disturbed child and family may benefit from outpatient services, day treatment, case management, or other services which may not be available. Even if services are available, many families are unable to take advantage of them. They may not have financial resources or insurance to pay for services; they may not have transportation; or they may not be amenable to the types of services that are available. In addition, some programs report that the available ongoing service programs often are not congruent with the approach and philosophy of the home-based program.

The difficulty in obtaining appropriate, ongoing services presents a particular dilemma for the short-term, crisis program models. Workers experience frustration withdrawing from those families for whom appropriate ongoing services and support cannot be accessed; families experience a similar feeling of frustration and abandonment. Thus, it appears that the resources available in a community should be an important factor in determining the type of home-based service model that can be implemented effectively. It may be more difficult to provide very short-term home-based services in communities where there are limited resources for ongoing support to those families needing longer-term assistance.

LINKAGES

Children and families commonly have multiple service needs and are involved with numerous service providers. Typically, there is little communication and coordination among providers, and services are provided in a piecemeal and fragmented manner. The varying goals, philosophies, and treatment approaches used by different providers may cause conflict and confusion for families and may impede progress.

Home-based services are based on an ecological systems orientation and attempt to include all involved persons in the service delivery process. The emphasis on communicating, collaborating, or "networking" with all agencies and professionals that affect the family is a distinguishing feature of home-based programs. For the Family Advocate Project, working with the network of involved providers is as important as working with the family. A major goal of the home-based intervention is to empower the network to fulfill its role more effectively, thereby helping to bridge the gap between the family and the outside world. There are many advantages to establishing linkages with relevant community agencies and individuals and to working with the network as well as the family (Balis & Harris, 1982; Cutler & Madore, 1980; Gatti & Coleman, 1976). Networking with involved agencies prevents conflict and confusion and assures that providers are not working at cross-purposes. Further, it allows multiple providers to develop a service plan which clearly delineates mutual expectations, roles, and responsibilities.

One of the first tasks completed by home-based programs is to obtain written permission from the family to contact and communicate with other involved agencies and providers. Many home-based programs proceed to work with other agencies by creating "individual networks" of significant agencies and persons involved with each family. The worker begins to contact other care givers in order to begin the process of working together. Workers may telephone or visit network members to clarify the role and services of the home-based program and begin the process of reaching agreement on service delivery objectives, strategies, and responsibilities. The home-based worker is a logical coordinator and convener for interagency collaborative efforts.

Meetings or staffings of all involved agency personnel may be held early in the service delivery process and at various intervals to continue the collaborative planning efforts. The Satellite Family Outreach Program holds full staffings for the family's network every six

months to review progress and plan further interventions. The Family Advocate Project generally holds a large network meeting early in the intervention which is seen as an organizing meeting. Additional network meetings may be held in the middle of the intervention and during the transition period. Some agencies involve the family in the network meetings or staffings to ensure that the perceptions and priorities of the family are kept at the forefront. The Family Advocate Project notes that families generally do not attend the first network meeting since many providers come to the initial meeting with negative feelings and frustrations about the family that they need to vent. In between meetings, workers maintain close contact and communication with key network members.

Some programs also have permanent networking structures which are used as a basis for their interagency collaborative efforts. Each home-based service program in Maine operates under the guidance of a regional, multi-agency, interdisciplinary steering committee. These committees consist of representatives from all of the child-serving agencies in the area served by the program including representatives from the education, human services, mental health, and corrections systems. Most agencies which refer families to the programs are represented on the steering committees, and the committees function in an advisory capacity to the home-based programs. Hinckley and Ellis (1985) outline a number of clear benefits of the interagency steering committee:

- It serves to reduce the distance between the mental health system and other community systems and helps participants to understand each other's roles, responsibilities, and limitations.

- It helps participants to remain clear about referral criteria and procedures and reduces inappropriate referrals for home-based services.

- It surfaces the need for changes in the program and its procedures.

- It allows members to coordinate services and jointly discuss problems with particular cases.

- It serves as a significant political force in the region and at the state-level to advocate for needed services for children and families.

The Family Advocate Project coordinates the Family Support Team, a standing, multi-agency task force which was involved in designing the home-based program. The Family Support Team acts as the steering committee for the program as well as reviewing intakes and fulfilling a coordinating role.

Programs undertaking networking efforts emphasize the importance of approaching other agencies with a positive, cooperative attitude. Workers must convey respect and be sensitive to the perspective of other helpers rather than coming across as knowing more and "telling" others what to do. It is essential to express the need for the input and participation of the other agencies and to be willing to do the extra work often involved in collaborative programming (Lloyd & Bryce, 1984). Initially, programs may encounter resistance to networking attempts and must work to overcome the antagonism and turf issues that so frequently impede interagency cooperation. A great deal of groundwork may be needed in order to create a cooperative tone and atmosphere.

Programs also report that there may be certain agencies who remain less responsive to attempts at establishing functional linkages. For some programs, the linkage with the education system represents the greatest challenge to networking attempts. The Family Advocate Project places special emphasis on working with the schools, holding meetings at times and locations convenient to school personnel. However, many programs find it difficult

to maintain working relationships with the multiple autonomous school districts within their jurisdiction and encounter resistance in arranging for special education or support services for their clients. Regardless of the difficulties and barriers, the networking or coordinating role of home-based programs is central to the success of the interventions.

CLIENTS

Most home-based service programs share similar acceptance criteria. In order to be considered appropriate for home-based services the following criteria generally are applied:

- The family must reside within the geographic area served by the program.
- The child must be at high risk for out-of-home placement.
- At least one parent must be willing to work with the program to keep the family together.
- There is no serious threat of violence or physical danger to staff.
- Less intensive services are not adequate to meet the family's needs.

The major criterion for involvement in home-based programs is that a child be in imminent danger of out-of-home placement. When a child and family are referred for home-based services, more traditional types of interventions frequently have been exhausted, and the child is at the point of removal from the home. Providers who refer families for home-based services typically are asked to document that, without the home-based intervention, out-of-home-placement would be the most likely next step -- home-based services are the last resort. In order to eligible for the Homebuilders program, the referring agency and staff must agree that at least one family member will be placed in an alternative living situation if the referral is not accepted.

Some programs have additional criteria for assessing eligibility. Programs may exclude children and families for a variety of reasons. For example, programs might not accept families with children who are actively suicidal, extremely violent, acutely psychotic, severely retarded, or severe substance abusers. If the family situation is judged to be dangerous and the child's safety cannot be ensured, then home-based services also may be considered inappropriate. Additionally, if the child is currently in an out-of-home placement and is not likely to return home within a specified period of time (often 10 days), the referral would not be accepted.

Home-based services have been used successfully with a wide variety of populations. Lloyd and Bryce (1984) outline the types of families for whom home-based services may be effective:

- Families of adolescents in conflict with family and community, i.e., acting out adolescents and status offenders.
- Families at risk of child abuse or neglect.
- Families of emotionally disturbed children.
- Families of children with developmental disabilities.

Programs may target one of these populations for their services, or they may define their target populations even more narrowly. Family Support Services provided by Day One in Cumberland County, Maine, targets youth who have substance abuse problems for their home-

based intervention. Many programs serve a mix of these populations, and the experience of home-based programs in Maine suggests that the services are equally effective with children categorized as "emotionally or behaviorally disturbed," "delinquent," or "abused or neglected" (Hinckley & Ellis, 1985).

Since home-based services are focused on families, many programs do not keep records or assign diagnoses to the involved children. While the child's behavior or situation precipitates the referral, programs tend to avoid focusing too heavily on the "identified patient." As a result, it is somewhat difficult to obtain an accurate profile of the children involved in home-based programs. Of the programs responding to the survey, the vast majority serve children from infancy through age 18; three programs extend their age limits to 21. Programs appear to serve slightly more early adolescents than any other age group, with approximately 35 percent of the children falling in the 13 - 15 age category. Approximately 28 percent of the children served across programs are ages 6 to 12; 23 percent are ages 16 to 17; and 11 percent are ages 0 to 5. Less than 3 percent of the youth served by these home-based programs are over age 18. Some programs target younger children for their services (two programs in this sample), while others work exclusively with adolescents (four programs in this sample).

The home-based programs included in the survey appear to serve a higher percentage of males, approximately 63 percent versus 37 percent females. The racial characteristics of the children served vary widely with the location of the program. Across all programs responding to this survey, approximately 75 percent of the children served are white; 21 percent are black; 3 percent are Hispanic; and less than 1 percent are in other racial groups such as Native American or Asian.

With respect to diagnoses, most programs characterize the children as having behavioral/conduct disorders (57 percent of the children served) or emotional disorders (27 percent). A much smaller percentage are considered to have schizophrenic or other psychoses (2.4 percent). It should be noted, however, that programs may have used different definitions to distinguish between these categories, and there may be considerable overlap. Kaleidoscope reports that about 60 percent of the children served in the Satellite Family Outreach Program can be classified as severely emotionally disturbed, and the Homebuilders program similarly indicates that a large majority of the children they serve have a DSM III diagnosis. Thus, whether the referral originates from the mental health, child welfare, juvenile justice, or education system, many of the children involved in home-based programs have emotional or behavioral disorders and share similar characteristics including acting out, poor impulse control, depression, and poor peer relationships.

While programs often do not describe children by diagnoses, they do provide behavioral descriptions of the children they work with. The Child Adolescent Program in Champaign County, Illinois, serves adolescents with the following problems (Clayton-Fechtman, & Seibold, 1981):

- Chronic acts of violence to self or others including serious suicide attempts, self-mutilation, assault, etc. which are often accompanied by community pressure for institutionalization;

- Symptoms of severe mental illness (psychosis, clinical depression, etc.) which cause dysfunction in several life domains;

- Incidents of neglect or abuse, typically evidenced in behavior problems of the adolescent such as status offenses, misdemeanors, etc., and

o Signs of serious psychosocial dysfunction in several life domains.

The children served by the home-based service unit of the Hennepin County, Minnesota, Child Welfare Division are described as having numerous and serious problems (AuClaire & Schwartz, 1987). All children involved in the program were approved for out-of-home placement with 72 percent recommended for placement in either group treatment homes or residential treatment centers. All children exhibited a wide range of behavioral problems at home and at school, and 40 percent of the children had a history of previous out-of-home placement. In most cases, parents described their children as "out of control."

The families involved in home-based service programs commonly face a multitude of social, economic, and emotional problems. Familystrength of Concord, New Hampshire, reports that the families served have multiple service needs related to poor job skills, housing and food inadequacies, alcoholism, family violence, and mental illness. Data from the Satellite Family Outreach Program reveals extremely high rates of substance abuse among parents (approximately 75 percent) and high rates of intrafamilial conflict such as spouse abuse or child abuse. Two-thirds of the families are headed by single parents, and there are high rates of unemployment as well as dependence upon some type of income maintenance or welfare.

The families targeted by the Family Advocate Project are severely dysfunctional families characterized by such problems as lack of coping and problem solving skills, frequent crises, lack of hope, social isolation, economic deprivation, and a high incidence of child abuse and neglect. These families typically are unable or unwilling to utilize more traditional service approaches. They may not have transportation, telephones, or the verbal skills needed to benefit from traditional therapy. Further, many families have had negative experiences with agencies and may lack trust in service providers. Home-based services offer an opportunity to reach families in need who are not likely to participate in or benefit from more traditional types of approaches.

Home-based services can be adapted to many special types of populations. For example, the Homebuilders program has used interpreters to work with deaf children. Special projects have been undertaken by the program to apply the model to developmentally disabled children and their families and to families who have adopted special needs children. The home-based intervention has been used successfully when the adoption appears to be on the verge of failure. A pilot project funded by the Washington Mental Health Division applied the Homebuilders model to children as a direct diversion from admission to psychiatric hospitals. Home-based services also have been used with sexually abused children, working with the child and family once the offender is removed from the home.

Programs report that some types of children and families present greater challenges to home-based workers. For example, delinquent children returning from institutional or residential placements are considered particularly difficult by workers. In addition, serious substance abuse among parents (particularly if they are unwilling to seek treatment) presents a major obstacle to home-based interventions. Some programs accept parents with severe substance abuse problems only if they agree to participate in a rehabilitation program (Lloyd & Bryce, 1984).

Home-based services are ideally suited to work with minority families (Lloyd & Bryce, 1984). Mental health and social service agencies typically have not been sensitive to differences in cultural, ethnic, racial, or other characteristics of their client populations. These differences have been neither respected nor considered in planning and delivering services. Thus, many service delivery approaches have been less effective with minority populations. It has been further charged that minority children may be more vulnerable to out-of-home placement due to a number of factors including cultural bias, negativity of providers and public officials

toward certain cultural and ethnic groups, and language and communication problems (Lloyd & Bryce, 1984).

Home-based services potentially can overcome many of the problems and barriers inherent in working with minority children and families. Workers are present in the home and in the neighborhood and are, therefore, easily able to observe and understand differences in culture, lifestyle, and values. Awareness of the environment and of the level of acculturation of the family are essential for planning appropriate services (CASSP Technical Assistance Center, 1986). The flexibility of home-based services allows workers to vary the intensity and types of services offered to adapt to the needs of each individual family. The emphasis on linking families with natural support systems also is well suited to minority families, who often turn to extended family, churches, and indigenous healers for assistance and support.

Programs serving large minority populations tend to recruit minority staff to serve as home-based workers. While it is not always possible to match staff and families, minority staff also can serve as a resource for nonminority staff, helping them to overcome misunderstandings, prejudices, and myths (Lloyd & Bryce, 1984). Home-based programs also obtain, on an as-needed basis, the assistance they need to work with particular families. For example, a program reported hiring an interpreter to help the home-based worker to communicate with an Asian family. The interpreter's role extended to helping the worker to understand the culture, beliefs, and customs of the family, and to observe the expected protocol as a "guest" in the family's home. Thus, the flexibility and adaptability of home-based services make them uniquely suited to accomodate minority families.

STAFF

Line staff is the most important resource for home-based programs, and the quality of staff is a major factor in a program's success. Accordingly, many special considerations enter into the selection, training, and support of home-based workers. Haapala and Kinney (1979) emphasize that the job of a home-based worker is far more demanding and stressful than traditional office-based counseling. Workers must be able to function well in unstructured, unpredictable, and potentially dangerous situations. They must be willing to work evenings, weekends, and holidays and must be highly flexible in order to respond to crisis situations that may arise at any time of day or night. They must be willing to do "hands-on" work with families and fulfill case management functions in addition to clinical work. They also must be able to juggle the demands of their own lives and families with the unpredictable schedule and the often overwhelming needs of clients.

The flexibility and variability which may make home-based work stressful and difficult for many persons are the very characteristics which make this type of work attractive to others. Some persons enjoy being at home during daytime hours with their children or accomplishing personal chores, and working with clients during the afternoons and evenings. Some programs, such as the Family Advocate Project, hire part-time professionals to increase flexibility and to attract qualified professionals who, for any reason, may prefer a part-time position with flexible hours. The arrangement may be particularly appropriate for professionals with families who do not want a traditional, full-time job. Home-based programs report that it is essential to recruit and select individuals who can adapt to the demands of home-based work and the difficulty in setting boundaries between personal life and work life. For home-based services, "job fit" is equally as important as qualifications in selecting staff.

In selecting home-based workers, programs generally look for a particular combination of educational background, previous experience, and personal qualities. The educational background of home-based workers varies across programs. Most programs use professional staff at either the Bachelor's or Master's level to provide services. The Family Advocate

Project uses Master's level staff, preferably with training in counseling, psychology, or social work. The rationale for using Master's level staff is that the families involved in the program frequently are the most challenging families, and that staff must have strong clinical training and skills. While the degree is not a requirement, most Homebuilders staff are at the Master's level.

The Satellite Family Outreach Program found that many graduate school-trained staff had difficulty accepting the program's values, philosophy, and approach. As a result, many of the program's staff are at the Bachelor's level. Other programs employ skilled paraprofessionals to provide home-based therapeutic and support services to families. Maine's home-based programs report good results with highly motivated staff with less than a Bachelor's degree. Knowledge of the community and its mores was found to be more important than academic credentials in working with troubled families (Hinckley & Ellis, 1985). Decisions regarding the staffing of home-based programs sometimes reflects the need to provide highly intensive services within limited budgets.

Home-based programs tend to look for staff with specific types of experience, including experience in crisis intervention, family therapy, parent training, and case management. Prospective staff are not necessarily expected to have experience in all of these areas; rather, programs look for a background that bears some relationship to the types of skills needed for home-based services. The Family Advocate Project looks for staff that has worked with families in some type of nontraditional setting or circumstance rather than applicants who have worked primarily in traditional office settings. The Homebuilders program looks for staff with a behavioral/cognitive background and teaching experience. The program does not expect staff to have all the requisite skills for home-based work but does attempt to select staff members who are willing to learn and accept feedback.

Along with education and experience, programs place a heavy emphasis on the personal qualities and characteristics of staff. The following characteristics were cited by programs as important for home-based workers:

- Engaging, friendly, warm, good social skills.
- Commitment, dedication.
- Motivation, enthusiasm, self-starter, high energy level.
- Good communication skills, ability to relate to a wide variety of people.
- Empathy, high degree of interest and caring for clients.
- Nonjudgmental, ability to respect and accept others.
- Flexible, adaptable, ability to be versatile in treatment techniques, willing to get "hands dirty."
- Good judgment, common sense.
- Good problem solver.
- Stable, mature.
- Good sense of humor.

- o Patient, ability to live with limited goals.
- o Persistent.
- o Nonpretentious, comfortable in homes of extreme poverty and with families with different lifestyles and values.

Programs often have extensive screening and selection procedures to ensure that staff possess the right combination of training, experience, and personal qualities. Many programs use role play and hypothetical situations to test the potential reactions of applicants to a variety of situations. The Homebuilders program screens applicants by telephone followed by a series of interviews. The first interview is with the county supervisor, and the second interview involves role plays coupled with a debriefing session on the role play to assess the applicant's receptivity and attitude toward supervision. Other staff can participate in the role play or can view a videotape of the role play to assist in judging the applicant's appropriateness for home-based work.

The role of staff in most programs involves a combination of therapeutic, skill teaching, and resource brokering/coordinating functions. Staff members, functioning individually or in teams, are responsible for providing all needed services to a particular family. Some programs, however, separate these functions and assign different staff members to fulfill them. Based upon the experience of the Child Welfare Division of Hennenpin County, Minnesota, AuClaire and Schwartz (1986) advocate separating the functions of the in-home therapist and the case management/service procurement function. The home-based model described by Compher (1983) utilizes a team approach and differentiates between "family therapist" and "case manager," roles which require different sets of skills. Others have stated that highly trained social workers or psychologists should be used to provide therapeutic services while less highly trained social workers or paraprofessionals should be used to address resource deficits and/or provide day-to-day support (Tinjaca & Sands, 1986).

The Satellite Family Outreach Program operates with five teams of staff, each comprised of a group of family workers and one Master's level social worker. The role of the social worker involves coordinating the treatment process: planning the interventions, seeing the family monthly, and providing clinical support and consultation to the family workers. Family workers are responsible for providing direct services including counseling, skill teaching, and brokering and coordinating resources. It is clear that home-based programs use a wide array of professionals and paraprofessionals in a variety of configurations and roles.

Some programs augment their staff with medical or education specialists who are available to work with families and home-based workers as the need arises. A nurse is assigned to the Satellite Family Outreach Program to perform health screenings for all families and to provide ongoing services to families with medical needs. A physician operates clinics at the agency twice monthly to make medical care more accessible to client families, and staff, including a jobs coordinator, recreation coordinator and housing coordinator, also are available to assist the home-based program. The Oregon Intensive Family Services program relies upon Masters level therapists to provide services but supplements the staff with community resource specialists when needed. These specialists might include homemakers, parent trainers, mental health workers, school teachers, church counselors, community nurses, and vocational or employment counselors.

A major variable among home-based programs is whether they utilize staff individually to work with families or in teams. Many programs use two-person teams to deliver services to families. The St. Michaels Center In-Home Family Therapy Program in Maine uses two-person teams (preferably composed of one male and one female worker), as do all Maine's home-based

service programs. The Community-Based Service Program of the Baird Center operates an interdisciplinary team consisting of three family workers and one consulting teacher who work with families in any combination. One member of the team is assigned "case coordinator" and is responsible for all case documentation. Other programs, such as the Family Advocate Program of the Sunrise Family Resource Center in Vermont, use the concept of a primary and secondary worker. The primary worker is responsible for most of the direct service and resource brokering; the secondary worker functions as a back-up in case of emergency and maintains a relationship with the family so that the substitution is not disruptive.

A number of advantages to using a team approach to delivering home-based services have been cited (Lloyd & Bryce, 1984):

- Team members provide mutual support and assistance for each other in the context of demanding, unpredictable, and stressful work.
- Professional objectivity is enhanced as the second team member provides feedback.
- Service continuity and emergency coverage are enhanced, since, if one worker is unavailable, the second team member is likely to be available and already has an established relationship with the family.
- Expertise is expanded since fresh insights, knowledge, approaches, and ideas are contributed by both team members.
- Team members may assume complementary roles with the family, e.g. challenging versus nurturing.
- Safety of workers is enhanced, particularly in inner city environments, since they do not go to the families' homes alone.

While there are sound bases for using a team approach, many programs opt to use individual workers with each family. The Family Advocate Project notes that teams mitigate the intimacy of the worker-family relationship and that greater professional distance results. Conflict and competition may erupt between team members, and logistical problems related to coordinating schedules and responsibilities may complicate the workers' availability to families and responsiveness to their needs. It may be difficult to separate out "therapy" issues from other types of services, as some team configurations attempt to do. Further, there are major resource implications resulting from the use of teams since two workers are used to work with each family. Thus, reasons of economy also contribute to the decision to use individual workers rather than teams.

Home-based services are nontraditional interventions, and few colleges or universities prepare students of any discipline for providing these services. Some programs believe that formal education may be antithetical to the philosophy and approach of home-based services. As a result, some "restructuring" of worker attitudes and skills may be necessary in order to prepare them to be effective home-based workers (Pecora, Delewski, Booth, Haapala, & Kinney, 1985).

Many home-based programs provide intensive training experiences for newly hired staff members. Training generally includes a didactic component (reading and workshop experiences) coupled with on-the-job training experiences and supervision. The Homebuilders Program, for example, provides approximately four days of workshop training for new staff, followed by the opportunity to experience a case with a supervisor. The new staff member primarily observes the handling of the case and is then provided with additional workshop training. Following a

protocol of on-the-job training and active supervision, the new staff member takes a more active role on the second case with the supervisor observing. By the third case, the new worker generally is ready to take a lead role with frequent supervision and consultation. Many other programs also use an "apprenticeship" system whereby new staff are paired with more experienced staff for training purposes.

The line staff training provided by the Homebuilders program covers a wide range of topics, including crisis intervention, strategies of the Homebuilders model, therapist stress management, structuring before going out, assessment of the potential for violent behavior, structuring during visits, defusing and engaging difficult clients, assessment and goal setting, multiple impact therapy, what to do when progress isn't occurring, structuring between visits, behavioral strategies with families, teaching families communication skills, cognitive strategies with families, teaching families assertive skills, teaching negotiation and problem solving skills, termination issues, and special topics such as depression and suicide and anger management. The Satellite Family Outreach Program also has a specific training package for new staff which covers similar topics.

Haapala and Kinney (1979) state that home-based work may represent a difficult transition from more traditional service delivery and that it may be difficult for staff to adjust. They contend that training for home-based work must address three primary areas -- assumptions and awarenesses, process, and content. Regarding assumptions, staff must learn and adopt the basic philosophies and beliefs of home-based work (e.g. not considering any family hopeless; working on problems areas identified by the family rather than on the therapist's agenda; viewing family members as colleagues; etc.). Techniques such as active listening, modeling, and role playing are among the process skills that are needed by home-based workers; content includes a wide variety of concrete options that can be used to work with families such as behavior modification, rational emotive therapy, mood control techniques, rational emotive therapy, relaxation training, and cognitive restructuring. A resource guide developed by the Homebuilders Program reviews a wide variety of "content" skills that can be used by workers when appropriate (Kinney & Haapala, 1978).

The importance of using training to change workers' attitudes is particularly important for home-based services. A study conducted by Pecora, Delewski, Booth, Haapala, & Kinney (1985) demonstrated that training can be effective in shifting workers' attitudes to be more congruent with the philosophy and values of home-based services. Training was particularly effective in helping workers to recognize the importance of de-emphasizing previous diagnoses, allowing clients to set their own goals, delivering services in the home environment, providing "concrete" services as well as counseling, routinely working evenings and weekends, providing clients with the worker's home telephone number, and other principles. It is important that staff development efforts do not overlook worker attitudes while concentrating on process and content skills.

In addition to the intensive training experiences for new staff, many programs provide in-service training to enhance the knowledge and skills of staff in specific areas. Topics such as sexual abuse, minority issues, and advanced training in a particular skill are among the special training opportunities that may be provided. The Satellite Family Outreach Program arranged for training on Satanic cults and gangs when these appeared to be issues affecting some of the children involved with the program. The program also arranged for staff members to receive training in sign language to enable them to work with deaf clients. The Family Advocate Project arranged for training on dealing with dogs after two staff persons were bitten by dogs while making home visits. In addition to training provided directly by the programs, many programs arrange for staff to attend conferences, workshops, or institutes that will enhance their job skills. The Family Advocate Project encourages each staff member to select an area per year that they wish to work on and to seek out professional

development opportunities to focus on this particular area during the year. These types of opportunities for training and professional development are important factors in the retention of staff (Hinckley & Ellis, 1985).

Extensive individual and group supervision also is reported to be an essential factor in the success of home-based programs. It is important for staff to feel that they are not "alone" with the crises and overwhelming problems of families and that back-up and support are available to them at all times. The Family Advocate Project had a "buddy system" among workers for mutual support and consultation which now operates informally. Weekly staff meetings are considered crucial for case consultation, problem solving, and supervision as well as for creating a support system for staff. Home-based programs emphasize the crucial role of clinical supervision and specify that the opportunity for consultation should be available on a regularly scheduled basis as well as in crisis situations.

Staff burnout is a major issue to be considered by home-based programs. Over time, working with problem families and families in crisis can exhaust even the most energetic staff and can lead to frustration and discouragement (Kagen et al., 1986). The Satellite Family Outreach Program has a group of staff who have been with the program for more than five years. However, the average period of staff retention is approximately two years in that program. While the primary reason cited for staff turnover is the low salary level, program administrators acknowledge that "burnout" contributes to attrition.

Due to limited budgets, it is not always possible for programs to increase the salary levels of home-based workers. In fact, most programs report relatively low salary levels for staff. However, in order to reduce staff burnout, programs have implemented a number of strategies. Most of these involve "tuning in" to staff needs and helping them to feel recognized and appreciated. The strategies include:

- Providing good employee benefits such as vacations (some programs allow four weeks vacation), opportunities for leaves of absence, personal days, birthday off, compensatory time, annuity plans, dental plans, retirement plans, and the like.

- Providing regular opportunities for sharing information, ideas, problems, and support with other staff including team meetings, staff meetings, monthly staff breakfasts, and special staff events.

- Providing staff development opportunities for staff to pursue their interests and to grow professionally.

- Providing back-up, consultation, and support from supervisory staff that is available at all times.

- Providing high levels of acknowledgement, consideration, reinforcement, and encouragement from supervisory and administrative personnel.

The attitude of supervisory and administrative personnel should not be underestimated in its potential impact on staff satisfaction and retention. Programs use a variety of methods to recognize staff achievements both formally and informally. Staff of the Satellite Family Outreach Program, for example, receive a Kaleidoscope T-shirt of a different color each year to denote a year of "survival." Many other mechanisms are used to recognize staff and enhance job satisfaction.

In order to supplement professional staff, many programs utilize students and volunteers. Students generally go through the training protocol for staff and are used to expand the

service delivery capability of programs. Volunteers can be used by home-based programs in a variety of diverse and creative roles. They may be used as tutors, advocates, recreational aides, Big Brothers or Sisters, drivers, role models, or even lay therapists (Lloyd & Bryce, 1984).

RESOURCES

There appears to be fairly wide variation in the reported costs of home-based services. The variability in costs appears to be due to a number of factors, including widely disparate service intensity and duration among programs, differences in staffing patterns, and salary differentials (Hutchinson et al., 1983). The difficulty in determining and comparing costs is also attributable to different accounting and costing methodologies used by programs. Additionally, programs compute and report their costs for different time periods, with some reporting costs per family per month, some reporting costs per family per year, and some reporting costs per average episode of services to a family. The following data provide examples of costs reported for various home-based programs:

Family-Based Service (FBS) San Diego Center for Children	$3060 / six month program	Heying, 1985
Intensive Family Services Program Oregon CSD	$ 945 / three month program	Oregon CSD, 1985
Maine Home-Based Programs	$3125 to $6250 / family	Hinckley, 1984
Maryland Intensive Family Services (IFS)	$2820/family	Maryland Social Services Admin., 1987
Florida Intensive Crisis Counseling Programs	$1125 / family	Paschal & Schwahn, 1986
Iowa Home-Based Programs	$4900 / family	Bryce & Lloyd, 1982
Washington Home-Based Programs	$1470 / family	Bryce & Lloyd, 1982
Pennsylvania Home-Based Programs	$3665 / family	Bryce & Lloyd, 1982

These figures reflect the variability in reported costs for home-based services. Hutchinson (1982) reports that the cost of home-based services ranges from $1,000 to $10,829 per family across all types of programs. Despite these differences, two general conclusions can be reached regarding the cost of home-based services:

- The reported costs are incurred in serving an entire family. The investment is used to treat the entire family rather than to support the cost of one child in an out-of-home placement.

- The cost per average episode of out-of-home placement in any setting far outstrips the cost per average episode of home-based services.

The cost-effectiveness of working with an entire family rather than spending money to support a placement for one child is obvious. Further, there may be more than one child within a family who is at risk for out-of-home placement, which multiplies the value of the investment in an episode of home-based care.

Regardless of how costs are calculated, the costs of home-based services consistently compare favorably with the average costs of foster care, group home care, residential treatment, or hospitalization. Polsky (1986) compares the costs of home-based services (estimated at $3,000 to $5,000 per episode) with a variety of types of potential out-of-home placements and estimates the per year cost of foster care at $5000, group homes at $10,000, detention at $20,000, residential treatment at $30,000, and psychiatric hospitalization as high as $40,000. Although these costs are reported on a per year basis, it should be noted that, in many cases, children remain in out-of-home placements for multiple years. Bryce and Lloyd (1982) report that foster care expenditures range from $5,000 to $12,000 per child per year and that institutional placements range from $11,000 to $50,000 per child per year. They conclude that the total cost of providing home-based services to one entire family does not generally exceed the total cost of one average foster placement for one child and can be provided for one-half to one-tenth of the cost of residential or psychiatric hospital care for one child.

To illustrate the cost-effectiveness of home-based services, the Florida Department of Health and Rehabilitative Services (1982) reported that it costs $28,500 per year to support one full-time equivalent home-based therapist. An average episode of foster care placement (40 months) is costed at $12,840. Thus, the break-even point occurs if the therapist prevents only three children from entering foster care. In actuality, therapists work with approximately 32 families per year and are successful in preventing placement in far more than three cases.

Given the reportedly high success rates of home-based programs in averting out-of-home placements, the cost savings resulting from home-based services potentially can be substantial. A prospective analysis of a sample state revealed a net savings of over $8 million to a social service agency by providing home-based services and preventing out-of-home placement for significant numbers of children (Hutchinson, 1982). The analysis was based upon the conservative estimate that home-based services would prevent placement for 60 percent of the children who would have gone into substitute care. Haugaard and Hokanson (1983) also discuss methodologies and issues involved in measuring the cost-effectiveness of family-based services and out-of-home care. Their calculations indicate that a prospective per-case savings of over $27,000 might be realized if family-based services are provided in lieu of foster care.

Despite the cost-effectiveness of home-based services, in many states and communities funding is not available for these programs. Cuts in social service funding, coupled with pressure within child welfare systems to investigate escalating child abuse and sexual abuse complaints, have inhibited the growth of new programs and approaches. Mental health systems only recently have begun to recognize the applicability of home-based services to emotionally disturbed children and their families and to provide some funding for home-based programs. Third party funding for home-based services is only minimally available. Thus, many programs regard their funding as unstable or insecure, and strategies are needed to secure funding for new home-based programs.

The major funding source for home-based programs is state government. State departments of social services are the most frequent funding sources reported by programs responding to the survey, with many programs receiving 100 percent of their support from the state child welfare agency. The second most frequent funding source is the state mental health department; two programs reported that at least a portion of their services are funded by joint participation of the state social service and mental health agencies. Two of the programs responding to the survey receive funds from the juvenile justice system, and three programs receive education funds to provide home-based services. Several programs are funded primarily at the county level, and several receive grants from United Way or a foundation to support their operation.

Only one program reported any revenues from third party sources, the Home and Community Treatment Program, which is operated by the Mendota Mental Health Institute. Mental health agencies or hospitals may be in a better position to obtain third party reimbursement for home-based services provided by "qualified mental health providers." For example, the state Medicaid plan in North Carolina allows for reimbursement for services provided off-site, i.e., outside of a mental health facility. As a result, qualified mental health professionals may bill Medicaid for therapeutic services including home-based services. The Satellite Family Outreach Program receives Medicaid reimbursement for five hours of assessment performed on an in-home basis. In Vermont, some home-based services receive Medicaid reimbursement under Vermont's Home and Community-Based Medicaid Waiver program. Under this mechanism, Medicaid will provide reimbursement for certain types of services for a child who would otherwise by institutionalized. The documentation and reimbursement process is handled through the Department of Mental Health. Some programs charge client fees based upon ability to pay, although many feel that it is difficult to charge families for home-based services since many families are low income and many are "forced" to participate to avoid the possibility of having their child removed.

The Homebuilders program is funded solely by the Washington Department of Social and Health Services. Their contract requires the program to serve a specified number of cases per year, and funding is provided at the level of $2,600 per case. The Family Advocate Project is funded jointly by the Vermont Departments of Mental Health and Social and Rehabilitative Services. The Satellite Family Outreach Program is funded primarily by the Illinois Department of Children and Family Services, with a portion of its funding resulting from a joint initiative with the Illinois Department of Mental Health. This program receives its funds based upon the number of hours of service provided per month.

As these three programs illustrate, the types of contracts that home-based programs have with their funding sources vary significantly. Funding may be based upon the number of cases served or the number of hours of direct service provided by a program. Other programs operate on the basis of a fixed dollar contract that may specify performance targets such as the number of at risk children or families to be served and/or the goal of avoiding out-of-home placement in a certain percentage of the children served. The billing system under which a program operates frequently can affect its operation. For example, some contracts contain specifications for the number of direct service hours to be provided per family per month, which constrains the ability of staff to adjust service intensity to meet the needs of the individual family. Contracts may establish strict time frames to govern the duration of services or may not provide funding for follow-up services. Overly rigid constraints have been cited by programs as significant barriers in adapting their services and approaches to the needs of their clients.

Financing home-based services is a challenge that is receiving increasing attention. The Center for the Study of Social Policy (1986) outlined a series of financing strategies including both "fiscal opportunity" strategies and "reinvestment" strategies. Fiscal opportunity strategies involve maximizing the use of existing resources and programs such as Medicaid, AFDC Emergency Assistance Options, and federal reimbursement for the costs of necessary out-of-home placements. Claiming Medicaid match for health-related services and for counseling and therapy services provided by certified mental health professionals can be used for home-based services as well as using Home and Community-Based Waivers to target families at risk of institutional placement of a child. AFDC Emergency Assistance can be used for 30 days of continuous services in emergency situations; 11 states currently define abuse/neglect situations as emergencies and are using these monies for home-based interventions. Maximizing federal reimbursement for out-of-home placement frees up state funds for potential use in providing preventive, home-based services.

The reinvestment strategies described by the Center for the Study of Social Policy (1986) include transferring placement "savings" to home-based services designed to prevent placement. Cost-effectiveness analyses on pilot projects can illustrate the potential for substantial cost savings from home-based service initiatives. These results can be used to help create a favorable political context for realigning resources in order to expand prevention activities.

A third type of financing strategy described by Farrow (1987) is the "collaborative programming and financing strategy." This strategy involves joint initiatives among child-serving agencies and systems to fund, develop, and operate home-based services. Resources from the various agencies might be given to one of the agencies to actually provide or purchase the services, or resources might be pooled among agencies to operate programs. Collaborative funding requires high levels of cooperation among the various systems, and it further requires that family preservation be established as a priority across systems.

Specific actions that states have taken to begin to provide financing for home-based programs include:

- Funding demonstration projects prior to large-scale implementation and performing cost-effectiveness analyses.
- Providing grants to communities for start-up development of home-based programs.
- Organizing joint funding initiatives for home-based services among multiple agencies or departments.
- Providing legislative appropriations and mandates for home-based services.
- Placing a cap on expenditures for out-of-home placements.
- Shifting funds allocated from out-of-home care to home-based services.
- Creating fiscal incentives for home-based services and fiscal policies to discourage out-of-home placement.

EVALUATION

Evaluation of home-based services is a complex and challenging task. To date, the most frequently used measure of the effectiveness of home-based services has been the prevention of out-of-home placements. Based upon this index, programs have been reporting success rates of between 70 and 90 percent (Bryce & Lloyd, 1982; Hinckley & Ellis, 1985). Most programs are able to report the percentage of at risk children remaining in their homes at the time that the case is closed. Some programs also obtain follow-up data a various intervals to determine whether the child is still in the home at three months, six months, or one year post-termination. Success rates tend to fall slightly at follow-up points but consistently remain over 60 percent.

Some programs go beyond an assessment of the extent to which placement was avoided and add other components to their evaluation protocols (Cautley, 1979). These components might include assessment of changes in family functioning, assessment of changes in child behavior and functioning, measurement of treatment goal attainment, assessment of the perceptions or satisfaction of other professionals involved with the family, and assessment of the perceptions or satisfaction of participating families.

While the results reported by home-based programs are impressive and consistent, there are methodological shortcomings in most of the evaluation research that must be considered in drawing conclusions (Jones, 1985; Tavantzis et al., 1986). First, figures on avoiding placement usually pertain only to the period during which services were provided. As noted, many programs do not assess whether families continue to remain intact after home-based services have been withdrawn. Second, few evaluations have included control families with comparable characteristics and problems for whom home-based services were not provided. Further, many studies underestimate failure by neglecting to consider families who have dropped out of home-based service programs.

Jones (1985) elaborates on two of these issues. She notes that if the goal of home-based programs is to prevent placement, then it is essential to examine not only the short-term results of the intervention but also to do longitudinal follow-up studies of placement activity. Secondly, without comparison or control groups, it is impossible to predict whether comparable children would have entered out-of-home placement without the intervention. Programs presenting evaluation data tend to assert that only children at high risk of placement are accepted for home-based services and, therefore, that all of them would have entered placement in the absence of services. However, many programs admit that it is extremely difficult to ensure that **only** children at the actual point of entry are referred for home-based services and that it cannot be assured that all children would have entered placement without the intervention.

In reviewing studies with controls, Jones reports that the placement rate in the control groups was comparable to the experimental (home-based service) group and that in two studies the control group had a lower placement rate than the experimental group. A controlled, random assignment study of the New York State Preventive Services Demonstration Project, a long-term program, showed that only 46 percent of the controls entered substitute care as compared with 34 percent of the group receiving home-based services. Thus, the home-based intervention improved on the experience of the control group by 12 percentage points; approximately 12 percent of the control children might have been averted from out-of-home placement beyond the 46 percent who were not placed without the service. It would, therefore, be misleading to cite a 66 percent success rate for the experimental group. This type of data, the percentage of children receiving home-based services who did not enter substitute care, is typically reported by home-based programs. According to Jones, much of the currently available data present a flawed and incomplete picture of home-based services, and some of the claims made are "excessive."

A recently completed study assessed the effectiveness of the short-term, home-based services provided by the Child Welfare Division of the Hennepin County, Minnesota Community Services Department (AuClaire & Schwartz, 1987a, 1987b). Adolescents approved for out-of-home placement were randomly assigned to a home-based services group and a comparison group. With reference to the total number of episodes of out-of-home placement experienced, there were no significant differences between the treatment and control groups. However, there were marked differences with respect to several other variables. For example, adolescents in the home-based services group spent 1,500 fewer days in placement than did the controls, had significantly shorter placement stays than the control group, and tended to experience short-term shelter placements as opposed to other types of placements to a far greater degree than did the controls. Additionally, adolescents in the home-based services group used a much lower percentage of the placement days available to them than the control group used (19 percent as compared with 35 percent). Although there were no differences in the number of placement episodes in the two groups, there were significant differences in all other measures of placement activity (type of placement, length of placement, days in placement, etc.).

It appears that the results of controlled studies support the effectiveness of home-based interventions but suggest more modest results. With the above cautions as a given, the results reported by a number of home-based programs are summarized on the following pages. Where available, results obtained for comparison groups are presented as well. Data are presented in two ways: 1) as percentages of "at risk" or "potential removal" children involved in the program for whom placement was avoided (there may be more than one at risk child in a family served by the program, or 2) as percentages of families involved with the program that remained intact. The average duration of the services provided by each program is indicated in an attempt to distinguish between the various types of approaches. All results should be interpreted cautiously in the context of the above methodological questions.

Evaluation results suggest that home-based services are effective in achieving reunification of families with a child already in placement, although success rates are somewhat lower for reunification than for placement prevention. Heying (1985) found that for families served prior to placement, the success rate was 92 percent, while for families with a child who had previously been placed, the success rate dropped to 68 percent. In the New York State Preventive Services Demonstration, only 47 percent of the experimental group starting out in placement and 38 percent of the controls were reunified, with these results improving further at six month follow-up. In Wisconsin, 45 percent of the children referred for reunification were actually reunified as compared with an 87 percent success rate in preventing placement for at risk children (National Resource Center, 1985). Studies indicate that it may be most difficult to achieve success with children who have experienced multiple placements or who have spend long periods of time in out-of-home care (Jones, 1976; National Resource Center, 1985). The implication is that great effort should be expended to **prevent** placement and that to maximize the chance for successful reunification, home-based services should be initiated as soon after placement as possible.

Evaluation results also indicate that home-based services are effective in delaying or postponing entry into substitute care placements (Jones, 1985). For children who ultimately entered placement, experimental children receiving home-based services entered care in a median of 12.6 months while control children entered care in a median of 4.5 months. Even in cases where placement eventually did occur, it appeared that home-based services provided "a second chance for families." According to Jones, this delay of entry into placement appears to place children at no greater risk of harm and provides an opportunity for the delivery of preventive services. Jones recommends further efforts to understand the effects of delayed entry into care and how the delay may be prolonged into prevention.

Some evaluations have looked beyond placement prevention to assess improvements in child and family functioning. The results related to functional improvements resulting from home-based interventions are highly positive. An evaluation of Virginia's home-based programs found that 69 percent of the families improved in overall functioning (Virginia Dept. of Social Services, 1985); and an evaluation of Nebraska's Intensive Services Unit found that family problem levels dropped by one-half to one-third and that these improvements were sustained at a three-month follow-up (National Resource Center, 1984). In Wisconsin, significant improvement was found in many areas, including mental health of parents, mental health and behavior of children, school performance, discipline of children, family communication, and marital relationships. (National Resource Center, 1985).

In analyzing results from the mental health demonstration project, the Homebuilders program found significant improvements in child and family functioning. Eighty-five percent of the families with a family communication problem improved; 100 percent decreased the problem of violence to self; 92 percent improved the problem of violence to others; 78 percent improved the problem of violence to property; and 100 percent of family members with mental illness decreased the frequency and severity of symptoms. Global Assessment Scale ratings improved

EVALUATION RESULTS

PROGRAM	DURATION	RESULTS	REFERENCE
Day One Cumberland, ME	90 days	88% families at closure	Day One Evaluation Report, 1983
FamiliesFirst Davis, CA	4 - 6 weeks	70% children at 12 months 44% comparison group children	FamiliesFirst Program Description
Families Work Northeast Parent and Child Society Schenectady, NY	Average 15 weeks	89% children at closure 90% at 3 months 88% at 6 months 87% at 12 months	Tavantzis, Tavantzis, Brown, & Rohrbaugh, 1986
Family-Based Service San Diego Center for Children	6 months	85% children at 6 months	Heying, 1985
Family Preservation Network (Data for Nine Programs)	Average 9.7 weeks	92.1% children at closure	Maza, 1987
Family Preservation Project Henderson, NC	7 weeks	81% families at closure 79% at 3 months 15% eligible families not served due to lack of slots at 3 months	Owen, 1987
Familystrength Concord, NH		76% families at closure	U.S. House of Representatives, 1987
Hennepin County Child Welfare Division	4 weeks	children used fewer placement days than controls, more short-term placements, shorter lengths of stay	AuClaire & Schwartz, 1987a, 1987b
Homebuilders Behavioral Sciences Institute Federal Way, WA	4 - 6 weeks	87% at closure 90% at closure	Kinney, 1978 Kinney, Madsen, Fleming, & Haapala, 1977
Intensive Crisis Counseling Programs - Florida	6 weeks	86% families at closure 85.7% at 1 month 65.5% at 3 months 80% at 6 months	Florida Dept. of Health & Rehabilitative Services, 1982
		95% families at closure 83.8% at 12 months	Paschal & Schwahn, 1986 (1981 - 1986 data)

EVALUATION RESULTS CONTINUED

Maine Home-Based Programs	90 days	76% - 95% children at closure	Hinckley & Ellis, 1985
Maryland Intensive Family Services (IFS)	90 days	92.5% children at 90 days or closure 97% children at 12 months	Maryland Dept. of Social Services, 1987
Nebraska Intensive Services Project	average 6 months	86% families	Leeds, 1984
New York State Preventive Demonstration Project	average 14 months	66% experimental children 54% controls through study period (1974 1980) Placement delayed significantly in experimental group	Jones, 1985
Oregon Intensive Family Services Program	90 days	91% families at closure 61% families during 12 month follow-up	Oregon Dept. of Human Resources, 1985
Parsons Child and Family Center Albany, New York	median 10 -12 months	88% families during study period (1981 - 1985)	Kagen, Schlosberg, & Reid, 1986
Utah Family Preservation Projects	average 60 days	85% children at closure	Callister, Mitchell, & Tolley, 1986
Virginia Preplacement Preventive Services - 14 programs	average 5 months	93% children during study period	Virginia Dept. of Social Services, 1985
Wisconsin Child Placement Prevention Projects - 14 projects	1 - 18 months	82% children at end of data collection	National Resource Center, 1985

an average of 28 points, and Child Behavior Checklist ratings improved an average of 38 points (Behavioral Sciences Institute, 1986).

Home-based service programs also have reported success in linking families with needed ongoing services and supports. The Home Counselors Program in Maine found that 80 percent of the families participating in the home-based service continued with family or individual therapy following the 90-day intervention (Alderette & Foster, 1987). The Homebuilders program successfully linked 79 percent of the family members needing special school or work programs with these services (Behavioral Sciences Institute, 1986).

Finally, satisfaction with home-based services has been measured by some programs. In Wisconsin, 84 percent of the families felt that they had been helped very much or somewhat by the services received (National Resource Center, 1985). Workers referring and interacting with Florida's Intensive Crisis Counseling Programs were surveyed to determine their perceptions. Satisfaction of these workers was consistently high, with expressions of praise for the quick response time, good communication, willingness to work in the home, professionalism, and other aspects of the home-based service programs.

Some studies have attempted to identify critical factors in effective home-based treatment and factors correlated with the success or failure of the intervention. These efforts have been directed at identifying which family, child, or treatment variables might predict placement or problem recurrence. Research on the Homebuilders program found that the provision of "therapist hard services" (tangible goods and services) discriminated outcome groups, with those families receiving hard services more likely to remain intact. The implication of this finding is that the provision of tangible services in addition to counseling is critical to the success of the home-based intervention (Haapala, 1984).

A more recent study attempted to identify the factors that are associated with "failures" of home-based services. Service failure was defined broadly to include any out-of-home placement (including running away or placement with a non-relative) for more than two weeks during provision of home-based services or for 12 months following intake. The study sample was comprised of over 450 families served by the Homebuilders program in Washington and by two public child welfare agency offices in Utah, with a small control group consisting of referred families who could not be served because workers' caseloads were full. Successful outcomes were achieved with 76.3% of the children considered at risk of removal, and a number of variables were found to be associated with placement outcomes. In particular, the degree to which new parenting skills were learned and used was associated with avoiding placement. The results also suggested that success rates erode for older, more noncompliant, and delinquent children (Fraser, Pecora, and Haapala, 1988).

Research at the Parsons Child and Family Center also compared the "placed" group with the "not placed" group (Kagen et al., 1986). Two primary factors distinguished these groups. First, the placed group contained a large number of children referred by the probation department who were adjudicated as status offenders or delinquents and who manifested a sharply higher number of reported child behavior (acting out) problems. This result is supported by a study of the Families Work Program which found that families referred by the probation agency were at greater risk of negative outcome than those referred by the social service or other agency (Tavantzis et al., 1986).

A second major distinguishing factor relates to the "engagement" of the family in the intervention process. The placed groups evidenced less agreement with staff about problems, more canceled appointments, less satisfaction with services, and did not feel helped with serious concerns. This finding suggests that a critical variable in the success of home-based services is the worker's ability to engage the family in the intervention process.

The importance of engagement in the home-based intervention is substantiated by the study of the home-based services unit of the Hennepin County, Minnesota Child Welfare Division (AuClaire & Schwartz, 1986). Families who set treatment goals used a significantly lower proportion of placement time than families who did not set goals. This implies that the ability of the family and worker to cooperatively develop a set of problem-relevant treatment goals has major effects on the outcome of the intervention. Thus, families who are engaged in the intervention and are willing to establish and work toward goals are more likely to have positive outcomes. The researchers conclude that achieving and maintaining the participation and active engagement of family members appears to be central to successful program completion.

Another significant finding is that improvement in family functioning may be a more significant predictor of successful outcome than improvement in the child's functioning. Tavantzis and others (1986) found that changes in functioning of the adolescent referred to the Families Work program were not correlated with outcome, whereas changes in family functioning were correlated with positive outcome. This result suggests that changes in family interaction or coping skills may be more relevant to avoiding out-of-home placement than changes in the behavior of the youngster who is at risk. Tavantzis also reports the most favorable outcomes in families where the youngster's biological parents were married and living together and the worst outcome in blended families.

Jones (1985) found that the duration of services and the completeness of services were two significant predictors of successful outcome (not entering out-of-home care). Families receiving home-based services for a longer period of time and families with no apparent unmet service needs at case closure were more likely to remain intact. When services were terminated prematurely or when there were unmet needs at closing, the children were more likely to enter substitute care. Based upon these findings, Jones suggests a "preventative maintenance" approach to family preservation services with an emphasis on continuity, intensity of services rising and falling based upon the needs of the family, and permeable boundaries to permit families to easily enter, leave, and reenter services as needed. According to Jones, a time-limited intervention followed by case closure may not be as effective as a more continuous, comprehensive approach.

Additional research and evaluation data, particularly with control or comparison groups, are needed to further substantiate the effectiveness of home-based services. It may be especially useful to study home-based services of varying combinations of intensity and duration to determine the most appropriate uses of these approaches within an overall system of care. In addition, the importance of incorporating program evaluation into the design of new programs has been emphasized by those in the field. Evaluation results can be used to demonstrate the effectiveness and viability of home-based approaches to decision makers and can contribute to appropriations for new and expanded program efforts.

Despite methodological concerns, most researchers conclude that home-based services which include intensive counseling and concrete services can be effective in preventing, delaying, or reducing the length of placement and in enhancing the functioning of parents and children. Heying (1985) asserts that the home-based service delivery strategy has the potential for reshaping methods of treating severely emotionally disturbed children and their families. Greater availability of these services will enable many troubled children to remain with their families and will ensure that those children placed in residential treatment settings truly need to be there. Current data indicate that home-based services (brief, mid-range, and long-term varieties) are successful with many families, and there is ample evidence to justify the use of home-based services as part of a comprehensive system of care.

MAJOR ADVANTAGES AND CHALLENGES

Advantages

The advantages and benefits of home-based services have been reviewed extensively (Alderette & deGraffenreid, 1984; Bryce & Lloyd, 1982; Kinney, 1978; Lloyd & Bryce, 1984; National Resource Center, 1980). The responses of home-based workers, program administrators, staff from other community agencies, and families themselves, received during site visits, also lend an invaluable perspective in identifying the strengths of the home-based service approach. While by no means exhaustive, some of the major advantages of home-based services are summarized below:

- Home-based services represent a belief in the importance of the natural family and are clearly directed at family preservation and reunification.

Increasingly, all child serving systems have been questioning the extensive use of out-of-home placement as a response to the problems of children and families. In the mental health field in particular, the myth that good treatment must occur in a residential treatment environment is being challenged. Home-based services provide an approach for investing in a child's own family before resorting to out-of-home care, consistent with a belief in the value and importance of the natural family. Home-based services also can reduce the length of time children spend in out-of-home care and can increase the chances for a successful return home for children who have been in placements.

- Home-based services can help to ensure child protection because services are highly intensive, and workers spend a great deal of time observing and supporting families.

Home-based workers visit families frequently, spend many hours in the home, and are available on a 24-hour basis to respond to crises. This allows for close supervision and accurate assessment of the family's circumstances. Home-based workers are in an excellent position to assess risk to children or family members and to intervene immediately should any risk be observed. Families involved in home-based programs are aware that workers must report abusive behavior, and that if a child is in clear danger, workers will advocate for out-of-home placement.

If out-of-home placement is needed for the protection or treatment of the child, home-based services can facilitate planning for such placement. The family can be involved in the decision making process as well as in planning and working towards the child's return home.

- Home-based programs provide flexible services to focus on the total needs of the family.

Home-based services attempt to address the whole range of problems and issues facing a family. They provide a mix of counseling, skill teaching, and brokering and coordinating all of the services and supports needed by the child and family. Most programs are highly flexible and are committed to locating and accessing whatever resources are appropriate to meet identified needs. Families involved in home-based programs frequently reported that programs are willing to "do anything that is needed" in order to address their problems. Home-based services also provide an efficient mechanism for coordinating the multiple resources and services provided to families.

- Home visits are less threatening, less stigmatizing, allow the whole family to become involved, and provide a realistic setting for learning and practicing new skills.

There a numerous advantages to the use of home visits. With workers coming to the home, families tend to be less intimidated and threatened, and fear and mistrust can be overcome more quickly and easily. Further, home visits provide an opportunity to engage the entire family, particularly members who might resist coming to traditional office settings. The worker can observe the family in its own environment and can more easily and accurately understand and assess the family dynamics, problems, and strengths.

Of primary importance is the fact that the problem of transferring or generalizing skills to a different environment is eliminated through home-based services. The family can learn, practice, and apply skills in the environment in which they will be used. For emotionally disturbed children, the difficulty of transferring skills learned in a residential treatment setting also is avoided. Through home-based services, parents, teachers, and others all can become part of the treatment team, working with the child to achieve and maintain gains within the context of the family and community.

- o Home-based services increase accessibility of services to families who have the greatest needs and who often are unable or unwilling to access more traditional community services.

Home-based services overcome barriers related to transportation, difficult work schedules, lack of money to pay for services, the demands of other children, and more. Services are provided at a time and location convenient to families who often are overwhelmed with problems and demands. Further, home-based services can reach families who will not seek out and use more traditional services because of their distrust, loss of hope, or negative past experiences with service agencies.

Home-based services are particularly applicable to rural areas where traditional services may be difficult to obtain and community norms may encourage resistance to mental health services. Home-based services overcome transportation and financial barriers as well as psychological barriers to services.

- o Home-based services place few time limits on meetings with the family, and services are intensive enabling workers to provide assistance commensurate with needs.

While the intensity of home-based services varies, most programs provide levels of service far exceeding traditional mental health and social services approaches. Due to their characteristically small caseloads, home-based workers can work with families when and how it makes sense to do so. In the initial phases of the intervention, workers may see families daily if needed; during a crisis situation a worker may stay with a family as long as is needed to stabilize the situation and develop plans.

- o Home-based services provide timely responses to crises when families are highly motivated to work towards change.

Many home-based programs are crisis-oriented, providing timely responses to the initial crisis that precipitated the referral and responding (on a 24-hour basis) to any crises that may arise during the intervention period. Families often are most willing and motivated to change during a crisis period. The ability to intervene at a crisis point allows home-based service to take advantage of and capitalize on the opportunity for growth and change.

- o The relationship between the home-based worker and the family is uniquely intense and personal, overcoming the professional distance barrier.

Home-based workers develop highly intense and personal relationships with the family and overcome the "professional distance barrier." Their informal dress and manner, their

consistent availability, and their willingness to do whatever is needed help families to develop trust. Workers often are seen as helpers, guides, and "real people" rather than as clinicians or authority figures. The particularly close relationship of home-based workers and families helps to develop hope and motivation to change.

- o Home-based services are applicable to different types of communities, to families with different types of problems, and can be adapted to families of a wide variety of cultures and ethnic minorities.

Home-based services have been implemented successfully in urban, suburban, and rural environments. In rural communities, home-based programs can recruit workers who live within a reasonable distance and who can travel from their own homes to provide home-based services to families living in isolated areas. Home-based services have been found to be effective with a variety of populations including families with problems of child abuse or neglect, families of emotionally disturbed children, and others. Additionally, services can be adapted to different cultural and ethnic minorities by hiring minority workers, hiring interpreters, and otherwise adapting service delivery approaches to the culture, lifestyle, and values of each individual family.

- o There is less negative community reaction to home-based services than to residential programs of various types.

Home-based programs tend to be "lower profile" programs. Agencies report that groups homes and other residential programs tend to engender neighborhood complaints and resistance. Home-based programs, which do not require facilities and are less visible, avoid these negative responses.

- o Home-based services are more cost-effective than out-of-home placements.

While program characteristics vary, data uniformly suggest impressive success rates in keeping families together. As a result, significant cost savings are achieved by avoiding placements that would have occurred were it not for the home-based intervention.

Challenges

A number of problems related to the development and delivery of home-based services also have been identified. These are presented as "challenges" that should be considered and addressed in implementing and operating home-based programs:

- o Determining an appropriate time frame for services.

Home-based programs report considerable pressure to provide very short-term, time-limited interventions. While short-term, crisis services may be appropriate for many families, others may need longer-term, home-based services and support. Programs struggle to find the optimal mix of service intensity and duration for the program as a whole and for each individual family.

- o Coping with potentially threatening situations.

Home-based workers are more likely to encounter threatening or dangerous situations since service delivery occurs in families' homes and in the community. For example, home-based workers have reported such incidents as dog bites, sexual overtures, physically menacing family members, and robberies. These incidents are surprisingly rare considering that workers spend most of their time in the field. Despite the infrequency of such occurrences, programs

must prepare home-based workers for every possibility, teach them how to respond in threatening situations, and take all possible precautions to avoid placing them in jeopardy.

o Safeguarding the rights and privacy of families.

The fact that the site of service delivery is in the home requires extra vigilance to ensure that the rights of the family are not compromised (Levenstein, 1981). Ethical considerations include minimizing coerciveness to participate in a voluntary program, preserving the family's privacy by maintaining confidentiality, and respecting the family's style of living, culture, values, and beliefs. Of primary importance is minimizing unnecessary intrusions into the families' life. Due to the intensity of services, some families and others have perceived home-based programs as intrusive. Programs must work with families to guard against unnecessary intrusiveness and to keep the family's needs and wishes in the forefront.

o Preventing workers from becoming enmeshed in the family system and families from becoming overly dependent upon workers.

In some situations, home-based workers potentially can become enmeshed in the family system which can exacerbate rather than relieve problems. Another potential pitfall may occur when families become overly dependent upon the worker and, therefore, are less likely to be able to survive on their own following the home-based intervention. Programs address these challenges primarily through worker training and clinical supervision. The emphasis in most home-based programs on empowering families rather than taking over their role and responsibilities also serves to minimize the potential for excessive dependency.

o Providing follow-up services or maintenance services to families who have completed the intervention while, at the same time, serving current cases.

Many programs recognize the need for follow-up services for families completing the home-based intervention. Follow-up may take the form of periodic visits (weekly, monthly) for a period of time to reinforce skills and provide ongoing support as well as to be available for crisis intervention. A period of time with telephone contact might follow the "maintenance visits." Programs have difficulty working formalized follow-up contacts into their service delivery process along with the demands of new and ongoing cases.

o Accessing appropriate resources in the community to provide ongoing services and support to families following the intervention.

One of the most difficult challenges faced by programs relates to locating and linking families with the ongoing services and supports that they may need following the home-based intervention. Many communities do not offer the services needed by children and families, and families often cannot participate in available services due to financial, transportation, and other barriers. This problem is particularly relevant to the short-term crisis models of home-based services which are predicated, to a large extent, on linking families with other resources for longer-term services. This issue underscores the importance of not viewing home-based services in isolation but rather as part of a comprehensive system of care for children and families.

o Preventing worker burnout.

The demanding, unpredictable, and stressful nature of home-based work can lead to the exhaustion, discouragement, and eventual burnout of home-based workers. Home-based programs make concerted efforts to minimize staff burnout through such measures as staff training, strong agency and peer support, good employee benefits, vacation and compensatory

time, and other mechanisms for acknowledging and supporting workers and enhancing worker satisfaction.

o Recruiting qualified staff.

As noted, most undergraduate and graduate schools in the mental health professions provide little training in the concept or process of home-based services. Therefore, most potential candidates have little training or experience that is congruent with home-based services. Special attention to staff selection procedures is needed to ensure that staff hired have both the qualifications, personal characteristics, and life style that would adapt to home-based work. Further, intensive staff training activities may be needed to compensate for the lack of formal education and experience of most new home-based workers.

o Avoiding pressure to "dilute" the home-based service approach.

Home-based programs report that they must be constantly vigilant to ensure that the home-based model is not compromised. There is often a subtle pressure to increase caseloads, reduce service intensity, or serve more families. These types of changes may hinder the program's effort to provide highly active and intensive interventions to all families. Thus, programs report the need to protect the service and avoid diluting the approach so as not to decrease the intervention's effectiveness.

o Overcoming skepticism and resistance among other professionals.

Many home-based programs report that they encounter high levels of resistance and skepticism about the home-based approach from other professionals. Special efforts to educate and enlist the support of other professionals and agencies often are needed to combat such resistance. Resistance may be partially attributable to the fact that most service providers are not trained to work with families or to provide services in families' homes. The concept of intensive, home-based services is somewhat revolutionary, and other professionals may not understand the objectives or demands of home-based work. Programs located within mental health centers, for example, have found that other professionals may resent the lower caseloads and flexible hours of home-based staff. Overcoming skepticism and resistance and establishing collaborative relationships with other agencies and professionals is a challenge shared by all home-based programs.

PROGRAM DEVELOPMENT

Recently, there has been a significant surge of interest and activity in the area of home-based services. Sudia (1986) notes that family-focused prevention programs are gaining acceptance and support throughout the country and that an Annotated Directory of Selected Family-Based Service Programs now describes over 300 programs (National Resource Center, 1987). Beyond the development and growth of home-based service programs, other signs of progress include increasing interest and debate about home-based service approaches; the inception of provider and practitioner associations; national conferences devoted to home-based services; increased research on home-based services; increased technical assistance and training activities; an increasing number of journal articles on the subject; and growing interest in incorporating the philosophy and approaches into undergraduate and graduate social work curricula.

A major stimulus for progress was the 1980 enactment of P.L. 96-272, the Adoption Assistance and Child Welfare Act. This federal legislation established new criteria for states to qualify for federal child welfare and foster care maintenance funds. In order to qualify, states must have implemented a program of placement prevention services designed to reduce the need for removing children from their homes. The legislation also mandates that attempts be made to

reunite foster children with their biological families or provide permanent adoptive homes for children who cannot return home. The legislation supports the philosophy of family-centered services and has stimulated comparable state legislation. Nearly half of the states now have statutes or regulations related to family-centered services which provide direction to service providing agencies and courts; mandate that placement prevention services be provided; establish pilot home-based service programs; and appropriate funds for home-based services.

Despite noteworthy progress, however, the pace and achievement in implementing home-based services have not been uniform across the country (Center for the Study of Social Policy, 1986). While some states and communities have embraced the concept and philosophy as a foundation for their human service programs, other areas lag behind. Further, many of the home-based programs that have been developed are considered pilot or experimental efforts, implemented on a small scale to test their viability and cost-effectiveness. To date, the need far exceeds the availability of home-based services in most communities, and such services are not yet considered an essential component of a comprehensive system of care.

A major difficulty results from the fact that many states limit their new home-based prevention programs to the agency or department providing child welfare services. The Clark Foundation (1985) notes that mental health, juvenile justice, and special education departments also are responsible for the out-of-home placement of children but typically have lagged behind in the development of home-based, placement prevention efforts. As a result, a child and family may have differential access to home-based, placement prevention services depending upon which agency they happen to become involved with. The Foundation emphasizes that, in many cases, the same child could be served by any of these child-serving systems depending primarily upon which agency sees the child first or which category or label is assigned. Thus, progress varies not only geographically but also across the various child-serving systems, with the child welfare system taking a clear leadership role in the implementation of home-based, placement prevention services.

The National Resource Center on Family-Based Services at the University of Iowa School of Social Work has been a major resource to assist in the development of home-based services. The National Resource Center was funded by the Children's Bureau of the Administration for Children, Youth, and Families to assist agencies serving children and families to develop family-based alternatives to child placement. Some of the activities of National Resource Center include development of technical assistance materials, information dissemination, staff training, technical assistance in planning and developing family-based services, research, publication of a newsletter ("Prevention Report"), and operating an electronic bulletin board designed to exchange information on family-based services ("Aunt FABS"). An array of materials about home-based services are available from the National Resource Center including a handbook describing home-based services in detail (Lloyd & Bryce, 1984).

A number of other organizations have been active in promoting the development of home-based, preventive approaches including the Edna McConnell Clark Foundation, the Child Welfare League of America, the National Conference of State Legislatures, and the National Governors' Association along with state family-based service associations and other provider groups. The Edna McConnell Clark Foundation has provided funds for numerous home-based service programs as well as for research on home-based service models and technical assistance to child welfare and mental health planners, policy makers, and providers. The Family Preservation Network, funded by the Clark Foundation, consists of representatives of home-based programs working together to develop and promote family preservation services. In collaboration with the National Governors' Association, the Clark Foundation awarded grants to several states to experiment with ways to assist troubled families and to prevent unnecessary out-of-home placement.

A growing number of state associations are forming to promote family-based service services, and a national organization, the National Association for Family-Based Services, is now in the formative stages. The purposes of the Association are to share information, promote technology transfer, and to advocate for family-based services at the national level. The Association will attempt to involve members from all child-serving systems as well as representatives of many different "models" of family-based services.

As a result of collaborative efforts by many organizations, a national conference on family-based services was held in Minneapolis in 1987 and the 1988 National Conference on Family-Based services is in the planning stages. These conferences provide an opportunity for administrators and practitioners to share their experiences, problems, and results; discuss issues; learn about different program models; and network with colleagues from around the nation. The National Association will be responsible for planning and coordinating future conferences.

Technical assistance in planning and developing home-based services also is available from many operating programs. The Homebuilders program, for example, conducts a wide variety of training, dissemination, and consultation activities designed to assist other agencies in developing and operating home-based services. Training options are designed to assist agencies develop funding, select and train staff, design administrative and referral procedures, design service delivery procedures, and implement evaluation procedures. Training materials have been developed, including a Homebuilders Resource Guide (Kinney & Haapala, 1978) which outlines a number of techniques that may be needed by home-based workers such as assessment, behavioral techniques, anger and diffusion, assertiveness, communications, and socialization. The Homebuilders program has developed a training package and manual to provide assistance in the process of implementing a new home-based program.

There also is some evidence of progress in the training of professionals to provide home-based services. For example, the Ohio Department of Mental Health awarded a planning grant to the Center for Family Studies at the University of Akron to develop a multidisciplinary graduate certificate in home-based intervention. The certificate will be designed to train mental health professionals from various disciplines to provide home-based treatment for emotionally disturbed children and their families. The University of Kentucky College of Social Work has received a federal grant to improve the preservice training of social work students preparing to work with troubled children and their families. An interagency committee will assist the college to identify the essential competencies needed to provide community-based, family-focused services and to revise the current social work curriculum.

In order to move beyond the "pilot program" stage, it is necessary to identify and involve key policy and decision makers and gain support for the philosophy of home-based services. Further, it is necessary to review state funding policies and budgets for human services, across agency and system boundaries, to identify ways of providing funds for home-based services and reducing expenditures for out-of-home placements (Hutchinson et al, 1983). In testimony before the U.S. House of Representatives, Farrow (1987) indicated that successful implementation will require support for the family preservation philosophy, methods of financing to establish a secure funding base for services, and a clear relationship of home-based services to a full continuum of services for children and families.

The latter point is of overriding importance. Many have warned of the danger of considering home-based services (or any service) as a panacea or "magic solution" (Friedman, 1987; Lloyd & Bryce, 1984; Small & Whittaker, 1979). The advent of intensive home-based services has succeeded in "revolutionizing" the concept of "in need of out-of-home-placement" (Update, 1985.) However, it should be kept in the forefront that home-based services are only one component of a comprehensive system of care needed for troubled children and their families.

Regardless of the availability of home-based services and other nonresidential system components, there will still be a need for high quality therapeutic foster care, therapeutic group care, residential treatment, and hospital care for some children. Small and Whittaker (1979) note that, in some cases, temporary out-of-home care such as respite care or therapeutic foster care is necessary for the long-term maintenance of family integration. They emphasize that the goal is not merely to relocate services to the home and to prevent all out-of-home placement, but to develop more effective ways of supporting troubled children and their families. Thus, home-based services should be seen as one essential component of a comprehensive, balanced system of care, with all components organized to preserve, support, and assist families to the greatest possible extent.

REFERENCES

Alderette, P., & deGraffenreid, D. (1984). In-home family therapy and services to rural families. In W. Whitaker (Ed.), Social Work in Rural Areas: A Celebration of Rural People, Place, and Struggle. Proceedings of the Ninth National/Second International Institute on Social Work in Rural Areas. Orono: The University of Maine at Orono, Department of Sociology and Social Work.

Alderette, P., & Foster, R. (1987). Keeping families together: The Maine model of home-based family services. (Report 6 (2), pp. 20-27). Augusta, ME: Maine Department of Mental Health and Mental Retardation.

AuClaire, P., & Schwartz, I. (1986). An evaluation of the effectiveness of intensive home-based services as an alternative to placement for adolescents and their families. Minneapolis: University of Minnesota, Hennepin County Community Services Department and Hubert H. Humphrey Institute of Public Affairs.

AuClaire, P., & Schwartz, I. (1987a). Home-based services as an alternative to placement for adolescents and their families: A follow-up study of placement resource utilization. Minneapolis: University of Minnesota, Hennepin County Community Services Department and Hubert H. Humphrey Institute of Public Affairs.

AuClaire, P., & Schwartz, I. (1987b). Home-based services effective? A public child welfare agency's experiment. Children Today, 16 (3), 6-9.

Balis, E., & Harris, J. (1982). Re-empowering a disabled family network. International Journal of Family Therapy, 4 (11), 42-59.

Behavioral Sciences Institute. (1985). Homebuilders cost effectiveness with various client populations. Federal Way, WA: Behavioral Sciences Institute.

Behavioral Sciences Institute. (1986). Overview of the Homebuilders programs - Treatment effectiveness. Federal Way, WA: Behavioral Sciences Institute.

Brown, K., Miller, B., Dean J., Carrasco, C., & Thompson, S. (1987). Home-based intervention: Catalyst and challenge to the therapeutic relationship. Zero to Three, Bulletin of the National Center for Clinical Infant Programs, 8 (1), 8-12.

Bryce, M. (1982). Home-based care: Direction for the 80s. Iowa City: The University of Iowa School of Social Work, National Resource Center on Family Based Services.

Bryce, M., & Lloyd, J. (1982). Placement prevention and family reunification: A view from the child welfare sector. (Rev.) Iowa City: The University of Iowa School of Social Work, National Resource Center on Family Based Services.

Callister, J., Mitchell, L., & Tolley, G. (1986). Profiling family preservation services in Utah. Children Today, 15 (6), 23-25, 36-37.

Caplan, G. (1964). Principles of preventive psychiatry. New York: Basic Books.

CASSP Technical Assistance Center. (1986). Developing mental health programs for minority youth and their families. Summary of Conference Proceedings. Washington, DC: Georgetown University, CASSP Technical Assistance Center.

Cautley, P. (1979). Research objectives of in-home intervention. In S. Maybanks & M. Bryce (Eds.), Home-based services for children and families: Policy, practice, and research. Springfield, IL: Charles C. Thomas.

Cautley, P. (1980). Treating dysfunctional families at home. Social Work, 25 (5), 380-385.

Center for the Study of Social Policy. (1986). Preserving families in crisis: Financial and political options. Washington, DC: Center for the Study of Social Policy.

Clayton-Fechtmann, K.A., & Seibold, J.I. (1981). Community and home-based treatment planning for adolescents and their families. In M. Bryce & J.C. Lloyd (Eds.), Treating families in the home: An alternative to placement. Springfield, IL: Charles C. Thomas.

Compher, J. (1983). Home services to families to prevent child placement. Social Work, 28 (5), 360-364.

Cutler, D., & Madore, E. (1980). Community-family network therapy in a rural setting. Community Mental Health Journal, 16 (2), 144-155.

Day One Evaluation Report. (1983). Augusta, ME: Department of Mental Health and Mental Retardation, Division of Special Projects.

Edna McConnell Clark Foundation. (1985). Keeping families together: The case for family preservation. New York.

Eyde, D.R., & Willig, S. (1981). Home support for families with disturbed children. In M. Bryce & J.C. Lloyd (Eds.), Treating families in the home: An alternative to placement. Springfield, IL: Charles C. Thomas.

Fahl, M.A. (1981). Shaping parent-child interractions: A behavioral model in a family context. In M. Bryce & J.C. Lloyd (Eds.), Treating families in the home: An alternative to placement. Springfield, IL: Charles C. Thomas.

Fahl, M.A., & Morrisey, D. (1979). The Mendota model: Home-community treatment. In S. Maybanks & M. Bryce (Eds.), Home-based services for children and families: Policy, practice, and research. Springfield, IL: Charles C. Thomas.

FamiliesFirst. (1985). Preliminary report on FamiliesFirst home-based services project. Davis, CA: FamiliesFirst.

Family Empowerment Resource Network. (1987). Definition of home-based services. Middlebury, VT: Counseling Service of Addison County.

Farrow, F. (1987). Potential funding mechanisms for family preservation services. Presentation at the Meeting on Family Preservation Services to prepare recommendations for the 1987 Southern Legislators Conference on Children and Youth, Nashville, TN.

Fisher, S. (1980). The use of time limits in brief psychotherapy: A comparison of six session, twelve session, and unlimited treatment with families. Family Process, 19, 377-392.

Fisher, S. (1984). Time-limited brief therapy with families: A one year follow-up study. Family Process, 23, 101-106.

Florida Department of Health and Rehabilitative Services. (1982). Intensive crisis counseling program. Tallahassee, FL: Office of the Inspector General, Office of Evaluation.

Fraser, M., Pecora, P., Haapala, D. (1988). Families in crisis: Findings from the family-based intensive treatment project, Executive summary. Federal Way, WA: Behavioral Sciences Institute; Salt Lake City: University of Utah, Social Research Institute.

Friedman, R. (1987). Overview of the issues. Presentation at the Meeting on Family Preservation Services to prepare recommendations for the 1987 Southern Legislators Conference on Children and Youth, Nashville, TN.

Gatti, F., & Coleman, C. (1976). Community network therapy: An approach to aiding families with troubled children. American Journal of Orthopsychiatry, 46 (4), 608-617.

Ginsberg, G. (1986). A report on home-based family centered services. Waterbury: Vermont Child and Adolescent Service System Program.

Goldstein, H. (1973). Providing services to children in their own homes: An approach that can reduce foster placement. Children Today, 2 (4), 2-7.

Haapala, D (1984). A discrimination of successful treatment outcomes for in-home family therapy: Homebuilders model. Federal Way, WA: Behavioral Sciences Institute.

Haapala, D., & Kinney, J. (1979). Homebuilders' approach to the training of in-home therapists. In S. Maybanks & M. Bryce (Eds.), Home-based services for children and families: Policy, practice, and research. Springfield, IL: Charles C. Thomas.

Haugaard, J. & Hokanson, B. (1983). Measuring the cost-effectiveness of family-based services and out-of-home care. Iowa City: The University of Iowa School of Social Work, National Resource Center on Family Based Services.

Heying, K. (1985). Family based in-home services for the severely emotionally disturbed child. Child Welfare, 64 (5), 519-527.

Hinckley, E. (1984). Homebuilders: The Maine experience. Children Today, 13 (5), 14-17.

Hinckley, E., & Ellis, F. (1985). An effective alternative to residential placement: Home-based services. Journal of Clinical Child Psychology, 14 (3), 209-213.

Horejsi, C. (1981). The St. Paul family-centered project revisited: Exploring an old gold mine. In M. Bryce & J.C. Lloyd (Eds.), Treating families in the home: An anternative to placement. Springfield, IL: Charles C. Thomas.

Hutchinson, J. (1982). A comparative analysis of the costs of substitute care and family based services. Iowa City: The University of Iowa School of Social Work, National Resource Center on Family Based Services.

Hutchinson, J. (1986). Progress towards change: The national resource center on family based services. Children Today, 15 (6), 6-7.

Hutchinson, J., Lloyd, J., Landsman, M., Nelson, K., & Bryce, M. (1983). Family-centered social services: A model for child welfare agencies. Iowa City: The University of Iowa School of Social Work, National Resource Center on Family Based Services.

Hutchinson, J. & Nelson, K. (1985). How public agencies can provide family-centered services. Social Casework, 66 (6), 367-371.

Joint Commission on the Mental Health of Children (1969). Crisis in child mental health. New York: Harper & Row.

Jones, M.A. (1976). Reducing foster care through services to families. Children Today, 5 (6), 6-10.

Kagen, R., Schlosberg, S., & Reid, W. (1986). Prevention of placement: Critical factors in effective interventions. Paper presented at the Annual Meeting of the American Psychological Association, Washington, DC.

Kaplan, L. (1986). Working with multiproblem families. Lexington, MA: DC Heath and Company.

Kinney, J. (1978). Homebuilders: An in-home crisis intervention program. Children Today, 7 (1), 15-17.

Kinney, J., & Haapala, D. (1978). Homebuilders resource guide. Federal Way, WA: Behavioral Sciences Institute.

Kinney, J., Haapala, D., & Gast, J. (1981). Assessment of families in crisis. In M. Bryce & J.C. Lloyd (Eds.), Treating families in the home: An alternative to placement. Springfield, IL: Charles C. Thomas.

Kinney, J., Madsen, B., Fleming, T., & Haapala, D. (1977). Homebuilders: Keeping families together. Journal of Consulting and Clinical Psychology, 45 (4), 667-673.

Leeds, S. (1984). Evaluation of Nebraska's intensive services project. Iowa City: The University of Iowa School of Social Work, National Resource Center on Family Based Services.

Levenstein, P. (1981). Ethical considerations in home-based programs. In M. Bryce & J.C. Lloyd (Eds.), Treating families in the home: An alternative to placement. Springfield, IL: Charles C. Thomas.

Lloyd, J., & Bryce, M. (1984). Placement prevention and family reunification : A handbook for the family-centered service practitioner. (rev. ed.). Iowa City: The University of Iowa, National Resource Center on Family Based Services.

Maryland Social Services Administration. (1987). Intensive family services: Evaluation of foster care prevention in Maryland. Baltimore, MD: Department of Human Resources, Social Services Administration.

Maza, P. (1987). Family preservation network data analysis. New York: Child Welfare League of America.

National Resource Center on Family Based Services. (1980). Home-based family centered preplacement prevention and family reunification: A basic view. Iowa City: The University of Iowa, School of Social Work, National Resource Center on Family Based Services.

National Resource Center on Family Based Services. (1984). Evaluation of Nebraska's intensive services project. Iowa City: The University of Iowa, School of Social Work, National Resource Center on Family Based Services.

National Resource Center on Family Based Services. (1985). Evaluation of fourteen child placement prevention projects in Wisconsin - Executive summary. Iowa City: University of Iowa School of Social Work, National Resource Center on Family Based Services.

National Resource Center on Family Based Services. (1987). Annotated directory of selected family-based service programs. Iowa City: The University of Iowa, School of Social Work, National Resource Center on Family Based Services.

Oregon Department of Human Resources. (1985). 1983-85 biennial report of childrens' services division's intensive family services. Salem: Oregon Department of Human Resources.

Owen, M. (1987). Family preservation project. Presentation at the Meeting on Family Preservation Services to develop recommendations for the 1987 Southern Legislators Conference on Children and Youth, Nashville, TN.

Paschal, J., & Schwahn, L. (1986). Intensive counseling in Florida. Children Today, 15 (6), 12-16.

Pecora, P., Delewski, C., Booth, C., Haapala, D., & Kinney, J. (1985). Home-based, family centered services: The impact of training on worker attitudes. Child Welfare, 64 (5), 529-540.

Polsky, D. (1986, April). Keeping the kids at home: Crisis intervention therapists help families stay together when the courts want to break them up. Youth Policy.

Small, R., & Whittaker, J. (1979). Residential group care and home-based care: Toward a continuity of family services. In S. Maybanks & M. Bryce (Eds.), Home-based services for children and families: Policy, practice, and research. Springfield, IL: Charles C. Thomas.

Stephens, D. (1979). In-home family support services: An ecological systems approach. In S. Maybanks & M. Bryce (Eds.), Home-based services for children and families: Policy, practice, and research. Springfield, IL: Charles C. Thomas.

Stroul, B. & Friedman, R. (1986). A system of care for severely emotionally disturbed children and youth. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Sudia, C. (1986). Preventing out-of-home placement of children: The first step to permanancy planning. Children Today, 15 (6), 4-5.

Tannen, N. (1986a, Nov.-Dec.). A continuum of home-based services. Child Protection Connection.

Tannen, N. (1986b). Preventing the cycle of child abuse and neglect in highly dysfunctional families: Family advocate project final report. Middlebury, VT: Counseling Service of Addison County.

Tartara, T., Morgan, H., & Portner, H. (1986). SCAN: Providing preventive services in an urban setting. Children Today, 15 (6), 17-22.

Tavantzis, T. Tavantzis, R., Brown, L., & Rohrbaugh, M. (1986). Home-based structural family therapy for delinquints at risk of placement. In M.P. Mirkin & S. Koman (Eds.) Handbook of adolescent and family therapy. NY: Gardner Press.

Tinjaca, M., & Sands, A. (1986). Home based services for severely emotionally disturbed children: A design analysis bibliography. Topeka, Kansas: Kansas Department of Social and Rehabilitation Services, Office of Child and Adolescent Mental Health.

Turitz, Z. (1961). Obstacles to services for children in their own homes. Child Welfare, 40 (6), 1-6, 27.

United States House of Representatives. (1987). Preventing out-of-home placement: Programs that work. Washington, DC: Select Committee on Children, Youth, and Families.

Update. (1985). Program update: Home-based services. Update - Improving Services for Emotionally Disturbed Children, 1, (1), 6-7. Tampa: Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

Virginia Department of Social Services. (1985). A preliminary report on the pre-placement preventive services grant evaluation. Richmond, VA: Department of Social Services.

Weitzman, J. (1985). Engaging the severely dysfunctional family in treatment: Basic considerations. Family Process, 24, 473-485.

III. PROGRAM DESCRIPTIONS

FAMILY ADVOCATE PROJECT
COUNSELING SERVICE OF ADDISON COUNTY
MIDDLEBURY, VERMONT

History

The Family Advocate Project, operated by the Counseling Service of Addison County, is a home-based service program for troubled families who cannot utilize or benefit from traditional services. The two primary components of the intervention are home-based therapy and networking with the social service system.

The roots of the project can be traced to an interagency planning process which began in 1978. The Addison County Children's Task Force started meeting annually at that time to identify and address the needs of children and families in the county. When a particular need or service gap was identified, smaller multi-agency task forces were organized to meet during the year and develop solutions. In 1980, the highest priority issue identified by the Addison County Children's Task Force involved the need to find more effective approaches to serving highly dysfunctional, multiproblem families. The needs of these families seemed overwhelming -- they were constantly in crisis, and they were taxing the resources of numerous human service agencies in the county. In order to address this need, a task force called the Family Support Team (originally called the Dysfunctional Family Task Force) was formed.

The Family Support Team enlisted the assistance of a Middlebury College student intern to review research and information about programs serving highly dysfunctional families. Based upon the literature review, an intervention approach was designed, combining in-home counseling with interagency networking. The Department of Youth and Family Services of the Counseling Service of Addison County proceeded to apply for and receive a $3,000 "mini-grant" from the Vermont Department of Social and Rehabilitation Services (SRS) to pilot this approach. With the resources provided by this small grant, the Counseling Service hired one staff person in 1982 to work with five families for a one-year period. The five families involved in the pilot project were identified by county SRS workers as the most dysfunctional on their caseloads, and, in addition to their other problems, all five families had documented child sexual abuse.

The results of the pilot project were highly encouraging, and the Counseling Service received two additional mini-grants to complete their work with the five pilot families, to conduct follow-up on the pilot families in order to evaluate the interventions, and for training and dissemination activities. A Federal grant from the Office of Human Development Services was received in 1984 and provided funds for an 18-month period. The grant enabled the project to hire additional family advocates and to extend services to 22 additional families. The State of Vermont has supported the program's operation since the expiration of the federal grant. While the original focus of the project was on highly dysfunctional families, in 1986 the program expanded to offer a "continuum" of home-based services, including in-home assessments, short-term crisis intervention, mid-range home-based services for families in situational crises (up to six months), and long-term home-based services for highly dysfunctional families (six months to two years). This change enabled the program to broaden its focus and to increase its flexibility in working with families. Home-based services can now be provided in accordance with the needs and goals of each individual family rather than relying upon one formula for all families.

Community and Agency Context

The Family Advocate Project serves Addison County, which is located in the west central part of Vermont. Addison County has a population of approximately 28,000 to 30,000 people, almost entirely Caucasian. The County is comprised of three major population centers surrounded by rural areas with very low population density. Middlebury is the county seat and commerce center and is also the home of Middlebury College, a prestigious liberal arts institution.

Addison County is one of the largest dairy producing counties in Vermont and has several industries including Standard Register and Kraft Cheese. The majority of the residents of the county, however, are poor and scattered widely in rural, isolated areas. Their lives are further complicated by the long, severe winters which make travel treacherous if not impossible. Spring thaw brings "mud season" which often results in washed out roads and additional travel complications. During this time, even school buses may be unable to reach some families in especially remote areas, forcing children to remain at home until conditions improve. No public transportation system is provided in the county.

The Counseling Service of Addison County is a comprehensive community mental health and mental retardation center with an overall budget of over $2.5 million. The main office of the center is in Middlebury, and satellite offices are maintained in two additional areas of the county. The Counseling Service is comprised of five major departments: Youth and Family, Crisis Intervention, Adult and Substance Abuse, Community Rehabilitation and Treatment, and Mental Retardation. The Department of Youth and Family Services houses the Family Advocate Project as well as a number of other programs including the following:

- Outpatient Services - Outpatient services for children and families with an emphasis on family work. Specialized outpatient services include parent training courses and a variety of groups, including groups for sexually abused children and sex offenders.

- Community Friends - A big brother/big sister program for troubled children operated primarily with students from Middlebury College. With the assistance of student coordinators, more than 150 matches are made per year, and big brothers/sisters spend approximately two hours per week with their "friends." Special events such as Christmas and Halloween parties also are held.

- School Counselors - School counseling services provided to the school districts within the county on a contractual basis. Six school counselors are employed by the Counseling Service to conduct individual and group counseling in the schools, work with parents, consult with teachers, and network with other service providers. The other services offered by the Counseling Service are available as back-up at no additional cost to the schools.

- Wilderness Program - Five-day back packing trips for children ages 9 to 13 considered emotionally disturbed or at high risk. Four trips are offered during the summer for ten children per trip. Referrals come from school counselors and mental health center therapists.

- Channel II - Summer program for troubled adolescents ages 14 to 16 who are at high risk for substance abuse and dropping out of school. The program combines therapy, recreation, and vocational training. As a part of the program, youth perform community projects for which they are each paid a small stipend.

In addition to these services, the Department offers psychological testing and evaluation and has contracts with several other agencies to provide consultation and support. Such services

are provided to programs including Headstart, Essential Early Education, and the Parent/Child Center, which is a model day care and outreach program focusing on high risk infants.

The Department of Youth and Family Services has grown from a staff of four to a staff of 20 over the past ten years. This growth is considered a major accomplishment in an era of cutbacks in funding for mental health services, when many mental health centers have decreased or eliminated children's services. Creative use of grants, seed money, and funding pieced together from multiple sources has enabled the Department to develop new programs and expand services to children and their families.

Being part of a larger mental health center is considered an asset by Family Advocate Project staff. This placement affords easy access to a broader spectrum of services within the agency and many families are, in fact, linked with other services offered by the center.

The administration of the Counseling Service is perceived as supportive and respectful of the Family Advocate Project. Center leadership has allowed staff the freedom to develop programs and has placed no unreasonable constraints on the program or its staff. The mental health center is governed by a Board of Directors which is also perceived as supportive and proud of the Family Advocate Project. Overall, the program operates in a comfortable and supportive atmosphere.

Philosophy and Goals

The basic premise of the Family Advocate Project is that the needs of multiproblem families can be effectively and efficiently addressed with an intervention involving in-home therapy provided by a skilled family advocate and interagency networking. A set of basic beliefs form the foundation of the project:

- Hope - With traditional interventions, multiproblem families tend to utilize a disproportionate amount of service time, energy, and money. Frequently, little change is produced and both the family and social service system become discouraged and hopeless. The project is based upon the belief that in order to help families change, it is necessary to instill hope in them as well as in other involved service providers.

- Empowerment - All interventions of the project are directed at enhancing the self-confidence and coping abilities of the family. The project helps families to identify problems, set their own goals, and initiate changes. Rather than doing things for families, the project emphasizes teaching families the skills needed to function more independently.

- Ecological Systems Perspective - The project views the family as a system rather than focusing attention on an "identified patient." Further, the project is based on the belief that working with and helping the social service system or network is as important as working with the family.

- Strengths - The project emphasizes the importance of focusing on the family's strengths as well as problems. Focusing on strengths allows a sense of hopefulness to develop, which is essential for progress.

In the early phases of the pilot project, a set of operational hypotheses for the Family Advocate Project were developed in order to further clarify the program's underlying philosophy and assumptions:

1. Families will improve whose network of service providers is well-organized, with a clear allocation of responsibilities.

2. Families will improve whose problems are defined operationally (concretely) by themselves and their helpers.

3. Families will improve whose helpers are hopeful and recognize the importance of even small changes.

4. Families will benefit from a long and stable association with a professional who functions as their advocate, since dysfunctional families do not quickly internalize change.

5. Families will gain confidence and become self-reliant if helped to learn problem solving skills rather than having service providers perform basic functions for them.

6. Families will improve to the extent that they can see themselves, rather than other people, in control of their lives.

7. Families will benefit from being encouraged and assisted to participate in the mainstream of society (e.g., attending school conferences, etc.), since dysfunctional families tend to be socially isolated and to project anger onto society's institutions.

8. Families do not, as a rule, make steady progress even with great infusions of help and support. After long, apparently static periods, they make changes which seem to be sudden and indicate a new level of functioning.

Underlying every aspect of the program's operation is a humanistic approach to dealing with all people -- clients, other providers, and colleagues. The leadership and staff attempt to create an atmosphere of openness, respect, cooperation, nurturance, and "generosity of spirit" which pervades the project at all levels. This unusual level of concern, support, and cooperation is recognized by almost everyone who comes into contact with the program coordinator and staff.

The specific goals of the Family Advocate Project include the following:

- To empower families by enhancing coping and problem solving skills so that they can function more effectively and independently.

- To instill hope in families and the social service network.

- To preserve families.

- To stop patterns of dysfunction within families and to prevent child abuse and neglect.

- To help families get out of isolation and participate meaningfully in society.

- To establish a working network of agencies to coordinate service delivery.

Services

As noted, the Family Advocate Project has recently expanded its focus to provide a continuum of home-based services. The services offered by the program fall into four categories:

- Crisis Intervention - The crisis intervention component is targeted at adolescents in crisis. This component originally was a separate program initiative entitled the "Youth in Crisis" program but was incorporated into the Family Advocate Project as part of its service

continuum. The component offers short-term, intensive intervention to intercede in crisis situations and preserve families. A family advocate is provided to meet with the child and family for approximately one to five sessions. If the crisis situation cannot be alleviated, the youth can be placed voluntarily in a professional parent home for a period of one day to three weeks. The Family Advocate Project maintains six professional parent homes which provide youth with emergency, temporary shelter for a maximum of two weeks in the home of trained foster parents. While the youth is in the professional parent home, the family advocate provides intensive, short-term intervention to the child and natural family. If necessary, referrals are made for continued services from the Family Advocate Project or from other community resources.

- Assessment - Families are referred for assessment when home-based services are under consideration but the situation lacks clarity. A family advocates makes one to three home visits and consults with other service providers involved with the family. A report is developed which outlines the family's needs and makes recommendations for further treatment or referral. Many families referred for assessment are later involved in one of the other components of the family advocate project, are referred for outpatient services through the mental health center, or are referred to other appropriate community agencies.

- Mid-Range Intervention - Home-based services for periods ranging from two to six months are provided to families experiencing situational crises. Such crises may involve imminent removal of a child, extreme difficulty coping with a child, stress due to physical illness or disability, and so forth. A family advocate provides home-based services and networking, devoting approximately two to five hours per week to each family. Referrals for other services are made as needed.

- Long-Term Intervention - Long-term home-based services are provided to highly dysfunctional, multiproblem families according to the original design of the Family Advocate Project. Family advocates combine in-home therapy and networking, devoting approximately four hours per week to each family for a period ranging from six months to two years.

Since the expanded service framework is relatively new, the following description of the service delivery process is based primarily on the long-term model of home-based intervention used by the project to work with highly dysfunctional families.

The primary referral sources to the project are SRS workers and school counselors. To a lesser extent, referrals originate from agencies, including the Health Department, Essential Early Education, and Migrant Programs. The referring worker generally arranges an initial meeting with the family, and the process of service delivery is initiated. The Family Advocate Project conceptualizes the process of working with families as three distinct but overlapping phases -- joining, alliance for change, and transition.

The joining phase involves gaining information about the family, setting goals, and developing a trusting relationship, and engaging the family in the service delivery process. The first meetings with the family are used to clarify the program and the role of the family advocate, with particular attention to differentiating the role of the advocate from that of the SRS child protection workers. Assessment is a major component of the initial phase, and advocates concentrate on developing a family history and determining what the family perceives as its problems and what the family would most like to change. An important element of this first phase involves the development of a plan which identifies problems and strengths and establishes goals for the intervention.

The program emphasizes the importance of establishing a positive tone from the very first contact by conveying warmth, respect, and acceptance. Further, the program emphasizes

focusing on strengths from the outset and introducing a sense of hopefulness. Experience has taught family advocates that the joining or engagement process often is lengthy, requires patience and tenacity, and may include apparent rejections or testing by the family. The building blocks of the joining process include empathy, positive reinforcement, showing respect, setting realistic goals, demonstrating that change can occur, and establishing an affectionate rapport.

The second phase of service delivery is entitled "alliance for change." This phase of service delivery consists primarily of home visiting and networking approaches directed at helping the family to become empowered by learning coping and problem solving skills. Advocates are trained to reinforce small changes ("just noticeable differences") which indicate new behaviors or progress for family members. Further, advocates are trained to anticipate periods of regression to old patterns during the service delivery process. The elements of the intervention during this phase include:

- In-Home Therapy - A wide variety of therapeutic approaches are used when applicable to provide in-home therapy to families, including contracting, family meetings, mediation, insight therapy, re-parenting, role modeling, strategic and systemic family therapy, play therapy, and others. Sessions may be held with the entire family, with individual family members, or with any combinations of family members. Counseling sessions may occur informally while involved in various activities with the family such as meeting with the father in the barn, taking the children to the park, or meeting with the mother over coffee at McDonald's.

- Teaching Skills - Family advocates focus on teaching skills to families to enhance their functioning. Skill teaching centers around areas including parenting skills, problem solving skills, and communication skills.

- Moving From Isolation - Family advocates strive to bridge the gap between families and society. This involves encouraging and helping families to participate in various activities such as appropriate contact and involvement with the schools, participating in community events, accessing needed services and resources, and obtaining appropriate training or employment.

- Recreation - The program also attempts to set aside problem solving and to encourage families to engage in recreational activities such as family events or participating in community recreational opportunities. Advocates help families to plan outings or picnics and participate in recreational activities with the families as well.

- Family Communications Course - A four-session family communications course also has been offered as part of the intervention as an opportunity for teaching and for establishing a supportive, multifamily group. The topics covered include child development, logical consequences, setting limits, and family meetings; refreshments also are provided. Although transportation has been provided, it has been difficult to get consistent attendance at family communications courses.

- Flexible Funds - Advocates are provided with $25 per family to be used to meet special needs. Although this is a small amount of money, advocates use the funds creatively for a family intervention such as taking the family to a restaurant for lunch, purchasing games for the family to enjoy together, or purchasing Thanksgiving dinner for a family who otherwise could not afford it.

- Networking - Networking is considered an integral part of the intervention, emphasized as much as working with families. The family advocate assumes the case management role and

has both the time and the mandate to organize and convene the network of community providers who are involved with the family, to empower and instill hope in the network, and to coordinate service delivery.

Advocates are available on a 24-hour basis to respond to emergencies and provide back-up for one another. Clients are provided with the 24-hour emergency number for the Counseling Service. The Center's on-call emergency worker contacts the family advocates to respond to crises involving their clients. However, advocates report that families rarely contact them in crises and that the consistent, frequent, ongoing contact with families seems sufficient to avert crisis situation. The program has few resources to rely upon in emergency situations. The Baird Children's Center in Burlington, 33 miles away from the program, maintains one emergency bed which allows for a ten day residential placement for emotionally disturbed children ages 7 to 13, and another emergency bed is available for adolescents through the Northeastern Family Institute. A psychiatric unit at the University of Vermont has four beds for adolescents. Emergency situations challenge the program and other agencies to creatively bring a variety of community resources together to assist emotionally disturbed children and their families.

For the longer-term intervention, advocates devote approximately four hours per week to each family, divided between home-based therapy and working with the network of involved providers. The long-term intervention, provided for an average duration of one year, allows sufficient opportunity for the family and advocate to develop a trusting relationship, experience cycles of growth and retrenchment together, and solidify newly learned patterns.

The third phase of the process is conceptualized as "transition" rather than "termination." This phase begins when it become obvious that the family has made substantial gains and will be able to manage without the intensive involvement of the advocate. It often is difficult for advocates to begin the transition process as families continue to have many needs and are not "cured." Despite the difficulty, transition is initiated when primary treatment goals are met, there is no evidence of abuse or neglect, the family has moved from isolation, and the family is better able to handle problems of daily living. Transition involves a gradual process of less frequent visits. Over a period of several months, visits may be reduced to every other week and later monthly. Monthly checks may continue for a period of time before transition is complete. Generally, a final network meeting is held which the family attends and which celebrates the family's accomplishments.

In order to prepare for transition, families are referred to more conventional services if needed. The majority of families do not become involved with other mental health center services after transition, but many continue their involvement with the school counselor, summer programs, and the like. While the case management role is supposed to be assumed by another member of the network, most often the SRS worker, this does not always occur.

Family advocates make follow-up contacts at six months, one year, and two years after transition and may maintain contact with families through phone, correspondence, and occasional visits on an informal basis. Families are encouraged to contact the program if problems arise, and the program may provide additional assistance if appropriate. If families regress, a short-term "refresher course" may be provided to reinforce and rebuild previously learned skills.

A number of general rules guide the advocates as they provide services to families:

- Building trust and "joining,"

- Being respectful of the family,

- o Starting "where the family is at" and respecting their agenda,
- o Remaining hopeful in the face of frequent crises and problems,
- o Always being aware of strengths,
- o Respecting small changes and setting small, achievable goals, and
- o Always keeping a systems perspective.

Networking and Linkages

As noted, the Family Advocate Project considers networking to be as important as intervening directly with families. Families invariably are involved with numerous agencies, each addressing an aspect of the family's problems without seeing the whole. This fragmentation and disorganization encourages the family to become passive recipients in the service delivery process. Further, service providers working with dysfunctional families tend to become discouraged by the overwhelming problems presented. Thus, an explicit goal of the Family Advocate Project is to organize the service system into a functioning network.

A written consent form allowing advocates to share information with other providers is obtained from families at the very first stages; the program would decline to work with a family who refused to sign such a release. The first step in the networking process involves detective work to identify all involved providers. All providers are contacted and a networking meeting is called. This first meeting is seen as an "organizational" meeting, and families generally do not attend because discouraged workers tend to vent many of their frustrations and negative feelings at the initial conference. Families, however, are briefed fully regarding network discussions. The general pattern for networking is to hold two to three meetings for each case, in the beginning, middle, and transition stages of the intervention. Smaller meetings with subgroups of the network are held in the interim as well as ongoing contact with individual network members.

A similar format is used for most network meetings. The advocate involved with the family generally serves as chairperson for the meeting, and newsprint and markers are used to develop an intervention plan. The process may begin with the development of a genogram depicting the family with its history and interrelationships. A list is made of all agencies working with the family and their primary roles. The group then proceeds to identify the family's problems and strengths and to develop a plan which specifies goals and assigns roles and responsibilities for carrying out aspects of the intervention plan. At the close of the meeting, the advocate summarizes the discussion and plans and establishes a time for the next meeting. The advocate generally is perceived as the case manager and network coordinator.

Special efforts are made to ensure that schools are part of the network. Schools have tremendous potential for impacting the lives of children and families but routinely are left out of the networking process. The Family Advocate Project visits schools, establishes contact with teachers, principals, and special education personnel, and ensures that they are an integral part of the network of providers. Networking meetings often are held after 3:00 P.M. when school personnel can attend more easily.

In addition to networking around individual families, the Family Advocate Project is involved with a number of additional structures and mechanisms for maintaining close interagency linkages and collaboration.

- Addison County Children's Task Force - This task force was established in 1978 and is comprised of representatives of all agencies, professionals, and citizens concerned with children and families. The task force holds an annual meeting in which priority needs for the county's children and families are identified, and working task forces are established to address these needs. It was through this process that the Family Advocate Project originated.

- Family Support Team - The Family Support Team is a multi-agency group which serves as a steering committee for the Family Advocate Project. The team meets monthly to provide input and consultation on all aspects of the program. In addition, the monthly meetings provide a forum for discussing difficult cases; any professional in the county is invited to present a confusing or frustrating case, and the networking review process described above is used to develop an intervention plan. The team has also been designated as the County Child Protection Team to review difficult cases of abuse and neglect. A typical monthly meeting is attended by nearly 20 persons representing 9 or 10 different agencies.

- Quarterly SRS Meetings - The entire staff of the Family Advocate Project meets on a quarterly basis with the SRS staff to air problems related to service coordination and to devise solutions. The Family Advocate Project is highly responsive to concerns raised by SRS staff. For example, when SRS staff noted difficulty in locating and reaching advocates, the program instituted a series of procedures to ameliorate this problem, including leaving their schedules with the center receptionist, having the center call advocates at home to relay messages, and arranging for advocates to provide back-up for one another. Other agencies expressed appreciation for the willingness of the program to deal with problems and not interpret them as criticisms.

In addition to these structures, the Family Advocate Project reaches out to other community agencies by serving on boards and task forces, sharing facilities and equipment, providing services to other agencies, and arranging meetings with staff of other agencies.

Addison County is perceived as a model county in the area of linkages. Agencies and providers are willing to communicate and network, and many concrete, positive results have resulted from networking efforts. The Family Advocate Project, Parent/Child Center, and other services were initiated through interagency collaborative planning processes. Initially, some agencies were resistant to participating in networking efforts. It is reported that a great deal of groundwork was needed to involve providers, meet on their turf, create a cooperative tone and atmosphere, acknowledge and respect their roles, and, thereby, break down resistance. There are, of course, weak links in networking efforts. For example, juvenile justice agencies do not participate to the extent desired, and individual workers may be more defensive or less cooperative than could be wished for. The Family Advocate Project has developed a set of basic principles to guide networking activities which is presented at the end of this section.

Clients

Until recently, the Family Advocate Project targeted its services at highly dysfunctional families. The families served by the program must be unable or unwilling to use more traditional services. These families traditionally have received a disproportionate amount of service resources with insignificant results; they are unable to break the cycle of serious dysfunction, which in some families is multigenerational. The families served by the project can be characterized as disorganized, discouraged, socially isolated, and lacking in coping skills. Many families live in shacks or homes in various states of disrepair with littered yards, cluttered interiors, and extended family members and neighbors often present. Many of the families have a pervasive sense of hopelessness, with no sense that "things can get

better." A list of characteristics used by the program to define highly dysfunctional families is included at the end of this section.

Some data are available describing the 22 families who participated in the project during the period of federal funding. Sixty percent of the families had no phones and nearly half had no car. In 45 percent of the families the father was unemployed, and the majority of the families (68 percent) were receiving some type of government financial aid.

The program does not use diagnoses to describe the children and attempts to avoid focusing on an "identified patient" within the families. However, a significant portion of the 104 children in these families was emotionally disturbed, and some could be considered severely emotionally disturbed. Some of the problems experienced by the children include behavior disorders, poor impulse control, developmental delays, poor peer relationships, depression, suicidal behavior, and delinquency.

With the expanded range of home-based services now offered by the project, the target population served has also expanded beyond highly dysfunctional families. Currently, the program assigns an advocate to work with the families of all children assigned to special education classes for reasons of emotional disturbance.

Staffing

The Family Advocate Project is staffed by a coordinator and five part-time professionals who function as family advocates, approximately 2.5 full-time staff equivalents. The program has found that using part-time employees provides work opportunities for highly qualified professionals who also want to spend some time with their own children and families. In addition, having a larger group of staff brings varied talents and experiences to the project and allows for the creation of a team for mutual support. While the advocates function as a team within the agency, they work alone with the families assigned to them. Each family advocate carries approximately four cases at any given time. At the present time, all advocates are women who bring their own parenting experiences to the job. The program is attempting to add a male advocate, and the staff occasionally is supplemented through contracts with graduate interns.

All family advocates hold Master's Degrees in a human service field (counseling, social work, or psychology) as it is felt that strong clinical training and skills are needed to work with such challenging families. In addition, the program requires that advocates have extensive experience using nontraditional approaches to work with families or working in particularly challenging settings. For example, one advocate was a social worker in a children's hospital burn and sexual abuse units and worked with families under trying circumstances, and another previously provided in-home counseling to families with handicapped children. Beyond training and experience, the program looks for advocates who are flexible, good problem solvers, nonjudgmental, stable, committed, have a sense of humor, and can relate easily to others.

When the group of advocates initially was hired, two weeks of intensive training was provided to orient them to the new project and approach. The training covered such topics as philosophy, understanding dysfunctional families, in-home therapy, networking, community resources, record keeping, and getting started. In-service training events specifically geared to the needs of the advocates are held, and the advocates also attend monthly in-service training presentations given for the entire agency. Specialized training periodically is provided to the project staff. For example, a team was hired by the project to provide family therapy training and supervision for a series of five sessions. Additionally, staff are given opportunities to attend several external training events and workshops.

Advocates receive high levels of support and supervision. Group supervision is provided to the team on a weekly basis; individual clinical supervision is provided bi-weekly to each advocate. Half-day meetings to review problems and progress generally are held quarterly, and a full-day retreat for the staff is held at the beginning of each year to develop a shared vision, establish personal goals, and identify areas that individual staff members would like to develop during the coming year. Advocates feel that the consultation and support they receive is essential and helps them to feel that they are not alone with their difficult cases.

While the work of advocates is stressful and demanding, there has been almost no staff turnover since the project's inception. Despite low salaries, staff generally are satisfied and challenged by their work. They feel that home-based work taps into their idealism, allowing them to help families that more conventional service approaches cannot reach. The critical variable appears to be the extraordinary levels of support provided to advocates by each other and by the project coordinator. Initially, a buddy system among staff was used as a means of providing support, and this system is maintained informally. There is a strong sense of camaraderie within the group, and advocates help each other to maintain a positive perspective despite inevitable discouragements. Perhaps most important is the atmosphere of respect, concern, encouragement, and support which is established by the project leadership.

Resources

The costs of the Family Advocate Project have been estimated crudely by dividing the budget for a particular period by the number of cases served. The cost of the crisis intervention component is estimated at an average of $320 per family, and the cost of the longer-term intervention at an average of $1,920 per family per year. Overall, across the entire continuum of home-based interventions, the cost of services is approximately $960 per family per year.

The Family Advocate Project was initiated as a pilot project with a series of mini-grants from the Vermont Department of Social and Rehabilitation Services. For an 18-month period (September 1984 to February 1986) the project was funded by a federal grant from the Office of Human Development Services in the amount of $92,519. At the expiration of the federal grant, the program struggled in order to arrange for the state to pick up the project. The state provided interim funding for a period of time and ultimately made a commitment to fund the home-based effort.

The annual budget for the Family Advocate Program is $72,000. The contract with the Vermont Department of Social and Rehabilitation Services specified that the project will serve 75 families in the course of a year, approximately 20 families per month, through the various types of home-based interventions. No fees are charged to families and no third party reimbursements are received for the program's services. The funding for the program is shared equally by the Department of Social and Rehabilitation Services and the Department of Mental Health. There currently is some interest within the Department of Education to share in the funding of the Family Advocate Project and other home-based programs in Vermont. Efforts are underway to secure their participation, and the state budget for Fiscal Year 1988 contained $250,000 for home-based services to be overseen jointly by the Mental Health and SRS Departments.

The potential for some third party reimbursement for services exists through Vermont's Medicaid Waiver Program. The Department of Mental Health received approval of its home and community-based Medicaid waiver in 1982, allowing the state to offer a wide variety of nonmedical services to individuals who otherwise would require more expensive institutional care. The waiver program covers mentally ill children under age 22 who have been institutionalized or are at risk for institutional care in an inpatient psychiatric facility. Providers of such services must be community mental health agencies or other agencies

approved by the Department of Mental Health, and potentially reimbursable services include service coordination, client support, day activity, family education and training, intensive day programming, respite care, and residentially-based habilitation and training -- many of which are provided through home-based services.

In order to receive Medicaid reimbursement for services to a child and family, documentation must be provided that the child would be institutionalized without the services, and a six-month service plan must be prepared and approved. Reimbursement is provided through the Department of Mental Health on a six-month basis. Three children in Addison County currently are approved for services through the waiver program.

Evaluation

The results of the original pilot phase (five families) of the Family Advocate Project were highly encouraging. Seven children were identified by SRS as being at risk for removal at the project's inception; only one child was actually removed for a two-week period under a voluntary care agreement. Follow-up on the five pilot families was conducted to attempt to assess which interventions were perceived as helpful and what changes actually were achieved. All families found the program helpful, and the families asserted that the reliable, consistent presence of a professional brought them through times of crisis to higher levels of functioning.

More structured evaluation was performed during the period of federal grant funding (22 families). Evaluation procedures and results include the following:

- Ratings of families on a continuum from very significant change to insignificant change showed that four families achieved very significant change, seven achieved significant change, eight achieved some change, and three achieved insignificant change. Severe substance abuse among parents appears to be associated with lack of success in the home-based intervention. Additionally, the three families achieving insignificant change were never successfully engaged in the service delivery process or motivated to change.

- Pre and post ratings of specific problems revealed significant reduction of problems, including substance abuse, family violence, child abuse and neglect, truancy, and isolation from society. Additionally, significant increases in employment and vocational training among parents was achieved.

- Eighty-two percent of the families remained intact with no children placed in state custody.

- Scores on the Child Neglect Severity Scale showed significant improvement from the pre-test to the post-test. At pre-test, 14 families scored as "neglectful," whereas no families were in this category following the intervention.

- Social service workers rated each family on seven dimensions at the completion of the intervention as worse, no change, minimal positive change, or significant positive change. Ratings overwhelmingly rated minimal or significant change in each category.

- The majority of the 22 families (18) no longer met the criteria for being highly dysfunctional.

Current evaluation procedures used by the program are limited to the checklist of problems and strengths for each family. This is completed at intake, quarterly (to note changes), at termination, and at follow-up.

Major Strengths and Problems

Program administrators, staff, providers from other agencies, and families all cited the factors that make the Family Advocate Project successful and factors that they perceive as problematic. The following are the major strengths identified:

- Ability to work with families at home on an outreach basis.
- Flexibility in what advocates can do with families.
- Exceptional leadership.
- Concerned, competent, energetic staff.
- Support system for staff.
- Philosophy of empowerment.
- Open-ended time frame with no rigid contract with family regarding length of intervention.

It is clear that a major factor in the program's success is its exceptional leadership and staff, perceived by all to have high levels of talent and expertise as well as the ability to create a supportive and cooperative atmosphere with other agencies, families, and colleagues.

Several problem areas were noted as well. Managing staff resources is problematic, particularly balancing the assignment of short-term crisis cases with ongoing longer-term caseloads. Further, inherent in home-based work is the need to deal with situations that occur rarely in more conventional services delivery approaches. These include such occurrences as dog bites (which happened to two advocates), sexual overtures, or physically threatening behavior on the part of a family member.

Therapeutically, it is difficult for advocates to come to terms with the intractability of the dysfunction in some families. The most difficult situations occur when it is learned that abuse has occurred during the intervention and has not been detected by the advocate. While this occurs infrequently, advocates feel most vulnerable and guilty at these times and require high levels of support to work through their feelings. Finally, complications for service delivery are posed by the conditions of poverty as well as by climate and geography. Lack of telephones and transportation among families complicates the process, as do difficult travel conditions for advocates during winter and mud season.

Dissemination and Advocacy

The coordinator of the Family Advocate Project and staff have made countless presentations about the home-based service program to other agencies, state officials, legislators, provider groups, and at workshops and conferences. Training is provided to other home-based programs in Vermont which are at various stages of development. The program has developed a set of videotapes which are used for training activities.

In addition to these dissemination activities, representatives of the program are active in a group called the Family Empowerment Resource Network (FERN), an alliance of home-based programs in the New England area. The group meets quarterly and functions primarily as a support group of administrators and clinicians involved in home-based service provision.

The coordinator and staff also are active in advocacy activities on behalf of children and families in the state of Vermont. They advocate for children's services at the state level, in particular for a legislative appropriation for home-based services.

Currently, there are few parent support or advocacy activities in the area served by the Family Advocate Project. Local parent groups focusing on learning disabled, mentally retarded, and handicapped youngsters are being encouraged to include parents of emotionally disturbed children.

Case Examples

A 13 year old boy and his family were referred to the Family Advocate Project by a private therapist. The boy's behavior was out of control, and his overwhelmed parents, who could no longer manage him at home, were requesting out of home placement. A family advocate was assigned to intervene in the crisis. After several visits with the family and meetings with the therapist and school personnel, the advocate felt that the youth potentially had an attention deficit disorder. She arranged for an evaluation which confirmed this diagnosis. The advocate worked with the family to teach them management techniques and assisted the parents in working with the school to arrange for an IEP process and special education. With the assistance of a three-month home-based intervention, the boy has remained at home and the situation remains stable.

Family "H" was referred to the Family Advocate Project as a result of allegations of child neglect. These allegations arose when the parents refused to allow their developmentally delayed and emotionally disturbed son to participate in the Essential Early Education Project, a special education project for preschoolers. At the time that the program became involved, the mother was agoraphobic and was contemplating building a high fence around their trailer to further shut out the world. The advocate worked with the family over a 12-month period. The in-home therapy and networking approaches led to major changes in the family -- the mother has learned to drive; the son is picked up by bus and participates in the special education program; the son is no longer enuretic; the children and family play outdoors (the mother is no longer agoraphobic); and the family has food stamps and Medicaid. The advocate continued weekly visits with the family and assisted with the transition of the son to the public school. At one of the last visits, the mother was waiting outside, dressed up, wanting to go out to the local diner with the advocate for a cup of coffee.

Technical Assistance Resources

- Contract with the State of Vermont

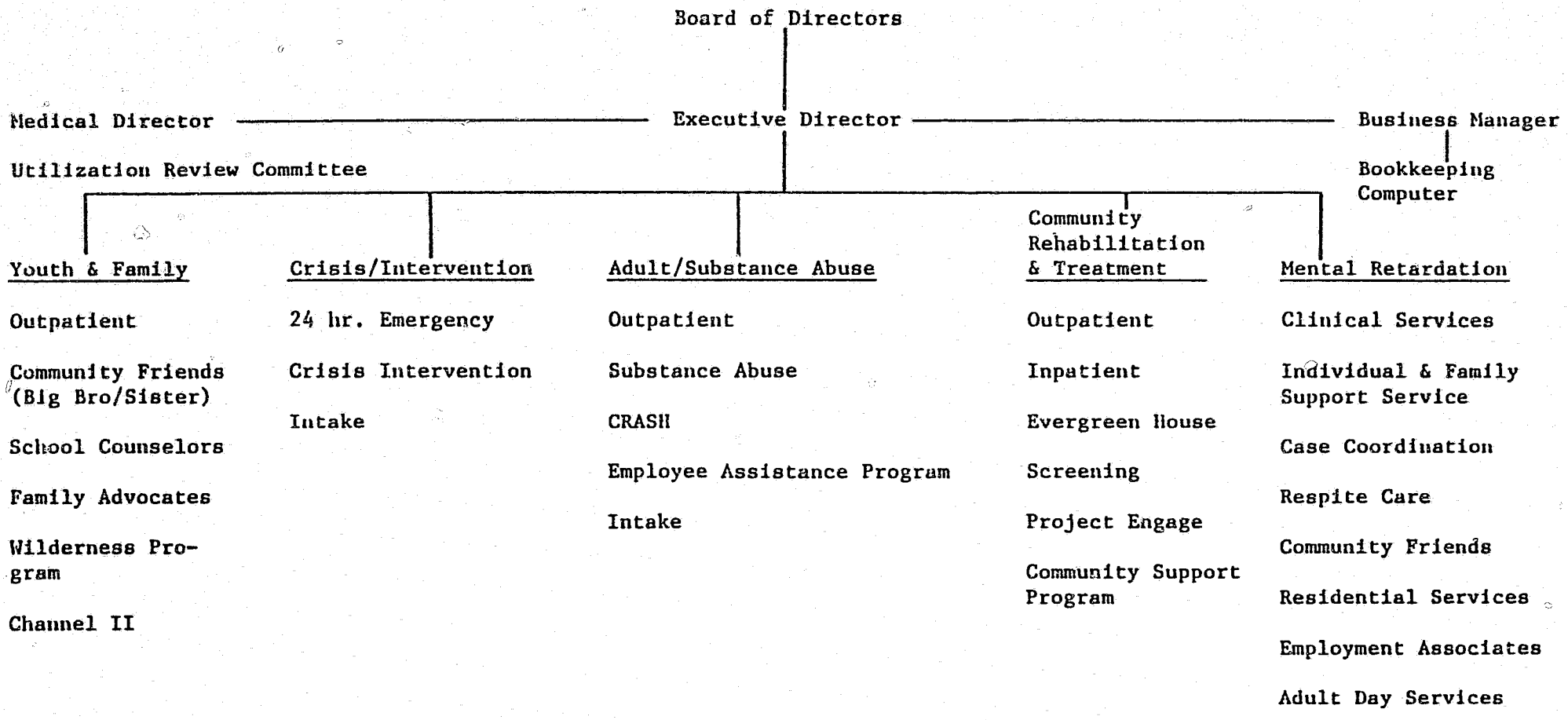
- "Preventing the Cycle of Child Abuse and Neglect in Highly Dysfunctional Families, Family Advocate Project, Final Report." Submitted to Department of Health and Human Services, Office of Human Development Services, 1986.

- Training Videotapes

- Program Forms:

  Referral
  Release of Information
  Intake/Family Information
  Social Service Involvement
  Problem Checklist
  Strength Checklist
  Quarterly Report
  Final Report
  Follow-Up Report

COUNSELING SERVICE OF ADDISON COUNTY, INC.



FAMILY ADVOCATE PROJECT

BASIC PRINCIPLES OF NETWORKING

1. Ecological approach - Multi-faceted problems need multi-faceted solutions. One agency would be overwhelmed by the complexity of either a client or system-wide problem.

2. Extend ourselves, reach out - Become members of each others' boards; willingness to leave your office signals a "peer" relationship; rotate meeting places among agencies; sensitivity to turf, symbolic gestures; respect for others' expertise.

3. Acknowledge that networking sometimes complicates the process.

4. Content/style of meetings - Comfortable, people get heard, have concrete goals, problem-oriented, positive, hopeful orientation.

5. Generosity of spirit - Sharing of equipment, bartering.

6. Look for problems and enjoy solving them.

7. Shared vision - Service providers gather and note the unmet needs of parents and children and everyone brainstorms and comes up with ideas.

8. Developing a track record of accomplishments - Success builds upon success; people develop faith in the process.

9. Creative problem solving.

10. Optimistic approach to work.

11. Networking needs to be subsidized - Release time for participants, etc.

12. Conflict is inevitable and can be used as a building mechanism.

13. Be supportive, give positive strokes.

14. A requirement of cultivating people is being trustworthy and accountable - Always keep your word, follow through.

FAMILY ADVOCATE PROJECT

DEFINITION OF HIGHLY DYSFUNCTIONAL FAMILIES

Criteria developed by Cutler and Madore (1980)

- A crisis state exists and is continuing to expand with no indications that spontaneous resolution will occur.
- Increasing distress within the family is producing symptoms in more than one member.
- Multiple contacts with many agencies are yielding little or no results.
- Temporary or permanent removal of the symptomatic family member is deemed either impossible, not helpful, or contraindicated.
- Family members and staff view the problem as being potentially disastrous without a major overhaul.
- Lack of interagency coordination serves to enhance communication problems thus adding to the blaming process.
- Agencies working with the family feel discouraged or are resigned to the fact that they are dealing with a "hopeless" family.

Criteria developed by the Family Support Team

- Family "falls apart" in times of crisis.
- Family frequently in crisis.
- Family members have difficulty adapting to social institutions.
- Family is socially isolated.
- Family has multiple problems.
- Numerous agencies are involved in trying to meet family's needs.
- Family has difficulty assuming responsibility for their own lives.
- There is evidence of child abuse and/or neglect in the family.

HOMEBUILDERS
BEHAVIORAL SCIENCES INSTITUTE
FEDERAL WAY, WASHINGTON

History

The Homebuilders program is an intensive, in-home program designed to prevent the out-of-home placement of children. With the goal of family preservation, the program intervenes in crisis situations, providing high levels of services to seriously troubled families for a period of four to six weeks.

The program was initiated in 1974 in Tacoma, Washington, at Catholic Community Services. Staff of that agency noted that, in many cases, removing children from the home resolved neither the child's nor the family's problems. They were considering the need for new programs to work with troubled children and families who were not responding to traditional services and who frequently were labeled as "hopeless" by the agencies working with them. During this discussion, the suggestion was made, somewhat facetiously, that instead of removing children from their homes when crises erupt, perhaps therapists should be placed in the homes with the families. The more the idea was considered, the more sense it made, and staff at Catholic Community Services determined that intensive, in-home intervention should be attempted.

A children's services staffing grant from the National Institute of Mental Health coupled with funding from Catholic Community Services enabled the program to begin working with families in 1974 with a staff of three therapists and a secretary. During the initial stages of the program's development, staff experimented with approaches in order to determine how best to work with families. Staff relate that, in the beginning, therapists carried sleeping bags in their cars since they did not know if they literally would have to move in with client families. Through the program's early experience, staff identified the essential elements of providing intensive, home-based services. Hence, the "Homebuilders model" evolved, including the basic premise of intervening at the crisis point when the family is highly motivated and a set of additional operational beliefs and assumptions.

In 1982, the creators of Homebuilders left Catholic Community Services in order to expand the program beyond the boundaries of the Catholic diocese to other areas of the state. They formed the Behavioral Sciences Institute, which operates the Homebuilders program and conducts training and research activities related to home-based services. Since its inception, the Homebuilders program has grown to a staff of 26 therapists and has served more than 3,000 cases.

Community and Agency Context

The Homebuilders program currently serves four counties in the state of Washington: King, Pierce, Snohomish, and Spokane counties. Each county includes urban areas such as Seattle, Tacoma, Everett, and Spokane as well as rural, isolated, and remote areas. Some of the communities served are in mountainous regions. Thus, the areas served by the Homebuilders program differ widely. Plans are underway to expand the Homebuilders program to serve additional counties in Washington during 1988 and 1989.

The minority population in the areas served by the Homebuilders program is concentrated primarily in the Seattle area (King County). Blacks, a variety of Asian groups, Pacific Islanders, Native Americans, and Hispanics are among the minority groups found in this area, and minorities comprise approximately 18 percent of the population served by the program, 29 percent in the Seattle area.

In addition to serving the four Washington counties, the agency launched a pilot program in 1987 in the Bronx, New York. Because of the challenges involved in implementing a home-based program in an inner city environment fraught with problems, the City of New York requested that the Behavioral Sciences Institute, with its extensive experience and expertise, develop the program. The two co-directors of the Behavioral Sciences Institute went to New York City for a period of at least one year to implement the program. As a result, the program has had the opportunity to test the application of its model in a highly urban environment that is notorious for high levels of poverty, substance abuse, violence, and disorganization.

The Behavioral Sciences Institute is a nonprofit agency that is dedicated to providing home-based services and developing and disseminating information about such services. The agency is comprised of three divisions. The Homebuilders Division houses the service-providing function of the agency, and the Research Division obtains grants for research related to home-based services. The Training Division is responsible for all training, dissemination, and public relations activities. This structure enables the agency to broaden its scope beyond service provision, with research and training being integral parts of the agency's mission.

The main offices of the Behavioral Sciences Institute are located in Federal Way, Washington, which lies between Seattle and Tacoma. Satellite offices are maintained in Snohomish and Spokane Counties and, as of 1987, in the Bronx, New York. Since home-based programs require tremendous staff mobility, the offices generally are used as meeting places and places to turn in paper work. In most areas, staff work out of their homes rather than traveling to the area office daily. In general, staff live in the counties in which they work and are required to live within a certain distance of the area they serve. When Homebuilders programs are developed in new areas, an attempt is made to have experienced staff move to the area to implement and operate the program. For example, when the program expanded to serve Spokane County, an experienced supervisor and two experienced therapists moved to Spokane to start the program. Additional staff were hired on site.

Each of the counties served by the Homebuilders program has a supervisor who provides clinical direction and monitors individual case goals, program goals, and the budget for that particular county. In the smaller counties, the supervisor may devote half-time to supervisory and administrative responsibilities and may carry a half-time caseload. The supervisors from each of the counties participate in a weekly management meeting as well as in occasional retreats. In addition to the active role of supervisors in agency management, the Behavioral Sciences Institute attempts to involve staff in the policy and administrative decision making processes to the greatest possible extent. Key decisions (such as the initiation of the New York City program) are brought to the group for input, and staff committees are established to address such administrative issues as the development of a new salary structure or the revision of personnel policies.

The Board of Directors of the Behavioral Sciences Institute is comprised of an array of professionals with interest in services for children and families; it meets on a quarterly basis. The Board is characterized as both challenging and supportive. In addition to its regular oversight and decision making responsibilities, the Board focuses on special issues that affect the program, including the opening of the New York program, difficulties related to malpractice insurance, and crises that may arise related to specific cases.

Philosophy and Goals

The Homebuilders program is based upon the belief that there are many benefits for children, families, and the community when families remain intact and problems are resolved in the

context of the family rather than through out-of-home placement. When family preservation services are successful, families learn to handle their own problems more effectively, and the emotional damage that can result from family separation is avoided. The overriding philosophy of the program is that children have a right to benefit from the special and enduring family ties that are present in even the most seriously disturbed families.

The Homebuilders program is based upon a set of basic premises which shape the intervention:

- o Intervening at the Crisis Point - Services are provided to families when they are in crisis. At times of crisis, families are experiencing the most pain and, as a result, are highly motivated and open to change.

- o Treatment in the Natural Setting - The program works with families in their own homes where the problems are occurring.

- o Accessibility and Responsiveness - Therapists are available to families 24 hours a day, seven days a week and are able to meet client needs and schedules. Families are given as much time as they need, at the times that they need it.

- o Intensity - High levels of services are provided and are concentrated in a limited period of time, lasting approximately four to six weeks.

- o Flexibility - A wide range of services are provided including helping families to meet their basic needs as well as therapeutic interventions and family education in areas such as parenting skills, child development, mood management skills, and communication.

- o Low Caseloads - Homebuilders' therapists carry only two cases at a time. This allows them to devote large amounts of time and energy to each family during the intervention period, addressing both the clinical and concrete service needs of families.

- o Accountability - The Homebuilders program carefully monitors and evaluates its progress on individual cases as well as for the program as a whole. Therapists track client progress toward specific goals formulated with the family at the start of the intervention, and the program monitors outcomes and obtains feedback from participating families.

In addition to these premises, a set of basic "assumptions and awarenesses" about working with families has evolved through the experience of the Homebuilders program. These include such philosophical stances as:

- o No family is hopeless. The program has found that few families are "hopeless," even in cases where different types of counseling services have been provided previously with little success. With new skills, most families can live together as a family.

- o Labeling can be harmful, particularly the label of "unmotivated." The experience of the Homebuilders program suggests that psychiatric diagnoses and other labels bear little relationship to behavior or prognosis. Labels can contribute to the fallacious belief that a family is hopeless, and, as a result, can have a negative effect on the therapist and other providers working with a family. Labeling clients as unmotivated can be particularly misleading. Often, those assigning that label neglect to account for what actually motivates clients and clients' perceptions of their own needs. Further, providers must recognize that motivating clients often is a part of their job.

- o Therapists are not perfect. The Homebuilders program emphasizes that therapists do not have all the answers and are willing to acknowledge this with client families. This stance

helps clients to recognize their own personal responsibility as well as to view the therapist in a more realistic way.

- Family members do not usually intend to hurt each other. Another awareness emerging from the experience of the program is that family members do not usually intend to "do each other in." Even in the most troubled situations, family members generally care a great deal for one another and are trying to do the best that they can, given their current level of knowledge and skills. This optimistic viewpoint leaves room for hopefulness and positive expectations in the intervention process.

- It is most helpful to view family members as colleagues. The program attempts to view families as colleagues and peers rather than as "patients." This conviction is based upon the fact that the families themselves have the best data about their situations and problems. Further, it is essential to match methods and intervention strategies with the values and beliefs of the family in order to succeed. In addition, clients as well as others respond best to being treated with respect, courtesy, tact, and dignity.

The Homebuilders program strives to achieve two primary goals:

- To prevent out-of-home placement.

- To teach families the basic skills needed to remain living together.

As a short-term, crisis intervention program, Homebuilders does not expect to solve all of the family's problems. Rather, the program works towards stabilizing families and leaving them with additional skills that they may use to function more effectively in the future.

Services

The services provided by the Homebuilders program are multifaceted. Going far beyond conventional counseling, the program emphasizes skill building and coordination and advocacy with a variety of community agencies and resources. The intervention for each family is highly individualized and is based upon a well-articulated and goal-oriented treatment plan developed with the family in the initial phase of service delivery.

The service delivery process begins with referrals which must all be routed through the State of Washington Department of Social and Health Services, Division of Children and Family Services (DCFS). Within DCFS, two departments are eligible to refer cases to the program--Children's Protective Services, which handles abuse and neglect cases, and Family Reconciliation Services, which handles cases primarily involving youth in conflict or status offenders. These agencies are provided with clear referral guidelines which state the goals of the Homebuilders program and specify which types of referrals are appropriate and inappropriate.

Upon referral, DCFS personnel must document that without the Homebuilders intervention, out-of-home placement is the next likely occurrence in the family. Further, referring workers must indicate that other intervention efforts to assist the family have failed to prevent the need for out-of-home placement. Family members must concur that placement will occur unless substantial changes are initiated immediately.

The program has no waiting list and operates on a "space available" basis. Incoming referrals are routed to an intake worker who maintains a calendar indicating when each therapist is "open" to accept a new case. If there is no opening on the day a referring worker calls, he

or she is encouraged to call back to check for openings. Some referring workers report that they call daily at 8:00 A.M. in hopes of obtaining a service slot for their client families. The demand for Homebuilders' services far outstrips the program's service capacity. In 1986, for example, the program received 1,098 referrals and was forced to turn away 61 percent of these referrals because the program was full.

When an opening exists, the intake worker obtains basic information about the family and supplies this to the assigned therapist. When possible, the intake worker attempts to consider specials needs or requests in assigning cases to therapists (e.g., requests for a male therapist or a black therapist). However, due to the high demand for services, there generally is only one opening at a given time and, therefore, no choice for case assignment. The therapist may call the referring worker prior to the first home visit if there is a need to assess the risk of violence or to obtain additional information.

The therapist typically meets with the family within 24 hours of the referral and is required to hold the first session within a maximum of 72 hours. If the family is not available to begin the intervention immediately, the referring worker is asked to wait and refer the case again at a more appropriate time. Additionally, if the targeted child is not at home at the time of referral, there must be an agreement among all involved parties that the child will return home within seven days of the referral. Therapists are given a maximum of three days or three visits to determine if a family meets the eligibility criteria for the program. For a six-month period in 1986, approximately 7 percent of the intakes were terminated after this brief assessment period. Some of these cases (3 percent) were considered inappropriate referrals for such reasons as placement was not imminent, no plans for a child in placement to return home, or parents unavailable to work with the program. In 4 percent of the cases, a family member (parent or child) refused to have the child remain at home. Any case seen longer than the three-day assessment period automatically becomes an accepted case for the complete Homebuilders intervention. Homebuilders' therapists make concerted and persistent efforts to engage reluctant families and to encourage them to work with the program.

The initial visit may last from one to seven hours or more and may involve meeting with family members individually as well as together. While some families may require "ice breaking" techniques, others are eager and relieved to share their distressing problems, and still others require interventions to "defuse" the initial crisis to preclude violence and other destructive behavior. Homebuilders therapists have developed many techniques to structure situations to reduce the likelihood of violence and to rapidly teach family members new ways of coping with emotionally charged situations. Regular phone contact with the therapist between visits (hourly if needed), environmental changes, and using friends and relatives to assist in structuring the situation are examples of the approaches used by therapists. Crisis cards often are used with parents and children to provide a list of behaviors they can try when troublesome feelings escalate. These activities often enable clients to "catch themselves" before negative feelings such as anger and depression become too intense to control. Active listening is used extensively by therapists to ensure that each family member feels listened to and understood; this frequently reduces tension within the family and enables the intervention process to proceed productively. Children may be seen individually as soon as possible, since they may be reluctant at first to share their feelings with their parents present.

The initial phase of the intervention is devoted to relationship building as well as to assessment and goal setting. For the Homebuilders program, assessment is seen as a way of identifying and stating problems so that all involved can understand them and can participate in exploring options for problem resolution. Therapists are provided with specific guidelines for assessing client families including:

- Be as clear and specific as possible. Use behavioral descriptions.

- Avoid making inferences about people; rely on behavioral observations.

- Phrase things in ways which increase options instead of closing them off.

- Avoid "generalized labeling of people" (GLOP).

- Avoid putting anything in the record that you would not feel comfortable having clients see.

Generally, by the second or third visit, the process of setting goals and priorities is well underway. Together with the family, the therapist selects two or three goal areas to concentrate on during the brief intervention time frame. Therapists attempt to establish realistic expectations with families from the outset, emphasizing that they are not miracle workers but will work with the family to address several specific problem areas. For each of the goals selected, a ranking system (-2 to +2) is developed to allow the family and the worker to objectively assess progress. Examples of goals that might be identified for a family include improving anger management capabilities, curtailing stealing behavior of a child, or increasing knowledge of specific parenting skill options. Weekly treatment plans are developed to address each goal. A sample goal sheet is provided at the end of this section which outlines one aspect of the intervention for a family with a 14-year old suicidal girl with a history of psychiatric hospitalization.

The interventions are generally comprised of three major facets:

- Counseling - Individual, family, and marital counseling may all be a part of the Homebuilders intervention, as appropriate. Counseling may occur with family members at specified times or may occur as part of other activities conducted in the home or in the community. A variety of therapeutic approaches and techniques may be used depending upon the needs and characteristic of families. In some cases, multiple impact therapy is used whereby a number of therapists go to a family's home and see each family member individually. Subsequently, the entire group comes together, and the therapists share their impressions in an effort to encourage and facilitate family communication.

- Skill Building - The program emphasizes skill teaching in order to leave clients with the skills needed to cope and function more effectively. Therapists take advantage of "teachable moments" that arise in naturally occurring events and settings to teach and practice a wide variety of new skills in areas including communication, negotiation, emotion management, child management, assertiveness, household management, cognitive restructuring, and others. To assist the therapist in skill teaching, a range of resources are available, including lecturettes, readings, homework sheets, videotapes and audiotapes, and more. Therapists may design special materials for individual families in order to facilitate the learning of particular skills.

- Concrete Services and Coordination - Homebuilders' therapists work with a wide variety of community agencies and resources to coordinate and arrange for services needed by family members. For example, if there is a school problem, the therapist works with school personnel in order to resolve problems and advocate for needed services and supports in the school. A major aspect of the intervention involves connecting families with appropriate community resources for ongoing services. This may include helping the family to obtain food, housing, clothing, financial assistance, transportation, medical or dental services, employment or training, legal aid, child care, recreational activities, and the like. While therapists utilize an array of community agencies in this effort, they also undertake to involve natural supports such as extended family where appropriate. In addition,

Homebuilders' therapists provide a great deal of concrete services themselves. This may involve a wide variety of types of direct assistance ranging from providing transportation to scrubbing floors with a family.

Thus, the intervention includes both clinical and concrete services and addresses the multiple needs of children and families. The Homebuilders Resource Guide assists therapists by offering a wide variety of techniques to use with clients in various situations. The authors note, however, that specific interventions will not be effective unless the client-therapist relationship is positive enough to facilitate change, and the interventions are consistent with the values and priorities of the families.

The services provided by the program are augmented by an Educational Consultant who works with the program on a volunteer basis. The consultant is available to serve as an advocate for children needing special education services within the schools or to assist with any other school-related problems.

During the intervention period, therapists are available to respond to family's needs 24 hours a day, seven days a week. Families are provided with the home telephone numbers of both their therapist and their therapists' supervisor. If neither of these individuals can be reached, clients are given a third number to access a team member who can be reached by a pager system. Staff report that very few families take advantage of the therapists' accessibility, and, in some cases, families have to be encouraged to call their therapists when appropriate. Most families do not call unless there is truly a crisis situation. Further, many crises can be anticipated, and therapists generally check in with clients on a regular basis if the situation is judged to be precarious.

If a crisis arises involving potential danger to a child or family member, the therapist is required to seek consultation from a supervisor. With a clear and imminent threat of danger, the therapist may call the police to intervene and/or recommend removal of the child. In other situations, the therapist might provide high levels of support and supervision within the home, e.g., 24-hour home supervision for a suicidal youngster. To date, there have been no incidents of violence or harm to a Homebuilders' therapist.

If it becomes clear that a youngster cannot be maintained within the home due to emotional problems, the therapist contacts the local mental health center to assist in the evaluation. Crisis staff assesses whether the youngster meets the criteria for hospitalization which involve danger to self or others. Short-term hospitalization for stabilization purposes may be considered as well as longer-term therapeutic placements if necessary and appropriate. Staff report that these types of situations occur very infrequently.

The average duration of the Homebuilders intervention is four and a half weeks. During this time frame, therapists devote approximately 15 hours per week to each family, approximately 10 of those hours representing direct face to face contact with family members. The intervention typically is more intensive in the beginning due to the crisis situation; the therapist may see the family four or five times during the first week and three times a week thereafter. Therapists have the flexibility to adjust the intervention to the needs of the family. In one case, for example, the therapist visited the family twice daily for a period of time to work with the family on improving troublesome morning and bedtime routines.

Staff report that many have expressed skepticism about the four week time frame of the Homebuilders intervention, questioning whether change actually can occur in so short a time. Clients, therapists, and staff of other agencies agree that with additional time, more could be accomplished with many families, and there would be more time to link clients with needed community resources. However, the program has found that there is always more that can be

accomplished with a family no matter how long the intervention, and once the crisis has subsided, many of the motivators for change are lost, and progress is slower. Further, the short time frame appears to influence both the therapist and the family in several ways:

- It creates the expectation that change can occur rapidly.
- It keeps the therapist and client focused on specific goals.
- Therapists and clients are more likely to use the time productively and "give their all" when they know there is a definite limit.
- Many families have reached a plateau after four weeks and are ready for a respite from intensive work and changes.

Therapists point out that due to the intensity of the services, families receive the equivalent of a year of traditional outpatient therapy during the four-week intervention. Although four weeks is the guideline, therapists are able to request an extension if they feel that there are specific goals that can be accomplished with an additional one or two weeks of intervention time. An extension is considered appropriate if out-of-home placement is still imminent and if the family still has treatment goals that they wish to pursue, or if the threat of placement is averted but the risk of redisintegration is high without additional intervention. The therapist and supervisor carefully assess whether an extension is appropriate and what goals and interventions would be undertaken.

Since its inception, the Homebuilders program has experimented with durations of eight weeks, six weeks, and the current guideline of approximately four weeks. This reduction in the duration of the intervention has resulted primarily from pressure to serve more families, and data indicate that decreasing the duration has not affected the overall success rate of the program. The time limits enable the program to serve more cases while preserving the low caseloads and service intensity. Further, the time limits are consistent with the crisis-oriented goals of the program -- resolving the immediate crisis in order to prevent out-of-home placement and teaching the skills needed to remain living together.

The process of termination actually begins during the first session when the therapist impresses upon the family that the intervention is time-limited. The therapist and family remain conscious of the time limits throughout the intervention, using such devices as calendars and weekly progress reviews to keep attention focused on the time limits.

An integral part of the termination process involves identifying community services and resources that the family will need after treatment and completing referrals for these services. The therapist attempts to make necessary referrals as early in the intervention process as possible to allow time to complete application procedures and initiate services. The therapist may accompany the family to appropriate agencies to expedite the referral process or, in some cases, may meet jointly with the family and the agency on one or more occasions. The Homebuilders therapist attempts to actively monitor the referral process to ensure that needed services are obtained.

Locating and linking families with appropriate resources for ongoing services frequently is a difficult challenge for Homebuilders' therapists. Many families have had negative experiences with community agencies and may be reluctant to get involved; many do not have the resources to pay for ongoing services, even with a sliding fee schedule. In some areas, follow-up resources are not available or may be inconsistent with the Homebuilders behavioral and psychoeducational approach. Therapists often look beyond community agencies to a wide variety of natural supports for families such as self-help groups, recreational and camp

programs, extended family, and churches. A research project being conducted collaboratively with the University of Washington is exploring the use of informal social supports for families and how to facilitate these connections.

Within five days of termination, the therapist is required to write a termination summary letter to the referring DCFS caseworker which summarizes the goals of the intervention and the progress achieved. While the DCFS worker is the official case manager and maintains ongoing responsibility, the Homebuilders' therapist is the primary service delivery person in the family's life during the four-week intervention. This temporary case management role and responsibility is transferred back to the caseworker upon termination. The caseworker is expected to remain in contact with the family to monitor progress and to follow through on any pending referrals.

The Homebuilders' therapist often schedules a follow-up visit with the family to occur one or two weeks following termination. Although there is no prescribed follow-up process, therapists and families may remain in contact informally, calling each other to check in or to report significant news. Additionally, families are made aware that they can call the program if problems recur and that telephone consultation and one or two in-home "booster shot" sessions are available if necessary. The telephone consultation or additional sessions are used to review skills and provide support. If the family experiences another crisis in which out-of-home placement is again imminent, the DCFS caseworker may re-refer the family for an entirely new intervention after 90 days. Approximately 3 to 4 percent of the families completing the intervention are re-referred for additional services.

Networking and Linkages

As noted, therapists attempt to work closely with a wide variety of community agencies. The intent of these activities is to obtain needed resources for families and to coordinate the efforts of the multiple agencies which may be involved with families.

The task of accessing services is not an easy one. There are significant gaps in the state's system of care for troubled children and families, and therapists frequently encounter waiting lists and other barriers. Often, Homebuilders' staff must be aggressive advocates in order to secure services from other providers. In some situations, an agency may have "given up" on particular children or families. In one particular case, the school system wished to provide home tutoring to a troublesome youngster rather than maintain him in the school environment. The efforts of the Homebuilders' therapist resulted in the hiring of an aide to work with the child in school on a full-time basis, a more satisfactory and cost-effective solution for both the child and the school district. The volunteer Educational Consultant working with the program may be used to supplement the therapist's efforts to arrange for special education services within the schools.

Service coordination generally is handled on an individual basis with each involved provider. The Homebuilders' therapist works with the school, the Probation Department, the Youth Service Bureau, and any other agency which may play a significant role for the child and family. Meetings of all agency representatives involved with a family are generally not held, but group staffings or networking meetings are called when a special need arises. There are no organized, formal interagency structures or mechanisms in the areas served by the Homebuilders program. Thus, linkages tend to be between individual staff persons rather than at the "system" level.

The closest linkage for the Homebuilders program is with DCFS. The Protective Services and Family Reconciliation caseworkers are the referral sources for the program and must assume ongoing responsibility for the families following the intervention. Annually, the entire

referring staff and the Homebuilders' staff meet to review progress and problems and to coordinate activities. In the interim, contact between individual providers occurs regularly with respect to shared cases.

Clients

The Homebuilders program is designed to serve only the most seriously troubled families, those for whom other community resources have proven insufficient to prevent the need for out-of-home placement. In all cases referred to the program, referring agency personnel and family members must concur that placement will occur without the Homebuilders intervention. More specifically, the Homebuilders program specifies a number of criteria which determine eligibility for services including:

- The family must reside in the area served by the program.
- The family must be a client of DCFS.
- There must be a high potential for family dissolution.
- At least one parent must consent to work with the program with the goal of keeping the family together.
- There must not be a high potential for physical danger to staff.

The program also specifies several situations which would make families ineligible for services. If a child is already in an out-of-home placement, there must be an agreement among all parties that the child will return within seven days. If it is not anticipated that the child will be home within seven days, the referral will not be accepted. Similarly, a family would not be accepted if the child has run away or if all family members are unwilling to work with the program. If the goal is merely to keep the family together until an out-of-home placement can be arranged, this too would be considered an inappropriate referral.

Cases at the Homebuilders program are considered to be children who are "potential removals" (PRs) from their families. The goal for the contract year 1986 - 1987 was to serve 414 PRs in the four Washington counties, but, typically, the program exceeds its contract goals. In the preceding year, the program exceeded its contract goal by 32 percent. From 1982 through 1985, the program served 936 families with 1248 PRs. In the absence of the Homebuilders intervention, it was projected that 78 percent of these PRs would be placed in foster care, 21 percent in group care placements, and 1 percent in psychiatric facilities. Approximately 30 percent of the PRs have been in previous out-of-home placements.

Most of the families involved in the program have low incomes, with 72 percent earning incomes below $20,000 per year and 39 percent of the families at or below the poverty level. The majority of the families served by Homebuilders are white (82 percent), approximately 10 percent are black, and the remaining clients are primarily Hispanic, Asian, and Native American.

A wide range of presenting problems can result in a referral to the Homebuilders program. These include family conflict, delinquency, child abuse and neglect, mental health and emotional problems, developmental disabilities, sexual abuse, and more. The most frequent presenting problems are family conflict and child abuse or neglect. While emotional problems may not be the primary presenting problem, staff report that a large majority of the children in the families served evidence emotional difficulties. The program does not designate

diagnoses for family members, but, according to staff, a large proportion of participating children could have a DSM III diagnosis.

The appropriateness of the Homebuilders program for severely emotionally disturbed children has been demonstrated through a pilot project conducted by the Homebuilders program. In 1979, the legislature authorized a grant of $135,000 to evaluate the effectiveness of the Homebuilders model as an alternative to hospitalization for mentally ill and severely behaviorally disturbed youngsters. All potential clients were reviewed by the Pierce County Office of Involuntary Commitment (OIC), the mental health agency that assesses the need for hospital care. Children were referred to the Homebuilders program only after the OIC determined that they were in need of hospitalization. The specific criteria for inclusion in the mental health project included:

- Gross, ongoing distortions in thought processes (e.g. psychoses such as schizophrenia) and resultant behaviors (e.g. school failures, bizarreness, suicide attempts) or
- Major chronic mood problems (e.g., depression, mania) and resultant behaviors (e.g., school phobias, suicide attempts, etc.) or
- Chronic, grossly maladaptive behaviors (e.g., violence associated with above, high physical hyperactivity combined with poor attention span).

Additional criteria considered included the duration of the child's disturbance, diagnoses assigned by other service providers, degree of violence toward self and others, extent of previous services that have been ineffective, previous hospitalizations, and other indices of severe and persistent disturbance. All of the children participating in the mental health project evidenced major impairments in their functioning due to their severe symptomatology.

The success rate, or the percentage of children avoiding out-of-home placement, was somewhat lower for the 25 youngsters involved in the mental health pilot project (76 percent as compared with an overall success rate of 94 percent). Of the children that were placed, most were placed in settings less restrictive than psychiatric hospitals; all of a small group of comparison cases were placed in psychiatric facilities. Further, youngsters participating in the mental health project showed significant improvements in global assessment ratings, ratings of behavior, reductions of symptomatology, and in such areas as violence toward self, others, and property. Thus, the mental health project demonstrated that the Homebuilders model can be effective with a population of severely emotionally disturbed youngsters.

The program did adapt its approach somewhat to meet the needs of the children and families participating in the mental health demonstration. The most experienced therapists were used to implement the project, and they were provided with additional supervision time. In addition, psychiatric consultation was made available as well as additional training to address such topics as psychotropic medications and working with suicidal clients. The program found that the mental health cases took a somewhat longer time than other cases, an average of eight and a half weeks per family.

Although the Homebuilders program no longer has specialized funding for the mental health project, these children continue to be served by the program to some extent. Referrals no longer come from the Mental Health Division, Office of Involuntary Commitment but must be channeled through DCFS. Thus, severely emotionally disturbed youngsters may be referred to the Homebuilders program if they are involved with DCFS.

The Homebuilders program also has demonstrated the adaptability of its model to a number of other special populations. For example, interpreters and TTY phones have been used to enable

the program to work with deaf clients. With the help of special community resources such as the Sexual Assault Center, the program successfully works with sexually abused clients. Additionally, a small pilot project was completed which successfully utilized the Homebuilders intervention with developmentally disabled youngsters at the point of crisis to prevent removal from the their current placements and placement in more restrictive settings. The program also conducted a special project to work with adoptive families of children with special needs when the adoption was on the verge of failure.

Currently, the program is conducting a reunification project which focuses on children in crisis residential centers in the Seattle area. Children are placed in these centers for short-term care as a result of a wide range of behavioral, emotional, and family problems. This project involves working with the children and their families for as long as eight weeks in order to plan for and assist with the reunification process.

Staffing

The Homebuilders program is staffed by seven supervisors and 26 therapists in its Washington and New York locations. The program relies on a "single therapist" approach to working with families rather than utilizing teams. Each therapist is responsible for conducting the entire intervention with assigned families but has access to the larger team for support and back-up. A number of reasons are cited for using the single therapist approach. Different workers assigned to the family might tend to advocate for particular family members rather than for the family as a whole. A single therapist may be more likely to work toward a good synthesis with all family members, and families may find it easier to trust and relate to one person. Logistically, a team approach requires more planning, coordinating of schedules, debriefing, and consultation. Accountability (both accomplishments and problems) can be blurred by using a team approach, and, perhaps most significant, a team approach costs twice as much.

The majority of the Homebuilders' therapists are at the Master's level, with degrees in a human service field, including social work, counseling, psychology, or education. In advertising for staff, the program specifies such requirements as experience working with children and families; knowledge of crisis intervention, communication skills, parent skills training, and cognitive and behavioral intervention. Additionally, the program requires staff to have a driver's license and their own transportation, a necessity for home-based work. An extensive screening process is used for staff selection which includes screening of resumes, telephone screening, an initial interview with the county supervisor, and a second interview which involves role plays of potential situations. Staff can participate in the role plays, which are used not only to assess the applicant's intervention skills but also to assess how well he or she accepts feedback and supervision. Beyond the educational and experiential requirements, the program looks for staff who are flexible, friendly, engaging, empathic, energetic, optimistic, and, above all, trainable. Applicants are not expected to have all the skills but must be willing and able to learn the skills, attitudes, and values needed to implement the Homebuilders model.

In making hiring decisions, the therapist's personal situation also must be considered. For home-based work, the notion of "job fit" is as important as other qualifications. For example, flexible child care, willingness to work weekends and holidays, the ability to respond to crises 24 hours a day, and family support for this type of job are critical factors for succeeding in a home-based service program. The Homebuilders program attempts to support staff in balancing their personal lives with the demands of the job. For example, staff who have had babies have come back to work on a part-time basis.

The role of Homebuilders' therapists includes providing both therapeutic and "hard" services such as helping families to clean house, driving them to the grocery store, and more. These

tasks are seen as good way to observe and engage clients, to create opportunities to teach clients important skills, and to have more informal counseling interactions with family members. While some programs separate the therapeutic and concrete service/case management role, the Homebuilders program contends that it would be difficult and confusing to assign different roles to different workers.

Homebuilders' therapists work with two cases at a time. This low caseload allows the time to provide intensive intervention and to address both the therapeutic and concrete service needs of families. The size of the caseload also has a direct impact on the accessibility and responsiveness of therapists. With only two families, Homebuilders' therapists have the capability to respond quickly to crises, to stay with families as long as is needed to work on emergent issues without the interference of other appointments, and to spend the large amounts of time often needed to accompany and assist families in meeting their concrete service needs (such as going to the welfare office).

Extensive training and supervision are provided to Homebuilders' staff. Initially, new staff participate in four days of workshop-style "line staff training." This training is followed by a carefully designed apprenticeship system whereby staff work with a supervisor. The new staff person observes the supervisor handling the first case and takes an active role in the second case. By the third case, the therapist may be ready to function independently with extensive supervision. An additional four days of advanced line staff training are interspersed with the apprenticeship period and later. The line staff training addresses staff attitudes and beliefs, process skills such as active listening, and content skills which cover a wide variety of interventions that may be used with families (behavioral strategies, cognitive restructuring, mood control techniques, etc.). The training program also includes an "ethnicity exercise" to sensitize staff to issues of ethnic identity and their effect on service delivery. The training program includes modeling, role playing, practicing, exercises, videotaping, and feedback from trainers in addition to didactic instruction.

This type of training process is used for students working with the Homebuilders program as well as for new staff. Staff hired to start the New York City program came to Washington for a period of time to participate in the line staff training program and to be assigned to a "mentor" with whom they could experience a number of cases. Additional in-service training also is provided, with a special interest seminar committee coordinating requests for training and arranging for training activities. Staff attending workshops or other training events are asked to share their experience and knowledge with the other therapists.

Extensive consultation and supervision are provided to Homebuilders' therapists. Supervisors are available 24 hours a day to discuss problem situations. Therapists are encouraged to seek consultation not only for crises but whenever they are experiencing difficulty with a case or when they are feeling overwhelmed, tired, or discouraged. Staff are required to call their supervisor immediately if they feel that there is a potential for danger to themselves or to a family member. In addition to individual supervision, all staff spend at least two hours per week in case consultation groups. The group consultation is used to support and learn from one another, to update staff on cases so that they can cover for each other if necessary, and to foster team building and a sense of mutual support.

While the potential for staff burnout in home-based work is high, the Homebuilders program reports relatively low levels of staff turnover. A number of factors appear to reduce the problem of staff burnout including:

- Extensive training so that staff have the requisite skills for the job and many resources (books, handouts, videos, etc.) to help staff perform their roles.

- Close supervision and support from supervisors who provide intensive on-site training and 24-hour back-up.

- Training in cognitive skills and stress management for therapists to help them to view their jobs and lives in a positive way and to handle feelings of frustration and failure.

- Mutual support of teammates.

- Flexible schedules, four weeks vacation, and good benefits.

- High levels of administrative support and encouragement and participation in management decisions such as hiring and personnel policies.

A key factor in staff retention appears to be the supportive attitude of supervisors and administrators who strive to make staff feel recognized and valued and to emphasize the "team effort" at all levels. Additionally, staff report that they enjoy seeing many types of families and that it is rewarding to see very disorganized and troubled families begin to change. Therapists routinely get feedback from families on each case, and it is extremely reinforcing for them to hear how much they are valued and appreciated by families.

Resources

The total budget of the Behavioral Sciences Institute is approximately $1.4 million, with approximately $1.1 million allocated to the Homebuilders Division. The costs of the Homebuilders intervention is estimated at $2,600 per family, a figure obtained by dividing program costs by the total number of clients served. This cost of an average intervention is compared with the average costs of a range of placements in Washington in 1986-1987 as follows:

Foster Care - Average 19.4 months @ $400/month	$ 7,760
Group Care - Average 13 months @ $1,721/month	22,373
Residential Treatment - Average 13 months @ $2206/month	28,678
Correctional Institution - Average 159 days at @ $91/day	14,469
Acute Psychiatric Hospital - Average 4 months @ $11,250/month	45,000
Long-Term Residential Psych. Treatment - Average 14 months @ $7,350/month	102,900

The cost of serving families under the mental health pilot project were considerably higher, estimated at $5,130 per family. However, this increased cost still compares favorably to the alternative placements for this population. On the basis of these cost comparisons, the cost-effectiveness of the home-based services provided by the Homebuilders program is firmly established.

Homebuilders' services are provided at no charge to families. The major source of funding for the program is the State of Washington Department of Social and Health Services which contracts with the program for its services. The contract specifies a certain number of cases (cases are considered "potential removals") per year that the program is required to serve. In order to ensure that this requirement is fulfilled, the program closely monitors its progress toward serving the targeted number of cases. Payment is provided in the amount of $2,607.50 per case served, up to the maximum contract amount, and paid in monthly installments. In addition to the DSHS contracts, the Homebuilders program receives special grants to work with specific population such as the mental health project or the adoption project.

Funding for the Homebuilders program is considered relatively stable, and the program has expanded gradually since 1983. In fact, the governor's budget for fiscal year 1987 contained $400,000 for expansion of home-based services throughout the state, some of which may be allocated to develop new Homebuilders programs. To advocate for expanded home-based services in the state, the Behavioral Sciences Institute has a part-time lobbyist on staff who attempts to educate and influence policymakers and legislators.

Evaluation

A number of approaches have been used to evaluate the effectiveness of the Homebuilders intervention. Most commonly reported are success rates, defined as the percentage of potential removals who remain out of state-funded foster care, group care, or psychiatric placements. Since 1982, the program has maintained an overall success rate of 94 percent at three months after termination of services. At 12 months following intake, the success rate remains high at 88 percent.

In addition to reporting an overall success rate, the program has attempted to analyze its effectiveness with respect to different client populations. Success rates at three months post-termination vary somewhat according to the client population category:

Families in Conflict	94%
Child Abuse/Neglect	96%
Delinquency	92%
Child Mental Health	83%
Developmental Disability	94%

The success rates for families in which the primary problem is related to child mental health are somewhat lower than for other groups. It should be recalled that this result is based upon the small sample of children who participated in the mental health demonstration project designed to intervene as an alternative to psychiatric hospitalization. Success rates also may vary according to the timing of the intervention. In working with delinquent children prior to placement, the success rate is significantly higher than in attempting to phase delinquents back into their families after a period of institutionalization. The program also has broken down its success rates by racial and ethnic groups and has found that the intervention has an equally high success rate among minority families; recent data suggest that the program may have a higher success rate among minority families.

Evaluation of the mental health demonstration project showed that the program is successful in resolving problems and improving functioning as well as in preventing placement. Overwhelmingly, families and children improved with respect to problems identified at intake. The vast majority of families (85 percent) improved communication; 100 percent of the clients experiencing symptoms of major mental illness showed significant improvement; and 95 percent evidenced improvement in behaviors such as violence toward self and others. Global Assessment Scale ratings improved by an average of 28 points, and ratings on the Child Behavior Checklist improved by an average of 38 points.

High levels of client satisfaction are reported with respect to the program. Based upon a 1985 client feedback survey, 94 percent of the families were very satisfied with services and their therapist, and 94 percent found the service more helpful than previous counseling. Eighty-seven percent rated the service as either very helpful or helpful. Families uniformly provided positive feedback about their service delivery experience including the therapist coming to the home, the degree of caring and understanding of the therapist, and the scheduling of appointments at times convenient to them. Ninety-seven percent of the families

responded that they would recommend the Homebuilders program to a family in a similar situation.

Several attempts have been made to conduct comparison studies regarding placement. In 1977 a comparison sample of youngsters that the Homebuilders program could not take because of full caseloads were tracked. It was found that 76 percent of these youngsters were placed. During the mental health demonstration project, it was found that five comparison cases (also turned away due to full caseloads) were all placed in psychiatric facilities at an average cost of $17,623 per case. There are a number of reported complications in conducting comparison studies. For example, it may be desirable to randomly assign cases to treatment or control groups, but if caseloads are full, the case cannot be taken regardless of random assignment to the treatment status.

Two studies have been conducted to attempt to discriminate factors that differentiate successful cases from "unsuccessful" cases in which children were placed out-of-home. Haapala (1984) used a critical incident and structured interview method with families who received Homebuilders' services. The most salient finding was that "hard services" provided by the therapist differentiated among cases; the more the therapist was perceived as doing something concrete for the child and family, the more likely the child was to remain at home. This finding underscores the importance of moving beyond counseling to address the whole range of needs experienced by the family.

A study nearing completion has been conducted jointly by the University of Utah School of Social Work and the Homebuilders program. The project examined home-based services in both Utah and Washington in order to identify factors associated with "failure" of home-based interventions. Failure is defined broadly as any time a child is in foster, group, institutional, or receiving care, on the run, or in any placement with non-relatives for a period of two weeks or longer. The subjects for the study were drawn from families served by the Homebuilders program and those served by the public child welfare agency in Utah. Data with respect to client characteristics, treatment, and system influences were collected on over 450 families receiving family-based treatment. The family, the home-based worker, and the caseworker were all interviewed when an out-of-home placement occurred to determine the circumstances and cause of the placement. High success rates in preventing out-of-home placement were achieved despite the broad definition of service failure, and a number of caretaker and child characteristic plus treatment response variables were found to be associated with outcomes. Most notably, the study found that families experiencing treatment success made significant positive changes in family functioning, particularly with respect to learning and using new parenting skills.

Major Strengths and Problems

Staff and administrators of the Homebuilders program as well as workers from other agencies and families themselves identified a number of factors which contribute to the success of the Homebuilders program:

- Multi-service, holistic approach.
- Flexibility, 24-hour availability, and ability to respond to crises.
- Goal orientation, use of clear behavioral contracts, and emphasis of skill teaching.
- Positive, hopeful, optimistic approach ("positive ethic").

- High quality of staff who are open, nonjudgmental, comfortable individuals with high levels of commitment and expertise.

- High levels of acceptance and support within the agency.

- Creative ideas and methods for working with families.

In addition to these strengths, several problems with the operation of the Homebuilders program were identified. The most frequently mentioned problem relates to the brief duration of the program. Respondents from within and outside of the program mentioned that the time frame, in some cases, is not sufficient for accomplishing all of the targeted goals or for completing the necessary referrals for ongoing services. Thus, at the completion of a four- to six-week intervention, some families may remain in precarious situations and may still require intensive services and support. In these situations, a number of options may be considered by the program, including referral to appropriate community resources, re-referral to the Homebuilders program for additional intensive intervention, or out-of-home placement in extreme situations. Since the program is designed to provide crisis intervention services, many families invariably will require additional services from the larger service system on completion of the home-based intervention.

A second problem area relates to the need for improved follow-up activities. Suggestions include a follow-up period with weekly or bi-weekly sessions for reinforcement and assessment purposes; follow-up groups such as parenting skills enhancement courses; a follow-up unit, or rotating follow-up responsibilities among Homebuilders' staff. These types of activities would assist families to stabilize over time and would provide additional support, capitalizing on the close relationship that has developed between the Homebuilders' therapists and the families. They also provide a mechanism for additional follow-through on incomplete referrals for ongoing services. However, the logistics and resources of adding a follow-up component to the program have proven to be problematic.

Other problems noted include:

- Not enough resources in the community for ongoing services; gaps in the system of care.

- Lack of a "weaning" period for transition to less intensive services.

- Frustrating referral process requiring frequent calls to obtain an open service slot.

- Difficulty in locating qualified applicants for staff positions.

Dissemination and Advocacy

The Behavioral Sciences Institute receives innumerable requests for information, visitation, consultation, and training. To date, consultation and training have been provided to over 200 agencies and groups in 28 states, the District of Columbia, and four foreign countries. Training and dissemination activities are conducted by the Training Division within the Behavioral Sciences Institute. Target groups for dissemination activities include state leaders as well as public and private service providers.

A variety of formats and approaches are used to provide information and training about the Homebuilders model. On-site workshops for agencies, individualized training for visitors at the Behavioral Sciences Institute, on-site consultation for new programs, telephone consultation, and presentations at conferences are among the modalities used for information dissemination. Written and audio-visual aids also have been developed for training purposes. Some of the

costs of these training activities are covered through fees for service, and a grant from the Clark Foundation provides additional resources to support the agency's dissemination efforts.

A range of training options have been designed by the Homebuilders program to assist agencies in their efforts to develop home-based service programs. These include:

- o Half-day introduction to the model.
- o One-day needs assessment and system planning.
- o Two-day proposal development and program preparation.
- o Staff screening and selection assistance.
- o Three-day administrative and supervisory training.
- o Line staff training.
- o Monthly half-day review for the first eight months of a new program.
- o Two-day site visits during months 4, 8, and 12 of a new program.
- o Telephone case consultation.
- o Homebuilders internship for supervisors and therapists.

Some agencies receiving training from the Homebuilders program have replicated the Homebuilders model fairly closely, while others have adapted the approach based upon the needs and resources in their own communities.

In addition, the Homebuilders program has prepared a training package outlining the steps for implementing new home-based service program. The outline for this training package follows as well as the outlines for the supervisory training program and the line staff training program.

The Homebuilders program is a member of the Family Preservation Network, a group funded by the Clark Foundation to develop and promote family preservation services. The program also is participating in a joint project with the University of Washington School of Social Work which is designed to explore the implications of the Homebuilders model for social work curriculum development. The project will result in a monograph, to be published by the University of Washington Center for Social Welfare Research, which will contribute to the development of family-centered social work curricula.

Case Examples

A 14 year old girl ("L") and her family were referred to the Homebuilders program. L was in a receiving home at the time of referral and had a history of running away, sexual acting out, depression, suicidal thoughts, and psychiatric hospitalization. She was also a victim of sexual abuse at the ages of 9 and 12. She had difficulty getting along with her mother, following house rules, and managing anger and depression. A major goal of the intervention was to teach L to identify early indicators of depression and to use techniques including crisis cards, daily mood ratings, and cognitive techniques. The therapist also worked with L and her mother, teaching them cognitive skills to decrease feelings of anger and to establish fair and reasonable rules with consequences and monitoring procedures. The family was referred to a

mental health center where they received counseling for six months following the Homebuilders intervention. Out-of-home placement was avoided and both L and her family showed improvement.

A 15 year old boy ("C") was referred to the Homebuilders program by the Mental Health Office of Involuntary Commitment as part of the mental health project, since placement in a psychiatric facility was under serious consideration. C was considered pre-psychotic and had daily temper outbursts during which he would scream obscenities, punch holes in walls and doors, destroy furniture, be abusive to his sister, etc. The relationship between C's mother and step-father was strained, and divorce seemed imminent. The therapist spent several days listening to all family members to ensure that their perspective was understood; all family members expressed relief and interest in learning new ways to cope. The therapist worked on a number of skills with the family. The mother learned active listening to help calm C, resulting in rapid reduction of his outbursts. C learned RET in order to tell himself calming statements as his feelings escalated. The step-father learned to leave lists of chores for C with allowance contingent upon completion, and the entire family worked on techniques for recognizing and controlling frustration and anger before the situation got out of control. Since C could not return to school, the therapist arranged for a home tutor. At the end of a five-week intervention, C had only two major outbursts, was doing 80 percent of his chores, and was getting nearly straight A's with his tutor. The therapist provided child care for a weekend while the parents took a vacation to renew their commitment and to work on marital issues. Instead of the last full week of treatment, the family opted to see their therapist weekly for a series of follow-up sessions.

Technical Assistance Resources

- Homebuilders Resource Guide

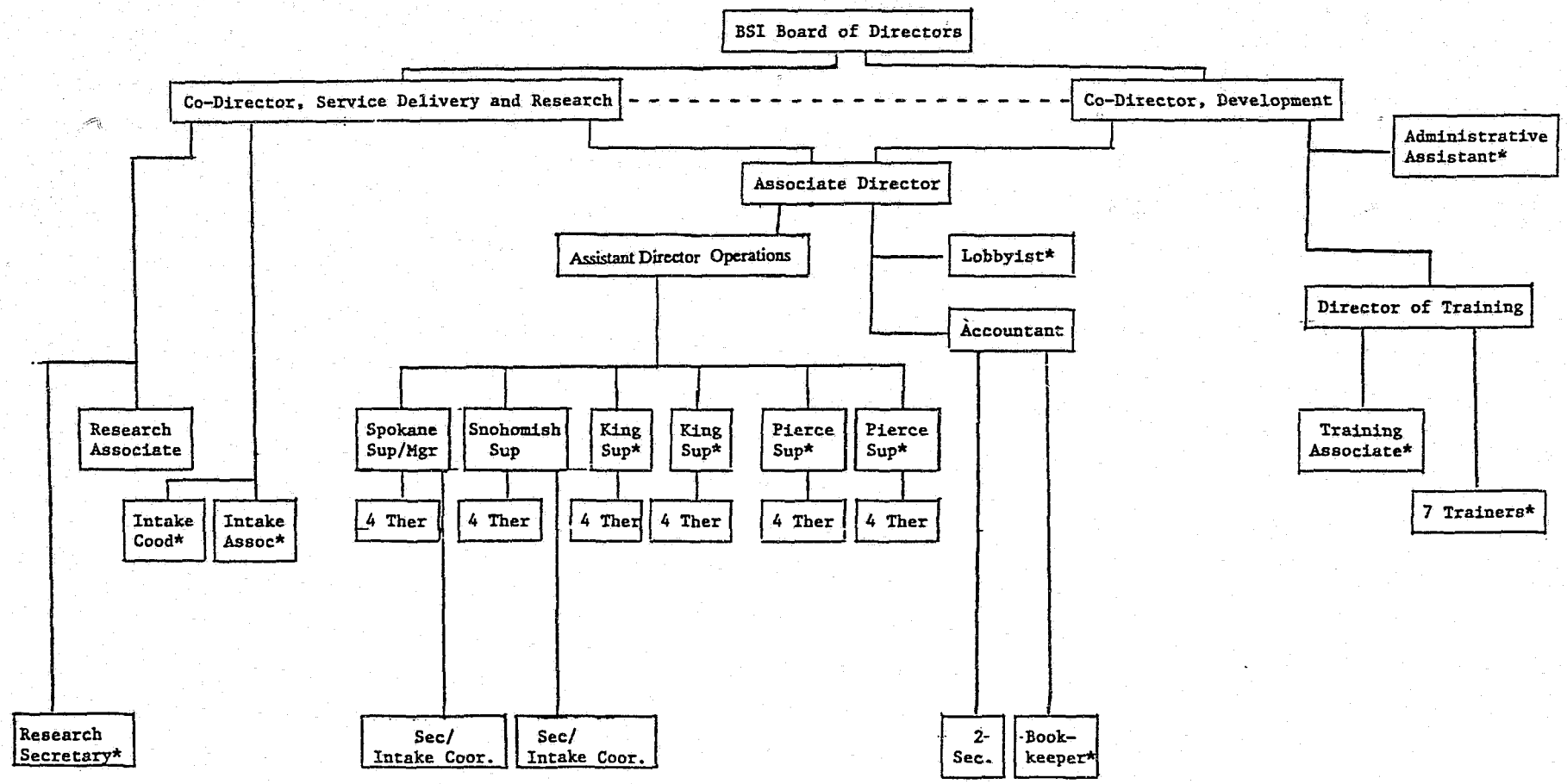
- Program Forms:

Homebuilders Referral Information
Intake Evaluation Sheet
Client Authorization for Treatment
Records and Release of Information Policy
Transportation Authorization
Consent to Exchange Information
Homebuilders Entry Document - Potential Removal
Homebuilders Family Characteristics
Goal Sheet
Weekly Summary Sheet
Social History
Termination Document
Termination Letter
Suicide Information
Clinical Services Checklist
Concrete Services Checklist
Goal Checklist
CWLA Family Assessment Scale
Social Support Assessment Tool

- Family Evaluation Questionnaire
  Client Follow-Up/Satisfaction Questionnaire

- Homebuilders Referral Guidelines

BEHAVIORAL SCIENCES INSTITUTE ORGANIZATIONAL CHART (1987)



* Part-time

GOAL SHEET

GOAL #1:Improve C.'s depression management skills

FAMILY NAME: THERAPIST: WHOSE GOAL: Family/Therapist

RATING WHEN GOAL SCALED (-1 or -2): -1 WEIGHT: 9
(9 most impt./1 least impt.)

STATEMENT OF PROBLEM: C. has been feeling very depressed over the past few months and had talked of wanting to kill herself. Because of the threats she has been placed at Fairfax hospital two times in the past month.

-2 C. is depressed and threatens suicide. Placement at Fairfax is made.

-1 C. is often depressed, does not threaten suicide, but placement at Fairfax is considered.

0 C. is sometimes depressed. Placement at Fairfax is not needed and C. is beginning to use depression management skills.

+1 C. is occasionally depressed and uses the depression management skills

+2 C. is rarely depressed and uses the depression management skills.

PLAN

WEEK #1 FROM: 8/20/84 TO: 8/26/84 RATING: 0

1. Contracted with C.
2. Introduced RET concepts
3. Introduced anger management
4. Develop relationship with C.

WEEK #2 FROM: 8/27/84 TO: 9/2/84 RATING: 0

1. Continue as above
2. Develop crisis card
3. Begin Daily Mood Rating
4. Practice RET

WEEK #3 FROM: 9/3/84 TO: 9/9/84 RATING: +1

1. Continue as above
2. Monitor progress
3. Help C. become involved in outside activities

WEEK #4 FROM: 9/10/84 TO: 9/18/84 RATING: +1

1. Continue as above

BEHAVIORAL SCIENCES INSTITUTE

HOMEBUILDERS LINE STAFF TRAINING MODULES

1. Introduction
2. Strategies of the Homebuilders Model
3. Stress Management for Therapists
4. Defusing, Engaging, and Confronting Clients
5. Assessment of the Potential for Violent Behavior
6. Structuring Before Visits
7. Assessment and Goal Setting
8. Structuring During Visits
9. Structuring Between Visits
10. Teaching Skills to Families
11. Teaching Families Behavior Management Skills
12. Teaching Communication Skills
13. Teaching Families Cognitive Intervention Skills
14. When Progress Isn't Occurring
15. Teaching Assertive Skills to Families
16. Anger Management with Families
17. Depression and Suicide
18. Multiple Impact Therapy
19. Teaching Families Problem Solving Skills
20. Teaching Interactions
21. Termination Issues

BEHAVIORAL SCIENCES INSTITUTE

HOMEBUILDERS SUPERVISION TRAINING OUTLINE

1. Overview

   History

   Basic Values and Beliefs

2. Staff Selection - Supervisors, Therapists, Secretaries/Research Assistants

   Job Descriptions

   Paper Screening

   Interview

   Role Plays

3. Staff Training - Supervisors and Therapists

   Management Team

   Apprenticeships

   Initial Training

   Initial Supervision

   Initial Contracts

   Case Consultation

   Utilization Review

   Library

   Specialized Topics

BEHAVIORAL SCIENCES INSTITUTE

FAMILY PRESERVATION SITE DEVELOPMENT
HOMEBUILDERS CONSULTATION AND TRAINING PACKAGE

1. Initial On-Site and Telephone Consultation

   Program Design and Implementation
   Developing Client Pathways
   Minimizing Barriers to Service Delivery
   Performance-Based Contracting
   Program Accountability and Evaluation
   Budget Issues
   Staff Selection and Hiring Procedures
   Proposal Development

2. Staff Screening and Selection

   Staff Qualifications and Initial Screening
   Applicant Interviews and Hiring Role Plays

3. Supervisory Consultation and Training at BSI

   Supervisor Roles and Skills
   Quality Assurance Procedures
   Case Consultation Procedures
   Referral Issues
   Supporting Staff
   Staff and Program Evaluation

4. Intake Staff Training

   Referral and Intake Procedures
   Record Keeping and Reporting
   Working with Referral Sources

5. Initial Line Staff Training

   Strategies of the Homebuilders Model
   Stress Management for Workers
   Engaging, Defusing, and Confronting Clients
   Assessment and Goal Setting
   Structuring Before, During, and Between Visits
   Teaching Skills to Families
   Teaching Behavior Management and Parenting Skills
   Communication Skills
   Cognitive Strategies
   Enhancing Social Support
   When Progress Isn't Occurring
   Termination Issues

SITE DEVELOPMENT CONSULTATION AND TRAINING, CONTINUED

6. Initial On-Site Consultation and Home Visits

   Home Visits, Intake, and Subsequent Sessions
   Case Consultation

7. One-Month Follow-Up Consultation and Training

   Home Visits
   Case Consultation
   Teaching Anger Management Skills
   Working with Depressed and Suicidal Clients
   Teaching Problem-Solving Skills
   Multiple Impact Therapy

8. Four-Month Follow-Up Consultation and Training

   Home Visits
   Case Consultation
   Teaching Assertive Skills

9. Eight-Month Follow-Up Consultation and Training

   Home Visits
   Case Consultation
   Follow-Up Training Issues

10. Twelve-Month Follow-Up Consultation and Training

    Home Visits
    Case Consultation
    Follow-Up Training Issues

11. Weekly Telephone Consultation

    Two hours/week first six months
    One hour/week second six months

        Case Consultation
        Supervisory and Administrative Issues
        Referral Issues

12. Written Utilization Reviews

    Evaluating Paperwork, Documentation and
    Intervention Strategies.

SATELLITE FAMILY OUTREACH PROGRAM
KALEIDOSCOPE
CHICAGO, ILLINOIS

History

Kaleidoscope, Inc. was founded in 1973 to provide alternatives to institutional care for seriously handicapped and troubled youth. At that time, public attention and scandal surrounded the expensive and often inadequate care that more than 900 troubled children were receiving in out-of-state institutional placements. Efforts were begun to bring these severely disturbed youngsters back to Illinois and to create community-based alternatives to meet their needs.

Kaleidoscope's first programs were located in Bloomington, Illinois, and consisted of therapeutic foster homes and family-like group homes, both of which offered youth the opportunity to participate in and learn from more normal family and community life. The need for such programs was identified in the Chicago area as well, and Kaleidoscope responded by attempting to develop small, family-style group homes similar to those established in Bloomington.

As more children were brought home from out-of-state placements, the demand for community services increased significantly. Staff report that the development of group homes in Chicago could not keep pace with the demand for services. Kaleidoscope proposed that, while children were awaiting other placements, child care workers could be provided to work intensively with them and their families within their own homes. The Illinois Department of Children and Family Services agreed to experiment with this approach. In 1974 Kaleidoscope hired several workers to provide intensive home-based services, with each worker assigned to three families and, in this way, began the Satellite Family Outreach Program.

The in-home approach proved to be highly effective in reuniting families of youth returned to Illinois from out-of-state placements. Further, the comprehensive service delivery approach used by the program was found to be effective in keeping families together and preventing out-of-home placement. The Satellite Program now operates with five teams of workers and serves approximately 55 to 60 families at a given time.

Interestingly, the group home approach in the Chicago area was abandoned after a relatively brief period of time, although the agency still operates group homes in the Bloomington area. Zoning problems, neighborhood opposition, improper selection and preparation of communities, and inexperienced staff were all factors that contributed to the demise of the group homes.

Community and Agency Context

The Satellite Family Outreach Program serves all of Cook County, which consists of Chicago and its suburbs to the north and south and has a population of approximately 5,250,000. The area is fraught with the economic and social problems facing most urban areas such as poverty, unemployment, crime, family disintegration, and others, and many of the problems experienced by children and families are magnified in the Cook County area. For example, more than half of all children who are in the custody of the State of Illinois are located in Cook County. Approximately 75 percent of the clients served by the Satellite Program are from the inner city, and 85 percent of the clients served are minorities, predominantly black.

The inner city environment has a major impact on both the agency and the program. For example, consideration must be given to the safety of workers visiting families in neighborhoods that may be dangerous. Security guards are needed for the agency's parking

lot to guard against theft and damage of staff's vehicles, and the Kaleidoscope offices have been burglarized on several occasions, necessitating the installation of a sophisticated security system.

Youth gangs are a pervasive phenomenon in the Chicago inner-city environment, necessitating careful consideration of the location of the agency offices. In relocating the agency several years ago, consultation from clients was sought to ensure that the office space under consideration was located in "neutral" territory so that youth affiliated with various gangs would be willing to attend. Additionally, in-service training for staff was provided by the police gang unit. Thus, the agency must address directly problems posed by providing services in an inner-city context.

As noted, Kaleidoscope was founded in 1973 with the mission of reaching out to children and youth considered to be the most difficult to serve or whom "no one else wanted." The agency has grown to be a multi-faceted, nonprofit child welfare agency with a budget in excess of $5 million and over 150 employees. The agency has two offices, one in Bloomington-Normal and one in Chicago. The Satellite Family Outreach Program is operated by the Kaleidoscope Chicago office.

The agency provides a continuum of services for seriously troubled children and youth who would otherwise be destined for institutional placements of various types. The various programs and approaches used by Kaleidoscope all evolved out of the need for service alternatives that offer children and families flexible, effective treatment in community settings. Kaleidoscope first offered therapeutic foster care and therapeutic family homes (group homes) and subsequently expanded its mission to include comprehensive home-based services to maintain and reunify children with their natural families whenever possible. The agency further expanded its mission to include services to better prepare youth for independent living as they approach adulthood. The agency provides a continuum of services and encourages children and families to move from one service option to others as their needs change and circumstances permit. In addition to the Satellite Family Outreach Program, the services provided by Kaleidoscope include the following:

- Therapeutic Foster Homes - Approximately 25 to 27 therapeutic foster homes to serve troubled and handicapped youngsters. The professional foster parents are considered primarily responsible for the care and treatment of the child placed in their home, and they are expected to integrate the child into their family system. Extensive training is provided to foster parents as well as consultation, support, clinical services, and 24-hour crisis assistance from Kaleidoscope staff.

  As part of the therapeutic foster home program, Kaleidoscope Chicago offers 15 to 17 professional foster homes for adolescent mothers and their babies. Young women may enter the program if they are pregnant or already have become mothers. The foster parents receive intensive specialized training to work with this population and serve as teacher, role model, and parent to the teen mothers. The agency offers an in-house medical clinic to provide well-baby care and to teach teen parents how to care and provide for their children. Fathers are involved in the program whenever possible, and the program focuses heavily on obtaining education and job training for the adolescent parents.

- S.T.A.R. Program (Specialized Team for AIDS Relief) - Foster homes for children and infants suffering from AIDS. Kaleidoscope Chicago recently began to develop and operate therapeutic foster homes for infants and young children with Acquired Immune Deficiency Syndrome (AIDS). Infants with AIDS often are the children of drug users who are unable to care for them, causing these children to experience extended hospital stays. The S.T.A.R. Program is based upon the premise that children with AIDS can be cared for in a

nurturing and accepting environment and have the right to live, and possibly to die, as part of a loving family. Professional foster parents are recruited specifically to work with this population and are provided with extensive training, including specific guidelines about caring for the infants and any necessary precautions. Medical supports are provided to the families as well as consultation, support, and back-up from Kaleidoscope staff. Special attention is devoted to dealing with issues of death and dying. Currently, nine children are in placement, ranging in age from two months to five years.

- Therapeutic Family Homes - Six small family-style group homes in the Bloomington-Normal area serving five to six children per home. The group homes are located in residential neighborhoods, and the youngsters attend public schools and use public recreational resources. The homes are staffed by six or seven full-time staff who rotate in 16-hour shifts, with two staff present at all times. This staffing pattern provides a sense of continuity and family life for the youngsters since the same workers are present in the morning, throughout the day, and at bedtime. The average length of stay in the group homes is approximately 18 months.

- Youth Development Program - Serves youth ages 16 to 20 with the goal of helping them to become self-sufficient. The program involves placing youth in apartments in the community and providing staff supervision to assist them in learning independent living skills such as household maintenance, budgeting, selecting and preparing food, using public transportation, and creating a support system. The program also focuses on helping youth to obtain appropriate education, training, and employment. Incentives are offered to encourage employers to hire troubled youth, and Kaleidoscope staff provide supervision, support, and follow-up in job placements.

In addition to these major programs, Kaleidoscope Chicago offers a number of recreational activities for youngsters involved in any of its various programs. These include boys and girls basketball teams and "Thursday Night Live" programs at the agency offices, which are used for both recreational and educational purposes. In addition, Kaleidoscope participates in Metrowork, a consortium of four agencies which has been instrumental in securing jobs and providing training for youth. This multi-agency group has successfully applied for grants to support its training and employment activities.

Kaleidoscope Chicago also operates the Second Chance Shop. Donations of clothing, toys, and household goods are solicited and organized, and youth and families can go "shopping" when they visit Kaleidoscope offices. Further, the agency is affiliated with the Kupona Network, an organization that supports and educates the black community on AIDS. This group is provided with office space at Kaleidoscope's offices. In exchange, the organization provides instruction to Kaleidoscope staff on AIDS and provides services to any Kaleidoscope youngster or family who is affected by the virus, including running an AIDS support group.

Until recently, Kaleidoscope's founder and chief executive officer was based in the Bloomington office. Upon his retirement in 1987 additional administrative responsibilities were invested in the respective directors of the Chicago and Bloomington regional offices. While the specific programs are administered on a regional basis, some administrative functions, such as financial, business, and evaluation functions, remain centralized. The agency administration, as well as its programs, operate on a team concept. The Executive Director and Associate Director of Kaleidoscope Chicago function as a team and act as resource and support persons to the programs they administer. The administrators tend to provide staff with a great deal of freedom to create and operate their programs, and, in addition, attempt to provide high levels of acknowledgement and recognition for staff.

The 12 member Board of Directors has five regularly scheduled meetings per year and conducts an annual planning process which involves reviewing programs, identifying and addressing issues and problems, and setting goals. The Board has functioning committees which meet to address such areas as program oversight and evaluation, personnel policies, and fund raising. Board members also serve as spokespersons and advocates for Kaleidoscope programs, particularly when public relations problems arise. In the Bloomington area, a Community Advisory Committee was established to promote and strengthen communication and support within the community. This step was taken to address strained community relations resulting from several incidents involving Kaleidoscope clients. The Committee is comprised of elected officials, city government officials, school and hospital administrators, and civic leaders.

Philosophy and Goals

As noted, the mission of Kaleidoscope is to provide services to assist children and families who are considered most in need, those who would otherwise be rejected or excluded from other community services. Staff report that the agency is "not easily intimidated," and is deeply committed to the concept of serving the "unwanted" or the most difficult-to-serve clients. As is evidenced by the development of the S.T.A.R. Program, the agency's mission allows room for expansion and changes to respond to the most urgent needs of children and families.

The Kaleidoscope philosophy, and that of the Satellite Family Outreach Program, is well articulated and is based upon several important premises:

- The Importance of the Family - The program is based upon the belief that children grow and learn best in families. Therefore, family services to prevent child placement and to reunite children with their families are of primary importance. The program also is built on the fundamental belief that all parents **want** to be good parents and have both strengths and weaknesses. Workers must capitalize on parents' strengths whenever possible in an attempt to preserve family integrity. This belief in the importance of the family also is evidenced in the nature of the out-of-home placements provided by Kaleidoscope. Substitute care, when necessary, is provided in therapeutic foster homes and family-style group homes to most closely approximate a family environment.

- Unconditional Care - The concept of unconditional care is reflected in many aspects of Kaleidoscope's operations. First, the belief in unconditional care is reflected in an inclusive admissions policy, the policy of accepting clients which other agencies have rejected. The agency will serve children and families regardless of the difficulty of their behavior problems, emotional disorders, handicaps, or needs. Admission is denied only if there is no room in a program or if a less intensive program or service would be more appropriate. Further, the emphasis in all Kaleidoscope programs is to adapt services to the needs of the child and family; the Satellite Program is committed to doing "whatever it takes" to assist a family to meet both their treatment and concrete service needs.

  The belief in unconditional care also is reflected in Kaleidoscope's commitment to continue working with a child and family regardless of the problems that may arise during the service delivery process. Regression, resistance, and other problems are not used as a basis for discharging families but rather are seen as signals for new treatment approaches. According to the agency's philosophy, children frequently are discharged or rejected from programs due to their "misbehavior" or continuing severe problems. In Kaleidoscope programs, an attempt is made to break the cycle of rejection that the child has suffered, to avoid punitive discharges, and to develop the amount and kinds of services and supports needed by each child to remain within the agency's care.

- Normalization - Kaleidoscope attempts to provide services in as normal an environment as possible. The agency's programs are based on the premise that institutional environments can be injurious to children and that no child should be denied the experience of family and community life. All of the agency's services and treatment are built on a base of family and community living in accordance with the notion that children can best learn to become normal, competent adults if they live in and learn from a normal environment. The natural pace of events can then be used for modeling, teaching, and coaching children and parents to cope more effectively with real life situations.

In addition to these basic values, the Satellite program is based upon a perspective which views the family as a system consisting of all extended family members and support networks within the community. The outreach and comprehensive service approach used by the program is based upon the belief that many families lack the structure and organization to participate in insight-oriented, office-based therapy. Therefore, the program brings services into their homes and develops a comprehensive treatment plan to address all of the family's needs. Staff seek to develop a family-like bond with all members of the client system and to use this "extended family" relationship to help the family to improve its functioning.

The primary goal of the Satellite Family Outreach Program is to help to maintain families as intact units. Families are referred to the program for either prevention or placement or for assistance with reunification. In cases of placement prevention, the goals of the program are:

- To achieve enough immediate improvement in family functioning to enable the family to reach a minimal level of stability, and

- To improve overall functioning of families by building social, emotional, and educational strengths.

In cases of reunification, the specific goals are :

- To normalize the child's environment as quickly as possible by arranging for schooling, medical care, basic needs, etc., and

- To help the entire family to cope with the child's return and to learn effective ways of handling the child's behavior.

Services

The services provided by the Satellite Program are intensive and include counseling and therapy as well as help with the basics: food, housing, income, home management, child management, and more. The program is highly flexible and attempts to obtain whatever combination of services, resources, and supports are needed by each family. In short, the program brings together treatment, advocacy, and friendship in order to assist families to remain together.

Three major types of services are provided by the Satellite Program. These include:

- Family Assessment - An assessment of the family system for a period of up to 90 days which is used for long-term planning purposes. The assessment process is designed to determine both the service needs of a child and family and the feasibility of maintaining (or returning) a child with the natural family. The assessment considers relationships within the family and with support systems, social skills, and ability to manage basic needs, and parenting demands. The program also works with the child and family during this time to prevent placement or to prepare for reunification as the situation dictates.

Recommendations are provided to DCFS concerning the potential for maintaining or reunifying the family and the services needed to provide assistance.

- Placement Prevention - Comprehensive home-based services provided for a period of 12 to 24 months. Both counseling and concrete services are provided according to an individualized service plan in order to address the family's identified problems. Services are directed to helping the family to remain together.

- Family Reunification - Comprehensive home-based services provided for approximately six months to assist families of children who are returning from an out-of-home placement. The program works closely with the child, with the natural parents, and with the residential program from which the child is returning to facilitate the transition and maximize the likelihood of a successful reintegration. Reunification services include arranging for, coordinating, and supervising home visits; preparing the child and family for the return; and arranging for appropriate school placements, medical care, and other services for the returning child. When the child returns home, the program continues providing services and support to the family (including counseling, parent education, brokering needed resources, etc.) until the home environment can be considered stable.

The majority of referrals to the Satellite Program originate with the Illinois Department of Children and Family Services (DCFS). One of five teams within the Satellite Program provides services through a Joint Service Children's Initiative, funded collaboratively by DCFS and the Department of Mental Health and Developmental Disabilities (DMHDD). The Joint Initiative is directed toward providing home-based services to prevent placement in psychiatric hospitals and other residential treatment facilities. This team may receive referrals from DMHDD as well as from DCFS. All referrals are channeled through the Assistant Director of Kaleidoscope Chicago, who consults with the referring worker regarding the appropriateness of the referral and the service needs of the family.

As noted, the program has an "inclusive" intake policy. Regardless of the nature or severity of the child's and family's problems, the program will accept the referral as long as there is an available service slot. If there are no openings, Kaleidoscope staff will attempt to serve as a resource and to locate another agency or service for the family. Cases also may be held on a waiting list for services; at a given time there may be between 15 and 25 families waiting for services. If an opening is anticipated, Satellite program staff may visit the family and provide crisis intervention services in an attempt to stabilize the situation prior to the actual initiation of services. The longest that families have had to wait for services is approximately three to four months.

The Satellite Program Administrator receives the information on referred families and assigns cases to the various teams. Two family workers are assigned to work with the family. The team social worker proceeds to contact the family and usually makes the initial visit; the social worker and both family workers generally make the second visit together. The initial visits are used primarily to explain the Satellite Program, to begin the assessment process, and to begin to develop a trusting relationship with the family -- the first phase of service delivery.

A well articulated treatment planning process is used to formulate service goals and methods, with frequent reassessments and reviews to make appropriate adjustments. An initial staffing generally is held within two weeks of initiating service delivery. This staffing involves the DCFS worker and any other involved workers and agencies as well as the Satellite Program Administrator, Social Work Supervisor, and other resource persons as indicated. This staffing is designed to identify the family's problems and formulate the initial treatment plan and approach. Another staffing is held after approximately 90 days of services to evaluate

treatment goals, monitor progress, and make needed changes in goals and methods. Formal staffings are held at least every six months thereafter, and treatment plans are reviewed and updated within the team meeting a minimum of once a month. An Identified Needs Checklist is used to guide the service delivery process by identifying and prioritizing specific needs; workers are then assigned to address these needs and target dates are established. A sample of the Identified Needs Checklist is included at the end of this section to show the wide range of areas considered by the Satellite Program, including the family's immediate needs and needs in social, educational, vocational, mental health, medical, and daily living arenas.

The interventions provided by the Satellite Program include the following:

- Counseling - Individual, marital, family, and group counseling are options available for family members. Family workers and social workers provide counseling to family members individually, as a complete unit, or in various combinations depending upon the situation. Further, much counseling is provided informally as workers assist the family in meeting basic needs or in recreational situations.

- Concrete Needs - The program provides direct assistance to families in an attempt to meet their basic needs. Examples of such assistance include task-oriented homemaker services to assist in the care of the home and family, financial planning assistance, food assistance through the Chicago Food Depository, and assistance with job finding and placement. In addition to direct assistance, families workers serve as brokers and advocates to access services and supports needed by families. In fulfilling this role, family workers assist families to obtain housing, health care, mental health services, special education services, work training. In order to access these resources, family workers often help families to make the initial contact, accompany the family to the first appointment, and remain in regular contact with the community agency to monitor service provision and progress.

- Health Services - A full-time nurse is assigned to the Satellite Program to provide health services to families. The nurse performs an in-home health assessment of all families and assists families in obtaining needed medical care. Regular visits to families with pertinent medical issues are made by the nurse, and more frequent visits may be made to families with urgent medical problems requiring careful and ongoing monitoring. The nurse also attempts to teach families how to take care of their health care needs and educates families in areas including nutrition, safety, birth control, AIDS, sexually transmitted diseases, and others.

  The health services provided by the Satellite Program include access to a medical clinic held twice a month at the Kaleidoscope offices. A physician specializing in adolescent medicine performs physical examinations, prescribes medication, and provides prenatal and well-baby care. The physician works with Kaleidoscope by arrangement with a local hospital. The hospital pays the physician, and, in turn, bills for services provided to Kaleidoscope clients under the medical assistance program.

The Satellite Program also offers a range of educational services to children and families such as sex education, drug education, nutritional consultation, first aid education, and education about AIDS. These educational opportunities generally occur in the normal course of service delivery. Additionally, Kaleidoscope offers a variety of recreational opportunities that children and families involved in the Satellite Program may attend. These include such activities as basketball teams and "Thursday Night Live" programs at the agency's offices. Further, each team is provided with $100 per month to spend on clients for a variety of purposes related to the treatment plan.

Satellite Program staff are available on a 24-hour basis to respond to crises. On-call responsibilities rotate among Satellite staff, with each staff member remaining on-call for a one-week period. An answering service handles incoming calls to the agency and contacts the on-call worker when crises arise. The on-call worker may attempt to reach one of the family workers assigned to the family or may handle the situation personally. Supervisory staff provide back-up assistance in crises whenever necessary. The program reports that crisis calls are relatively infrequent. More crises seem to occur in the early stages of service delivery when the family may be testing the commitment of the workers and the program.

If there is any suspicion of abuse or neglect, the workers are required to discuss the situation with the Kaleidoscope Chicago Director or Assistant Director. Based upon this consultation, a decision is made regarding reporting the suspected abuse and/or recommending removal of the child from the home. Each case is judged individually, and staff report walking a "fine line" between being a friend of the family and a "policeman" concerned about the safety of the child. Despite the Satellite Program's best efforts, out-of-home placement is indicated in some cases. In these situations, the program attempts to provide or facilitate community-based placement in the least restrictive, most family-like environment. Ideally, the child may be placed in a Kaleidoscope therapeutic foster home or group home. Satellite staff continues to work with the child and family to help them deal with and adjust to the out-of-home placement and, in appropriate cases, work towards eventual reunification.

When the child is a danger to him or herself or others, hospitalization may be considered. The inpatient resources available to the Satellite Program include a children's unit at the state hospital and private hospitals which will accept Medicaid patients. During the past year, the program has had to hospitalize children on six occasions. In five of these cases, the Satellite Program continued working with the youngsters and their families, and they were discharged to their families after three or four week stays. One youngster was transferred to a secure facility for long-term treatment.

The Satellite Program provides approximately 80 hours of service to each family per month. With the contractual requirement that 60 percent of this be direct service, a **minimum** of 48 hours per month or 12 hours per week of direct services are provided to each family. These hours are divided between the two family workers assigned to the family so that, in effect, each worker is expected to work with various family members for an average of six hours per week. Additional time is spent making collateral contacts, attending staffings, and working with the many community resources needed by the family. Service hours provided by the social worker and nurse also are counted in the monthly totals.

While these contractual requirements guide the program, the intensity of service provision can be adapted somewhat, according to the needs of families. In times of crisis, the hours spent working with a family may be increased, and as termination approaches, the hours of direct service may be reduced. Workers are conscious of tracking service hours, as this is essential for the reimbursement process, and supervisors monitor the direct service hours provided to families on a weekly basis. Supervisors are alert for situations in which direct service hours may be too high or too low, signaling possible problems or difficulties in the intervention process.

The program works with families for an average of 18 months in placement prevention cases. Staff report that they work with such dysfunctional families that a long-term intervention is required to assist the family to reach an optimal level of functioning. It is also emphasized that some families have ongoing needs for home-based services and supports in order to remain stable, and that providing such support remains a preferable and more cost-effective alternative to child placement. In one situation, the Satellite Program has provided ongoing services and support for a family for six years. There is some pressure from DCFS to keep

the intervention "within bounds." Any disagreements regarding the termination of families from Satellite services are discussed and resolved in staffings.

The Joint Service Children's Initiative, designed to serve children at imminent risk of psychiatric hospitalization or residential treatment, was originally conceived as a six-month intervention. The intent was to work intensively with the child and family during this period and to link the family with other agencies for long-term work. An evaluation of the services provided through the Joint Initiative revealed that the children and families were more difficult to serve than originally anticipated and that it was difficult to locate and link them with appropriate mental health resources. Thus, as of 1987, the six-month time frame specified by DCFS and DMHDD was abandoned, allowing programs to work with families as long as necessary to meet their needs. The Satellite team, which operates under a Joint Initiative grant, now operates much like the other teams in terms of services provided and service intensity and duration.

The termination or discharge process is a lengthy one and may take as long as six months. The process involves gradually weaning the family from services by slowly reducing service hours. Family workers discuss progress with the family, focus on remaining issues, talk about possible discharge, and often set a tentative discharge date. At the same time, the program uses a networking approach, identifying other agencies and resources to meet the family's ongoing service needs and creating appropriate linkages. Workers ensure that the family's continuing needs are being met before leaving the family. If a crisis arises, workers may increase their involvement temporarily.

The Satellite Program does not have a formal follow-up component. On an informal basis, workers and families frequently remain in touch through telephone calls and visits. Families may contact the program if a crisis occurs. In these situations, crisis assistance may be provided and, where appropriate and agreed to by DCFS, the family may become reinvolved in the program. The program reports that families often require periodic "boosts" of follow-up services and that an attempt is being made to include this aspect of service delivery in new grant proposals.

Several general principles in providing services are emphasized by Satellite Program staff:

- Start with the family's priorities.
- Start with concrete needs such as housing, public aid, etc. This allows clients to see that you are helping them to meet a specific need, which helps in developing trust and a positive response.
- Use nonthreatening approaches first in order to get established with the family, and pace the intervention, going slowly in the early stages.
- Acknowledge small accomplishments. Day-to-day accomplishments may appear modest in view of the family's overwhelming problems. Over time, however, small gains may add up to dramatic improvements in the family's functioning, and it is essential to recognize small, positive steps.

Networking and Linkages

As noted, Kaleidoscope Chicago provides a continuum of services and allows clients to move among programs as their needs change. Relationship among programs are cooperative, and Satellite clients receive priority for other services provided by the agency. If out-of-home placement is required, for example, an attempt is made to use internal Kaleidoscope resources

prior to locating other potential community placements. Consultation between program administrators may be used to access agency services, and joint staffings may be held if a family or various family members are involved in more than one Kaleidoscope program.

With external agencies, individual networks are developed centering around treatment planning and progress assessment for individual families. Family workers are responsible for reaching out and contacting every agency involved with a family in order to define respective roles, coordinate services, and encourage active involvement in the intervention process. Staffings, which include representatives of all agencies involved with the child and family, are held at the initiation of services and every six months thereafter.

The closest linkage of the Satellite Program is clearly with DCFS. DCFS caseworkers are in frequent contact with Satellite staff to jointly develop service plans and to coordinate services with other agencies. Overlapping roles between DCFS caseworkers and Satellite staff sometimes can create difficulties. However, DCFS workers often feel overwhelmed by their large caseloads and appreciate the intensive services and coordination offered by the Satellite Program. Good communication between DCFS and the program is reported to be essential, and differences of opinion between caseworkers and Satellite staff as to the handling of particular cases generally are resolved in the context of staffings. A problem encountered by the Satellite Program in maintaining this linkage effectively has been the high rate of staff turnover at DCFS. It is necessary to constantly establish new relationships and orient new staff to the philosophy and services provided by the Satellite Program.

The Satellite Program receives a grant to provide home-based services through the Joint Services Children's Initiative. The Joint Initiative is the product of an interagency agreement between DCFS and DMHDD, negotiated at the state level to resolve system barriers and problems between the two departments and to increase communication and joint planning. Specifically, the Joint Initiative is designed to enhance and expand the continuum of care for children and adolescents of mutual concern to both agencies. Grants to local agencies are provided through the Joint Initiative to develop models of networking among mental health and youth service agencies in order to improve multi-agency case coordination and to develop programs for early identification and intervention for youngsters at early stages of mental illness or emotional disturbance. Another category of grants is for programs which provide extensive outreach, networking, and case management to maintain youngsters in their homes or transition them to their homes or to the least restrictive, appropriate community setting. It is in this grant category that the Satellite Program participates.

The Joint Initiative reportedly has resulted in increased communication and coordination between the mental health and child welfare systems at state, regional, and local levels. The Satellite Program has noted improved relationships with the community mental health centers (CMHCs) in the area since the Joint Initiative. Previously, there was considerable skepticism among CMHC staff regarding home-based services. Working closely with the Satellite Program and observing the effectiveness of this approach has been an educational process for many CMHC staff, and perceptions have changed. In fact, some CMHCs are now attempting to develop home-based service programs within their agencies. Therefore, the Joint Initiative has provided an opportunity to share technologies as well as to improve working relationships among agencies.

Kalcidoscope is involved in a number of task forces, committees, and organizations that promote interagency collaboration. The Satellite Program Administrator, for instance, participates in a regional coalition of more than 50 agencies with meets monthly to engage in joint planning regarding services. Agency representatives also serve on various task forces to address particular service delivery issues, such as developing standards for independent living programs.

The weakest interagency linkages are reported to be with the schools. In Cook County there are 144 autonomous school districts, which creates a major problem for coordination. Meeting the special education needs of individual children is often troublesome, time consuming, and frustrating. The Chicago schools often take an inordinate amount of time to test children; the approval process is cumbersome, and the Board of Education is reluctant to pay for special education services.

While improvements have been noted, relationships with the local CMHCs have posed difficulties. With some exceptions, CMHC therapists have tended not to participate in staffings and have been skeptical of the therapeutic value of the home-based approach. Some CMHCs have long waiting lists and cannot respond to the needs of the families referred. Much education and public relations effort is needed to overcome some of these attitudes and barriers.

Clients

The Satellite Program primarily serves severely dysfunctional, multiproblem families. The program can serve approximately 55 to 60 families at a time. Eighty percent of the families served by the program are black, and the vast majority reside in low income areas of the inner city. In general, the families served by the program experience a host of problems, including high rates of poverty, dependency on welfare or other forms of income maintenance (80 percent), and unemployment. Two-thirds of the families served are headed by single parents. In addition, problems such as substance abuse, family violence, and severe psychiatric illness are common among families served; the rate of drug and alcohol addiction among parents is estimated to be as high as 75 percent. The families all have problems severe enough that out-of-home placement of one or more children is under consideration.

Referral to the Satellite Program is precipitated by the problems of a child. Kaleidoscope, as an agency, places its priority on serving youngsters who have been diagnosed as seriously disturbed or handicapped and who might otherwise be referred for residential treatment (or are returning home from residential treatment). Other agencies report that the Satellite Program worked with children whom many other programs are unwilling to work with, such as fire setters, sexually aggressive youngsters, or physically aggressive or violent youngsters. In fact, the program accepts referrals of children who have been rejected by multiple residential treatment programs.

It is estimated that 60 percent of the children involved in the Satellite Program can be classified as severely emotionally disturbed. A much smaller percentage is actually identified and designated as emotionally disturbed by the schools and assigned to special education services. While one child in a family generally precipitates the referral, there may be other children in the family who have emotional or behavioral problems. Some of the problems and characteristics noted for youngsters involved in the Satellite Program include:

- Severe behavioral problems
- Sexually and physically abused
- Substance abuse
- Truancy and dropping out
- Delinquency
- Early sexual acting out
- Physical violence or aggression
- Pregnancy and teen parenthood
- History of hospitalization
- Gang involvement
- Retardation
- Medical problems

The direct applicability of the Satellite approach to severely emotionally disturbed children has been demonstrated through the DCFS-DMHDD Joint Initiative. The target population for this effort includes children under age 17 who are diagnosed as mentally ill, emotionally disturbed,

or behavior disordered. The program can be used to deflect children from placement in mental health facilities or to reunify children currently in such placements with their families. An interagency committee consisting of representatives from DCFS, DMHDD, and the Satellite program screens referrals based upon the child's history and current needs. Of the first 20 children participating in this program, 65 percent had a history of out-of-home placement, nine children having histories of previous psychiatric hospitalization.

The Satellite Program also has worked successfully with families with special needs. For example, the program worked with a deaf couple who had three children. Staff were taught sign language so that they could communicate with the parents and networked with agencies serving the hearing impaired. Recently, the program became involved with the family of a child in the STAR program. The infant with AIDS was in a specialized foster home, and the Satellite Program worked with the mother to prepare for and adjust to reunification. These types of adaptations reflect the program's willingness to learn as they go and adjust their service to meet the special needs of individual children and families.

It should be noted that a case is identified as a family, not as an individual child. Further, even if the child ultimately requires out-of-home placement, the Satellite Program continues to work with the family to adjust to this transition and to work towards reunification. In some cases, the program serves foster families to achieve stability in the foster home placement and to prevent a more restrictive placement for the child.

Staffing

The Satellite Program is staffed by a program administrator, 20 family workers, 5 social workers, a social work supervisor, and a nurse. Approximately half of the staff are minorities. The staff is organized into five teams consisting of four family workers and a social worker. A team is responsible for approximately 11 families. Three of these teams are geographic, serving the west, north, and south areas of the county. The Assessment, Reintegration, and Aftercare (ARA) Team was started in 1980 as part of the Governor's Youth Services Initiative to provide 90 day assessments to children in out-of-home placements and their families in order to determine the feasibility of returning the child home. If reintegration was determined to be feasible, the Satellite Program would provide longer-term assistance to facilitate reunification. When the special initiative ended, this team began functioning much like the other Satellite teams, except without geographic boundaries. The Family Involvement Reintegration Services (FIRST) Team was formed in 1985 as a result of the DCFS - DMHDD Joint Initiative and provides services to children being diverted from placements in mental health facilities or returning from such placements.

When the Satellite Program began, a single worker assumed a caseload of three families. The Program found it difficult for one worker to provide all concrete and counseling services to a family and also to objectively evaluate the family and its dynamics. As a result, the program now assigns two family workers from the team to work with each family; each family worker has a caseload of about six families. The program has found that this team approach encourages informal processing of information and creates a sense of identity, cohesion, and support. In addition, it is safer for a team of two to work together in unpredictable, potentially dangerous neighborhoods.

The team approach also has potential problems, such as conflict and competition. The program encourages staff to deal with any such problems internally and to ensure that any discord is not taken out to the families or community. While such persistent conflicts are rare, on one or two occasions staff persons have been transferred because of conflicts within the team structure.

The social workers generally are at the Master's level; the Satellite family workers are required to have a Bachelor's Degree or an Associate Degree with five or more years of social service experience. Staff members tend to be young (23 to 35) and many have recently completed school. In hiring staff, the program recognizes that the degree or professional training is not the variable that predicts success. The challenge is to find staff with clinical skills who are willing to roll up their sleeves and do "hands on" work with children and families and who can relate to Kaleidoscope's nontraditional philosophy and approach. The program looks for persons with experience working with families and who have a variety of other qualities, including motivation, the ability to work with a minimum of supervision, social conscience and commitment, good judgement, common sense, sense of humor, good relationship skills with a variety of types of people, flexibility and adaptability, good personal support systems and stress relievers, and the ability to work well as a member of a team.

The Program Administrator does the initial staff screening, and extensive interviews with numerous hypothetical situations are used to select staff for the Satellite Program. As many as four interviews may be required to complete the staff selection process, with the Kaleidoscope Director and/or Assistant Director conducting the final interview and retaining "veto" power.

The primary role of Satellite Program staff is to become a "friend of the family" or an extended family member. The workers actively seek to develop a close relationship with all members of the family system and to use that relationship to encourage change. More specifically, the role of the family worker includes most of the direct service and interaction with families. Family workers provide counseling, education and skill training in a variety of areas, networking and liaison with schools and other community agencies. In short, the family workers do whatever is needed to assist a family. While they are not officially designated as case managers (DCFS retains this formal designation), family workers do assume a case management role.

The role of the social workers is somewhat different and involves consultation and clinical supervision as well as direct service. Social workers assist in the initial assessment of families, helping to identify problem areas and develop intervention strategies. They make monthly visits to each family for assessment purposes and provide ongoing consultation to family workers regarding treatment interventions. The social workers also are available to provide crisis intervention and to provide intensive counseling to members of one or two families depending upon the particular situation.

In addition to the family workers and social workers, the Satellite staff includes a full-time nurse. The nurse visits all families to conduct an initial health assessment, provides ongoing health services to families with medical issues, and operates a medical clinic at the Kaleidoscope offices to make health care services more accessible to clients. The program also can take advantage of other Kaleidoscope staff who are available to assist in the service delivery process when indicated such as a housing coordinator, recreation coordinator, and vocational coordinator. Psychiatric and psychological consultation are obtained as needed, and additional child care or clinical professionals are secured as needed on a temporary or consultive basis to meet the needs of an individual client. Student interns from the University of Chicago and University of Illinois Schools of Social Work also are used to supplement the staff.

Much training of Satellite staff is handled on-the-job by pairing new workers with experienced staff. In order to enhance training efforts, a training package was developed exclusively for the program. The training program consists of a series of twelve two-hour training sessions, generally held monthly. The training focuses on understanding clients and their needs, understanding worker values and needs, and gaining the knowledge and skills needed for

home-based intervention. Small group sessions, discussions, readings and other materials, informational presentations, role plays, and other techniques are all used in the various training sessions. The topics in the training program include organizational clarification (philosophy, structure, programs of Kaleidoscope), behavioral assessment and management, systems issues in family work, team building, crisis assessment and intervention, family systems, taking care of ourselves, child abuse and neglect, conflict management, child development, communication skills, and working in the community.

In addition to this program-specific training, Satellite Program staff participate in the all-agency in-service training series. Sessions are held every Friday morning, and agency staff are required to attend at least 20 in-service sessions per year. This requirement is reflected in staff performance evaluations. In-service training is provided on a wide variety of topics such as AIDS, agoraphobia, suicide and depression, schizophrenia, chemical dependence, adolescent sexuality, assertiveness, and public aid. Additionally, in-service sessions are arranged on special issues or problems clients may be experiencing, including gangs, multiple personalities and dissociative disorders, and satanic cults. The agency maintains a resource bank containing information about various topics that staff may refer to when needed.

Training in the area of supervisory and management skills is perceived as a training need within the agency. Most supervisory personnel are hired from the ranks of the direct care staff and lack specific experience in management. Kaleidoscope plans to obtain consultation or develop a program to address this need.

The Satellite Program Administrator provides overall direction and supervision to the program, working in tandem with the Social Work Supervisor who has line authority over the social workers. The family workers are directly supervised by three family worker supervisors who oversee the operations of the various teams. Close supervision and support of staff is considered essential to the effective operation of the program. Team meetings are held weekly for purposes including reviewing cases, sharing information, and addressing team issues. Collaboration meetings, which are team meetings attended by the Program Administrator and Social Work Supervisor, are held monthly and are used for case review and treatment planning. Monthly staff breakfasts for the entire agency are held for both information exchange and mutual support, with administrators doing all the preparation and cooking.

The Satellite Program has a detailed protocol for the evaluation of staff performance. All factors affecting job performance are considered, including adaptability, initiative, perseverance, responsiveness to client needs, fulfilling direct service hours, completing reporting requirements, and others. As part of each evaluation, accomplishments are reviewed and future objectives which the employee agrees to work towards during the next evaluation period are established. The outcome of the performance evaluation is directly tied to salary increases. New staff are evaluated at six-month intervals during their first two years on the job and could potentially receive up to a 14 percent increase over this period based upon performance.

The average tenure for staff in the Satellite Program is approximately two years, although there is a core group of staff within the program who have remained for five to seven years. The major factor affecting staff retention appears to be low salaries in comparison to the state pay scale and other social service agencies in the area. In addition, it is recognized that there may be a limit to the length of time that staff can continue providing highly intensive services to such severely dysfunctional families, work which can be stressful, demanding, frustrating and, at times, discouraging. A number of actions are taken by the agency to reduce staff "brown-out" and to enhance job satisfaction and retention:

- Providing a good benefit package including four weeks vacation (staff can borrow two weeks after six months employment), personal days, birthdays off, dental plan, annuity plan, etc.

- Promoting staff from within for supervisory and administrative positions.

- Team support to help staff determine how to cope with "brown-out" and with personal problems.

- High levels of support from agency supervisory and administrative staff.

- Acknowledgement and recognition for accomplishments such as T-shirts of different colors for each year of "survival," jackets for five and ten years employment, mention in the agency newsletter for particular accomplishments, and notices in the newsletter of five and ten year anniversaries and promotions.

Additionally, staff report that satisfaction is enhanced in providing home-based services. With counseling, results may not be readily apparent, but with concrete services workers can see that some things are accomplished immediately.

Resources

The costs of providing home-based services through the Satellite Program are estimated at $1,200 per month or $21,600 for an average episode of home-based services (18 months). This cost is compared favorably to the cost of residential treatment that many children would otherwise require. Further, in over 80 percent of the families served by the program there are at least two children for whom placement might become an issue. Thus, the program serves as an alternative to residential placement for two or more children and as a preventive service for other family members.

The annual budget for the Satellite Program is approximately $766,000. Support for the program is provided principally by a purchase of service agreement with the Illinois DCFS and a grant from the Joint Services Children's Initiative in the amount of $106,000. Under the DCFS contract, the primary funding mechanism for the program, reimbursement is provided in the amount of $15.57 per hour of service delivered. The agency can bill for an average of 80 hours of service per family per month, up to a maximum of 100 hours per month per family. The dollar amount of reimbursement currently is based upon the previous year's expenses. However, DCFS is considering alternative approaches for financing home-based services such as performance-based contracting or a variant of DRGs. These changes would eliminate the current cost-driven system which some charge has few incentives for efficiency. The Joint Initiative grant requires a similar hourly-based reporting system, but this is not tied to reimbursement.

In addition to state funding, the program will be eligible to receive Medicaid reimbursement for five hours of clinical assessment to be billed through DCFS up to a contract maximum of $100,000. Effort to raise funds privately also have been receiving increasing emphasis at Kaleidoscope. An organization entitled "Friends of Kaleidoscope, Inc." has been formed by the Board to solicit funds, and direct appeals are made through the agency's newsletter. Support is being sought from the private sector to finance vital services that the state cannot fund, including emergency cash, food, and housing assistance, specialized job creation services, purchase of leased facilities, and program evaluation. The agency has been successful in obtaining a $5,000 grant from the Robert McCormick Charitable Trust for fiscal year 1987 and a two-year grant from the Chicago Community Trust for approximately $50,000 to improve the client tracking and evaluation system. Additionally, a $10,000 grant was obtained from Dr.

Scholls for supplementary and aftercare services for independent living clients, and a $38,000 grant from the Illinois Department of Public Health was awarded for the recruitment of specialized foster parents for the pediatric AIDS program.

Funding for the Satellite Program is considered stable but cumbersome, requiring as many as 16 different proposals to access appropriate funding streams. Additionally, some contract requirements place constraints on service delivery and reduce flexibility in adapting services to meet individual client needs, such as the requirement of 60 percent direct service and 40 percent collateral time. A frustration for the program is that aftercare or follow-up services have not been built into contracts with funding agencies; the program is attempting to determine how to obtain support for this aspect of service delivery.

Evaluation

To date, the Satellite Program has not had resources to devote to evaluation activities. In the program's contract with DCFS, outcome goals are specified, including:

- At least 50 percent of the children referred for services will be maintained outside of the placement system for a minimum of 18 months,

- At least 50 percent of the families of referred children will be terminated with less intensive services required, and

- At least 90 percent of families referred to the program will be accepted except for lack of space in the program.

The Joint Initiative contract specifies that of the youth transitioned or deflected from the hospital or other residential placement, 75 percent will remain in their families for at least six months following termination from the program. Further, the contract states that 100 percent of the families successfully terminated will be linked with at least one appropriate alternative community resource. The grant recently obtained from the Chicago Community Trust will enable the agency to develop a computerized system with tracking and data collection capabilities that will enable more systematic monitoring of these goals. At present, the program obtains informal feedback from families at the time of termination.

Some data are available from a 1985 evaluation of the Joint Initiative. Of the first 20 cases served by the program, 9 had completed the intervention at the time of data collection. Of these nine cases, four were considered successful (successful completion of the service plan and aftercare arranged) and two were considered partially successful (successful completion of the service plan but no consistent aftercare). Three of the children were placed out-of-home, two in residential treatment, and one in foster care. For purposes of this evaluation, successful treatment was defined to include several criteria -- the family was stabilized, no placements or hospitalizations occurred, and the family was linked and actively involved in outpatient services. Thus, with these highly complex cases, the program was successful or partially successful in two thirds of the cases.

Major Strengths and Problems

Program administrators, staff, providers from other agencies, and families cited the factors that they feel make the Satellite Program effective. The major strengths identified include the following:

- Willingness to go to the home, where the clients are.

- o Flexibility and openness to a variety of different methods and to doing anything that is needed to assist a family.

- o Persistence, perseverance, and commitment to clients. Willingness to "hang in there" with families no matter what the problems and behavior, and to work with families over the long-term.

- o Approach of addressing the whole range of problems and issues affecting the family rather than focusing on pieces of the problems or on one particular child.

- o High quality staff and leadership.

Another strength or advantage cited for the Satellite Program is the fact that it is a lower profile, less visible approach than group homes or residential treatment centers. With group homes, there is a greater likelihood of community resistance and negative media attention. Youngsters involved in the program are easily identifiable and may get blamed for trouble occurring in the area whether or not they are responsible. With home-based services and therapeutic foster care approaches, these types of problems are largely avoided.

Several problem areas facing the program also were noted. Concern for the safety of Satellite workers is an area requiring vigilance, as workers enter dangerous neighborhoods and projects, black workers enter white, anti-black suburbs, and so forth. While no serious incidents have occurred to date, workers take necessary and appropriate precautions in the field.

Low staff salaries make it extremely difficult for the program to attract and retain staff. The relatively high turnover rate among entry level workers is costly for the program in terms of the effort needed to select and train new staff. Further, it is difficult to find staff for the program since much of the formal training provided in schools of social work is antithetical to the philosophy and approach of the program.

The inability to build follow-up services into contracts has been a barrier, as it is felt that follow-up services for a period of time would add an important dimension to the program that currently is lacking. Further, respite care and flexible funds to meet emergency and other needs are two pressing needs for families involved in the Satellite Program. Resources to meet these needs are not available.

Dissemination and Advocacy

Kaleidoscope sees its mission as transcending direct service to include leadership, dissemination, and advocacy efforts. These activities are based upon the belief that, ultimately, many more troubled children can be helped through dissemination and advocacy than can be reached in direct service. Thus, with the direct service role of the agency providing vision and legitimacy, staff become involved in numerous initiatives to promote home-based services in Illinois and nationally.

Kaleidoscope has been involved in numerous dissemination efforts related to the Satellite Program and other program models. A newsletter, "New Directions for Children, Youth, and Their Families," is distributed widely to publicize Kaleidoscope's programs as well as to seek support. Staff consult extensively regarding Kaleidoscope's philosophy and programs; consultation has been provided to public and private agencies in more than 15 different states, and staff speak at numerous conferences and workshops.

Kaleidoscope's advocacy activities are directed toward developing better policy and fiscal support for services to children who are most in need. A major policy initiative to which the

agency is dedicated is to expand family-based services in Illinois. To this end, Kaleidoscope leaders were among the founders of the Illinois Alliance for Family-Based Services, a coalition of individuals, agencies, and associations that provide or support intensive, home-based services to families. One of the goals of the Alliance is to encourage the development of direct service programs by creating a forum for the exchange of program models and service methods and providing training. The Alliance sponsored a conference on family-based services in 1986 and has plans to hold such conferences regularly. A second goal involves gaining stronger policy and budget support for family-based services in the state. The Alliance played a key role in successfully supporting and advocating for the Family Preservation Act of 1987, which creates a new emphasis on family preservation in child welfare services, expanding the use of family-based services similar to the Satellite Program. The Alliance has emerged as the major force for strengthening family-based services throughout the state.

Case Examples

A 12-year old black female ("M") was referred to the Satellite Program by DCFS as a result of her "out of control" behavior. She had frequent quarrels with her family, threatened her sister with a knife, played with fire, and had tantrums. In addition, she stayed up all night, had a history of bed wetting, and exhibited other aggressive and bizarre behavior. Her household included a mother who was agoraphobic, two bothers, and two sisters, one of whom had three young children in the home. The intervention with this family was multifaceted, including efforts to work with the mother to initiate treatment for her phobias and depression; working with the sister to help her to meet her overwhelming parenting responsibilities; and working with M Following an arrest for prostitution, M was placed in a Kaleidoscope group home in Bloomington. The Satellite Program has continued working the M and the family towards possible reunification, including visits between M and her family facilitated and supported by staff.

"T" is a 13-year old white female who was referred to the Satellite Program by the Day School, a private therapeutic school for emotionally disturbed children. T was characterized as a deeply disturbed child with behaviors including shuffling gait, grunting and groaning, rocking, hunching over, hiding behind her hands, hair, or coat, and refusal to eat or use the bathroom. She had been evaluated on several occasions and given diagnoses, including atypical psychosis, anxiety disorder, and others and was considered a candidate for residential placement. T's mother had an extensive history of mental illness and was divorced from T's father. The father retained legal guardianship, and the household consisted of the father, T and two sisters (ages 8 and 19). The Satellite Program became closely involved with the family and has provided concrete services (food, transportation, etc.); served as liaison with the schools and therapists; established a relationship with the mother; involved the children in recreation which focused on encouraging individual attention and expression; and provided the father with information and support to improve his parenting skills. The family also has continued weekly family therapy at a mental health clinic.

After four months of intervention, feedback from the Day School and mental health clinic has been positive. The father has improved in his parenting skills and has started behavior management programs in specific areas. The family has learned to better handle problems of day-to-day living, avoiding the continual crises which were common in their previous history. Additionally, T's behavior shows significant improvement at home, although progress in the school environment has been slower.

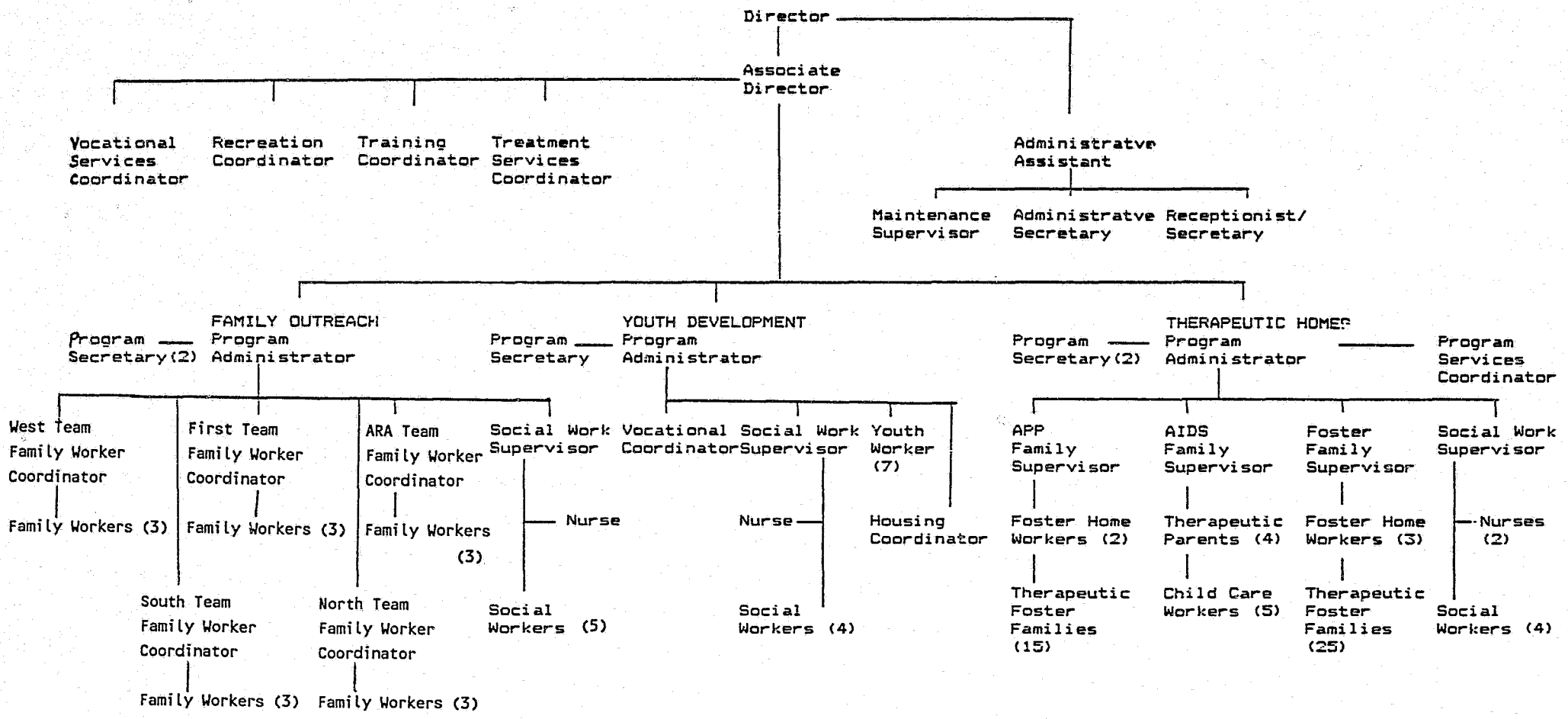
Technical Assistance Resources

- Program Forms:

  Referral Form
  Identified Needs Checklist
  Treatment Worksheet
  Assessment Form
  Satellite Family Visit Assessment Form
  Information Sheet for Treatment Conferences
  Consent for Release of Information
  Satellite Family Information Sheet
  Satellite Monthly Report
  Satellite Family Educational Report
  Satellite Family Worker Evaluation

- Satellite Program Training Materials

KALEIDOSCOPE CHICAGO PERSONNEL



KALEIDOSCOPE, INC.

IDENTIFIED NEEDS CHECKLIST

CLIENT: _____

TEAM: _____

PRESENTING PROBLEMS: _____

_____

_____

DATE OF BIRTH: _____

DATE OF ADMISSION: _____

A: assess

3: high priority need
2: moderate priority need
1: low priority need

	Initial	90 Day	6 Mo.	1 yr.	1½ yr.	2 yr.	2½ yr.	3 yrs.	3½ yr.	4 yr.
DATE & S.W. INITIALS:										
1) MAJOR ISSUES REQUIRING IMMEDIATE CHANGE OR ATTENTION: (Note: Relate to IQ & Diagnoses in determining needs and capacities)										
a. Eliminate Physical Abuse to Children										
b. Eliminate Overt Suicide Attempts										
c. Eliminate Sexual Abuse										
d. Eliminate Reportable Neglect										
e. Eliminate Ongoing Incest										
f. Eliminate Serious Physical Assault Outside of Family										
g. Decrease Family Violence (Adult, Leading to Serious Injury)										
h. Assist in Adjustment to Moderate or Severe Brain Damage/Retardation										
i. Assist in Adjustment to Acute Psychiatric Impairment in Functioning										

	Initial	90 Day	6 Mo.	1 yr.	1½ yr.	2 yr.	2½ yr.	3 yr.	3½ yr.	4 yr.
2) DISPLAY MORE SOCIALLY APPROPRIATE BEHAVIOR:										
a. Eliminate/Reduce Runaway (2)										
b. Eliminate/Reduce Prostitution (3)										
c. Eliminate/Reduce Stealing (2)										
d. Eliminate/Reduce Destruction of Property (3)										
e. Eliminate/Reduce Curfew Violation										
f. Eliminate/Reduce Verbal Assault										
g. Eliminate/Reduce Promiscuity										
h. Comply with Court Order (2)										
i. Maintain Conditions of Probation/ Parole										
j. Other:										

	Initial	90 Day	6 Mo.	1 yr.	1½ yr.	2 yr.	2½ yr.	3 yr.	3½ yr.	4 yr.
3) IMPROVE SOCIAL FUNCTIONING WITH PEERS & FAMILY:										
a. Improve Ability to Relate to Peers										
b. Improve Ability to Relate to Adults										
c. Exhibit Appropriate Functioning:										
Sex Appropriate										
At Developmental Level										
Social Role Appropriate										
d. Accept and Act on Appropriate Role Within Family (2)										
e. Improve Sibling Relationships (Natural)										
f. Improve Relationship with Natural Parents										
g. Improve Understanding of Natural Family										
h. Reduce Marital Instability (2)										
i. Increase Limit Setting & Follow Through Capacity of (Specify)										

	Initial	90 Day	6 Mo.	1 yr.	1½ yr.	2 yr.	2½ yr.	3 yr.	3½ yr.	4 yr.
j. Improve Social Network										
k. Complete Family Assessment Specify:										
l. Improve Parenting Skills (2)										
Environmental Stimulation										
Appropriate Discipline										
Appropriate Expectations										
Consistency/Follow Through										
Other:										
m. Improve Family Communication Specify:										
n. Improve Sibling Relationships (Foster)										
o. Improve Relationship with Foster Parents										
p. Gain Emotional Independence from Family (2)										
q. Other:										

4) IMPROVE EDUCATIONAL/VOCATIONAL FUNCTIONING:	Initial	90 Day	6 Mo.	1 yr.	1½ yr.	2 yr.	2½ yr.	3 yr.	3½ yr.	4 yr.
a. Determine Appropriate Educational/ Vocational Placement										
b. Complete _____ Grade/Class										
c. Improve Reading to _____ Grade Level										
d. Maintain School Attendance for _____ Months										
e. Obtain GED										
f. Enroll in Special Education										
g. Enroll/Complete Vocational Training Class										
h. Locate Appropriate Employment										
i. Maintain Job for _____ Months										
j. Other:										

5) IDENTIFY AND ACT ON MENTAL HEALTH NEEDS:	Initial	90 Day	6 Mo.	1 yr.	1½ yr.	2 yr.	2½ yr.	3 yr.	3½ yr.	4 yr
a. Eliminiate Self-Destructive Behavior (3)										
b. Eliminate/Reduce Alcohol/Drug Abuse (3)										
c. Eliminate/Reduce Encoprosis/Eneuresis (2)										
d. Obtain Psychl. Eval. (IQ and/or Proj.) Reasons:										
e. Obtain Psychiatric Eval. Reasons:										
f. Obtain Neurological Eval. Reasons:										
g. Obtain LD Evaluations Reasons:										
h. Obtain/Continue Intra-agency Counseling (ind., grp., natural family, foster family)										
i. Obtain/Continue Inter-agency Counseling (ind., grp., natural family, foster family)										
j. Resolve Feelings Around Loss/ Separations Specify: (2)										
k. Develop Appropriate Ways of Expressing Anger (2)										
l. Develop Understanding of Sexuality (2)										
m. Resolve Confusion around Gender Identity										
n. Resolve Feelings Regarding Past Sexual/Physical Abuse										
o. Assist in Adjustment to Residual Psychiatric Impairment in Functioning										
p. Cope with Learning Disability										
q. Cope with Mild Retardation Issues										
r. Other:										

6) IDENTIFY AND RESPOND TO MEDICAL NEEDS:	Initial	90 Day	6 Mo.	1 yr.	1½ yr.	2 yr.	2½ yr.	3 yr.	3½ yr.	4 yr.
a. Obtain Medical Exam (Annual or Specific) Reason:										
b. Obtain Dental Exam (Annual or Specific) Reason:										
c. Complete Family Health History										
d. Obtain Birth Control/VD Counseling (2)										
e. Complete Vision Assessment										
f. Complete Hearing Assessment										
g. Obtain Immunizations Type:										
h. Complete Substance Abuse Assessment										
i. Diet, Goal:										
j. Obtain Medication Maintenance Resource										
k. Obtain Medication Evaluation										
l. Improve/Maintain Health Status (of family)										
m. Other: (such as toilet training, pregnancy, muscle/speech development, cognitive development, birth defect, etc.). Specify:										

7) MASTER DAILY LIVING SKILLS:	Initial	90 Day	6 Mo.	1 yr.	1½ yr.	2 yr.	2½ yr.	3 yr.	3½ yr.	4 yr.
a. Obtain/Maintain Adequate Housing										
b. Maintain Current Living Situation for _____ Months										
c. Obtain Proper Furniture/Supplies										
d. Improve Housekeeping Skills										
e. Obtain/Maintain Stable Income										
f. Improve Money Management Skills										
g. Improve Clothing										

	Initial	90 Day	6 Mo.	1 yr.	1½ yr.	2 yr.	2½ yr.	3 yr.	3½ yr.	4 yr.
h. Improve Hygiene										
i. Improve Stress Management Skills										
j. Improve Leisure Time Skills										
k. Acquire Knowledge of Community Resources										
l. Other:										

cc: File, Team Book, Program Director

IV. PROFILES OF HOME-BASED SERVICE PROGRAMS

The first phase of the study of community-based services for children and adolescents who are severely emotionally disturbed involved identifying existing programs. A range of programs providing home-based services, crisis services, and therapeutic foster care were identified during the first phase of the study. A questionnaire was sent to each identified program in order to gather detailed information about the program's characteristics. The information from these questionnaires was summarized in the form of a one-page profile of each program in order to provide specific examples of a variety of programs.

The profiles contain the following information about each program:

- Type of Community - urban, suburban, rural, or mixed.
- Type of Agency - agency type and whether public, private nonprofit or private-for-profit
- Capacity/Staffing - number of children or families served at a given time and number of full-time equivalent (FTE) staff.
- Age Range - range in age of children served.
- Majority Age - age categories of majority of children served.
- Sex - percent of males and females served.
- Race - racial characteristics of children served.
- Diagnosis/Reasons For Not Accepting - percent of children served with various diagnoses and reasons for which children would be considered ineligible or inappropriate for services.
- Duration/Intensity - length of the intervention in weeks, months, or years and number of hours per week spent with the child and family.
- Description - brief description of the program and the services provided.
- Observations - funding sources, other services provided by the agency, interesting aspects of the program, availability of evaluation data, noteworthy evaluation results, linkages with other agencies, whether case management is provided, advocacy activities.

It should be noted that programs were asked to use readily available data to complete the questionnaire so as to minimize response time as well as response burden. Programs without data were asked to provide estimates for purposes of these profiles. Therefore, the data contained in the profiles should be considered estimates. Further, information in some categories (such as diagnoses) may be collected and used differently by each individual program. Thus, certain categories of information are not directly comparable across programs.

These profiles are not intended to represent the universe of home-based service programs. There are, of course, many more programs in existence. These profiles are intended as examples of a variety of programs to assist states and communities in their program design and development efforts.

APPALACHIAN MENTAL HEALTH CENTER, FAMILY SERVICES NETWORK
Beverly, West Virginia
Reg. III
Established: 1984

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Rural	Private nonprofit	27 children 216/year 19 FTEs	0-18	50% 13-15 27% 6-12 22.5% 16-17 .5% 0-5	62% Male 38% Female	95% White 5% Black	49% Emotional 33% Behavioral/Conduct 10% Schizophrenic/Psychotic Will not accept if: o severe retardation	4 weeks 12-15 hours/ week with child and family

DESCRIPTION

- o Provides intensive in-home intervention to families with SED child where child and/or family is in crisis and out-of-home placement is imminent
- o Services can be provided up to 20 hours per week
- o Has systems orientation - uses methods including strategic family therapy, behavior management, RET, etc.
- o Received a grant to hire three staff to provide aftercare and case management to the most seriously disturbed families

OBSERVATIONS

- o Funded 100% by West Virginia Department of Health
- o Agency also provides treatment foster homes, day treatment, wilderness/ stress adventure program and is in process of developing a residential treatment center
- o All children must receive in-home services prior to being eligible for other components
- o Case and class advocacy
- o Have evaluation data at 1, 3, 6 and 12 months follow-up

BAIRD CENTER FOR CHILDREN AND FAMILIES, COMMUNITY-BASED SERVICE
Burlington, Vermont
Reg. I
Established: 1982

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed nonprofit	Private	15-18 families 5 FTEs	6-14	80% 6-12 20% 13-15	80% Male 20% Female	100% White	80% Emotional Disorders Some undiagnosed Any child at risk of removal from home or school due to behavior	12-14 months 2 hours/week with child 4 hours/week with family

DESCRIPTION

- o Provides intensive services to families in their own homes, schools communities
- o CBS Treatment teams include family workers and consulting teachers
- o Services include working with schools, teaching child management skills, linking with and coordinating community resources, behavioral programming, training in social and communication skills

OBSERVATIONS

- o Funded 36% by United Way, 41% Private contributions, and 23% Vermont Department of Education
- o Baird Center provides a range of services including intensive in-home and in-school services, residential treatment, and on-site special education
- o Provides case management
- o Interventions aimed at improving the child management skills of parents and in-school consultation to improve performance in school

BEHAVIORAL SCIENCES INSTITUTE, HOMEBUILDERS
Federal Way, Washington
Reg. X
Established: 1974

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	52 families per month 26 FTEs	Infant - 17	44% 13-15 20% 6-12 15% 16-17 13% 0-5	49% Male 51% Female	82% White 10% Black Remainder Hispanic, Asian, Native American	Do not designate diagnosis. Will not accept if: o nonresidents of treatment area or non-DCFS client o no imminent danger of out-of-home placement o other less intensive services have not been utilized o parents unavailable to work with therapist in child abuse or neglect situations	4.5 weeks 10 hours/week face to face with child and family

DESCRIPTION

- o Intensive in-home crisis intervention and family intervention program designed to prevent out-of-home placement
- o 4-6 week program
- o Therapists work with 2 families at a time and are on call 24 hours a day
- o Psycho-educational intervention model based on cognitive/ behavioral approach
- o Provides concrete services to families as needed

OBSERVATIONS

- o Funded by Dept. of Social and Health Services
- o Broad acceptance criteria
- o Range of linkages with outside agencies especially information exchange, referrals and planning
- o Case advocacy
- o Short-term case management
- o Follow-up data available 3 months and 1 year after termination
- o Opened program in the Bronx, N.Y. in 5/87

BRINGING IT ALL BACK HOME STUDY CENTER APALACHIAN STATE UNVERSITY, HOME REMEDIES
Morganton, North Carolina
Reg. IV
Established: 1986

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Rural	Public	3 families 1.5 FTEs	0-17	50% 13-15 40% 6-12 10% 16-17	50% Male 50% Female	75% White 25% Black	75% Behavioral/Conduct 25% Emotional Will not accept if: o Primary problem which cannot be remedied (severe physical disability, severe mental disorder or severe retardation) o Primary problem which requires requires long-term remediation (chronic substance abuse, sexual abuse or emotional disturbance) o Immediate threat of violence o Family does not make itself available for intake within 72 hours of acceptance	6 weeks 15-20 hours/week with family

DESCRIPTION

- o Crisis intervention and family education program
- o Offers intensive short-term home-based services to children and families in which at least one family member under age 17 is at risk of out-of-home placement or is returning after placement
- o Employs psycho-educational model and individualized services
- o Provides services and training in communication skills, behavior management, anger management, and managing depression and stress
- o Each counselor serves no more than two cases at a time
- o Services available 24 hours a day

OBSERVATIONS

- o 100% funded by Juvenile Justice Delinquency Prevention
- o Founded on principle that first investment should be made in care and treatment of children in their own homes. Emphasis on empowering families and building on their strengths
- o Provides case management and advocacy
- o Study Center also provides therapeutic foster care, Teaching-Family Training Center (therapeutic group home)
- o Evaluation in developmental stage - will have behavior checklists, assessments of family functioning and satisfaction questionnaire

CHILDRENS CENTER OF WAYNE COUNTY, IN-HOME TREATMENT
Detroit, Michigan
Reg. V
Established: 1980

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Urban	Private nonprofit	30 children 2.5 FTEs	4-17	50% 13-15 25% 6-12 20% 16-17 5% 0-5	50% Male 50% Female	80% Black 10% White 10% Hispanic	50% Behavioral/Conduct 50% Emotional Will not accept if: o violent behavior	4 months 2-3 hours/week with child and family

DESCRIPTION

- o Intensive in-home services provided in an attempt to avoid inpatient hospitalization

OBSERVATIONS

- o 90% community mental health funds, 10% Medicaid
- o Childrens Center provides outpatient services, sex abuse unit, day treatment, foster care program, group home, teenage parent program, parent aide program, tutorial program, emergency services, etc.
- o Is developing programs for youngsters who are mentally retarded and emotionally impaired and preschoolers with emotional problems

COMMUNITY COMMITMENT, INC.
Point Pleasant, Pennsylvania
Reg. III
Established: 1972

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Rural/ Suburban	Private nonprofit	35-40 youth 7 FTEs	10-18	50% 16-17 45% 13-15	75% Male 25% Female	75% White 15% Hispanic	50% Behavioral/Conduct 35% Emotional Disorders Will accept anyone	8-9 months 10 hours/week with youth and family

DESCRIPTION

- o A program for court committed youth
- o Services include counseling, family therapy (not necessarily in home), tutoring and a variety of alternative or innovative forms of therapy, meditation, hypnosis, dance, etc.

OBSERVATIONS

- o 75% state funds; 25% county
- o Range of agency linkages
- o Intensive case advocacy
- o Describes program and staff as having 1960's idealism

COMMUNITY SERVICE PROVIDERS, INC.
Lionville, Pennsylvania
Reg. III
Established: 1982

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed, more rural	Private nonprofit	60-80 children 3 FTEs	Infant to 18	60% 0-5 37% 6-12	50% Male 50% Female	65% White 35% Black	19 % Developmental Disabilities Will not accept if: o referral from families directly	1-3 years 10 hours/week with family

DESCRIPTION

- o A program to educate parents in their own homes through role modeling and hands-on training so clients re-learn
- o Services include parent training and education, basic living skills training, transportation, and case management

OBSERVATIONS

- o Provides case management, advocacy, has range of linkages with agencies
- o Funding from County Children and Youth, MH/MR,

COUNSELING SERVICE OF ADDISON COUNTY, FAMILY ADVOCATE PROJECT
Middlebury, Vermont
Reg. 1
Established: 1982

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Rural	Private nonprofit	64 children 22 families 2.5 FTEs	Infant - 18	30% 6-12 30% 16-17 20% 0-5 20% 18+		100% White	Will not accept if:. o family is not highly dysfunctional and does not require long-term in-home services o family does not sign permission to share information with other agencies	52 weeks 4 hours/week with family

DESCRIPTION

- o Long term intensive home-based services as well as extensive work with a network of providers
- o Goal is to empower families through an intensive relationship with a skilled therapist and through service network
- o Services include in-home therapy, case management including multi-family groups
- o As of 9/86, offers a continuum of home-based services including short-term crisis intervention, mid-range services, and long-term

OBSERVATIONS

- o 70% state funds support this project
- o Counseling services is a CMHC; also provides individual and family therapy, therapist in schools, groups for abusive children, summer therapy programs
- o Network includes schools, child welfare agencies, mental health providers, vocational rehab advocacy, case management evaluation
- o Evaluation

CPC MENTAL HEALTH SERVICES, THERAPEUTIC COMMUNITY ALTERNATIVE PROGRAM (TCAP)
Eatontown, New Jersey
Reg. II
Established: 1985

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	16 children 3.2 FTEs	6-18	41% 6-12 29% 16-17 18% 18-21 12% 13-15	62% Male 38% Female	94% White 6% Black	20% Behavioral/Conduct 20% Emotional 15% Substance Use 10% Schizophrenic/Psychotic 10% Developmental Disabilities 10% Other (Abuse/Neglect) 10% Dual (Substance Use/Conduct) 5% Mental Retardation Will not accept if: o requires hospitalization o not at risk of psychiatric hospitalization	6 months 2 hours/week with child 1 hour/week with family

DESCRIPTION

- o Provides intensive clinical intervention and case management services to families with high risk children
- o Contacts occur at home, in hospital, at special schools and other special needs programs
- o Consult with staff in inpatient settings to establish plans for discharge and re-entry into community
- o Goals are to prevent hospitalization, reduce length of stay in psychiatric hospitals, and provide intensive treatment, coordination and services following discharge

OBSERVATIONS

- o Funding 100% by New Jersey Division of Mental Health and Hospitals
- o Agency also has 2 schools for SED children (Elementary, Junior HS, and HS), group homes, summer day camp (Camp High Point), partial hospitalization, outpatient psychiatric/psychological services, crisis services (Helpline & Crisis Unit), pediatric liaison services (psychologists placed in pediatrician's offices), student assistance program for substance abuse, TOTLINE, consultation to preschools, day care centers and schools, program for adolescent sex offenders, etc.
- o Has comprehensive network of services
- o Provides case management and case advocacy

DAUPHIN COUNTY, JUVENILE PROBATION, IN-HOME DETENTION PROGRAM
Harrisburg, Pennsylvania
Reg. III
Established: 1977

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Public	21 children 3 FTEs	10-18	56% 13-15 39% 16-17	91% Male 9% Female	49% Black 47% White	70% Behavioral/Conduct 20% Substance Abuse 5% Emotional 5% Mental Retardation Will not accept if: o child is at risk of committing additional crimes or if crime was so serious as to warrant unconditional placement	6 weeks 7 hours per week with child and family

DESCRIPTION

- o A short term program (maximum 60 days) supervising juveniles to determine their appropriateness for probation supervision (as opposed to placement)
- o Alternative for secure detention
- o Services include diagnosis, individual, group and family counseling, referrals

OBSERVATIONS

- o 75% of funds from County Commissioners; 25% Juvenile Court Judges
- o Linkages with agencies include referrals and information exchange
- o Case management

DENVER DEPARTMENT OF SOCIAL SERVICES, OPERATION HOME BASE (HBO)
Denver, Colorado
Reg. VIII
Established: 1980

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Urban	Public	168 children 144 families 13 FTEs including MSW	Infant - 18	38% 6-12 36% 0-5 19% 13-15 6% 16-17	60% Male 40% Female	36% White 36% Black 27% Hispanic	33% Child Abuse and Neglect 31% Behavioral/Conduct 15% Emotional Does not rule out any psycho-social problem area in accepting child but have been unsuccessful in treating active psychosis, severe substance abuse and severe behavior problems	Once a week face to face contact with child and family for 8 months

DESCRIPTION

- o Intensive in-home counseling and treatment services to families
- o Also serves children in foster care to reduce stay
- o Social workers available 24 hours a day, 7 days a week
- o Individual and family therapy provided at least weekly
- o Education specialists evaluate and serve as liaison to school
- o Homemaker provides support, parenting and household skills
- o Recreation funds available for families and to support activities

OBSERVATIONS

- o 80% state and 20% county funding
- o Program linked with other services of DDSS--homemaker, foster care, crisis shelter
- o Referrals and contact with range of service providers
- o Voluntary program as alternative to out-of-home placement
- o Case management and advocacy

EASTFIELD CHILDREN'S CENTER, ADOLESCENT IN-HOME TREATMENT PROGRAM
Campbell, California
Reg. IX
Established: 1985

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Suburban	Private nonprofit	9 families 5.5 FTEs	12-17	70% 13-15 20% 16-17 10% 6-12	60% Female 40% Male	58% White 24% Hispanic 15% Black	40% Behavioral/Conduct 40% Emotional 20% Dual (Emotional Disturbance with Substance Abuse) Will not accept if: o youth is actively suicidal or is uncontrollably violent	3 months 2-3 hours with child 4-6 hours with family

DESCRIPTION

- o Brief (90 day) program offering intensive family therapy to SED adolescents and families
- o Families referred in crisis
- o Treatment initiated in 8-10 hour "multiple impact" meeting in family home
- o Emphasis placed on family and community support systems
- o Treatment model: structural, strategic and multigenerational components integrated to empower families
- o Services: family therapy, individual counseling, evaluation, intense collaboration

OBSERVATIONS

- o Funding: 80% county mental health; 20% private
- o Center also offers residential treatment, school-based day treatment and an outpatient family clinic
- o Linkages with other agencies includes referrals, contract with mental health
- o Evaluation component

FAMILIESFIRST INC., HOME-BASED SERVICES
Davis, California
Reg. IX
Established: 1983

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	10 families 5 FTEs	Infant - 18	43% 0-5 32% 6-12 20% 13-15 5% 16-17	58% Female 42% Male	69% White 16% Black	Not applicable; referrals to program are prior to mental health evaluation services Will not accept if: o safety cannot be assured	4-6 weeks 10-15 hours/ week with child and family

DESCRIPTION

- o 24-hour home-based family centered child abuse treatment and prevention
- o Approaches include crisis intervention, cognitive/behavior modification, family systems
- o Services include assessment, crisis intervention, therapy, skills training, service coordination, referrals and follow-up
- o Contact is intensive; case loads include 1 to 2 families per month

OBSERVATIONS

- o Primarily supported through federal and state funding
- o FamiliesFirst also offers 3 group homes and special ed school
- o Referrals and information exchange with variety of agencies
- o All referrals from Child Protective Services
- o Case management
- o Involved in advocacy coalitions
- o UC-Davis evaluation

FAMILY & CHILDREN SERVICES OF THE KALAMAZOO AREA, HOME-COMMUNITY INTERVENTION PROGRAM
Kalamazoo, Michigan
Reg. V
Established: 1984

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	18 families 2.1 FTEs	0-18	40% 13-15 25% 0-5 25% 6-12 10% 16-17	55% Female 45% Male	88% White 12% Black	55% Behavioral/Conduct 40% Emotional 5% Dual Diagnosis (Emotional Disturbance/Mental Retardation Will not accept if: o danger to self or community o actively psychotic o needs 24 hour supervision o extreme substance abuse o family with violence, actively psychotic adults, extreme substance abuse o family is dangerous situation for child or uninterested in having child at home	6 months 3 hours/week with child and family

DESCRIPTION

- o Provides intensive, time-limited services to families of children who are at risk of out-of-home placement for mental health reasons or are returning home from placement
- o Uses structural approach to family therapy and provides intensive crisis interviews in-home, 12 week contracts with families with specific goals (renewable once), team approach to treatment, 24-hour crisis availability
- o Some families have stayed involved for more than 6 months for continued support
- o Have meetings with family and extended helping network

OBSERVATIONS

- o Funded 88.3% Michigan DMH, .8% Medicaid, 9.9% United Way
- o Part of continuum of single entry services for children's mental health system
- o Philosophy of least restrictive, most appropriate placement and maintaining families whenever possible
- o Provides case management
- o Program expanded to include less intensive, longer-term services as well as short-term
- o Have demographic data on families, clinical and service histories, service histories, service provision, outcome and follow-up data
- o Agency also provides therapeutic foster care programs
- o Valley Center outpatient and day treatment programs (after school and summer)
- o Have defined system of care coordinated by mental health board and service agreements with Juvenile Court and Department of Social Services
- o Single entry system

FAMILY SERVICE ASSOCIATION OF GREATER FALL RIVER, INC., HOSPITAL DIVERSION PROGRAM
Fall River, Massachusetts
Reg. I
Established: 1984

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	Capacity limited by number of staff - 2 ideally each staff has one case at a time	7-17	56% 13-15 23% 16-17	58% Male 42% Female	52% White 45% White/ Portuguese 3% Black	63% Emotional 33% Behavioral/Conduct 4% Schizophrenic/Other Psychotic Disorders Will not accept if: o children need protection of hospital o unwilling to participate o in need of housing	20 days 10 hours/week with child 5 hours with family

DESCRIPTION

- o 21-day crisis intervention program to prevent psychiatric placement
- o Services provided in-home include assessment, individual and family counseling, advocacy, recommendations and referrals
- o Focus to stabilize family situation

OBSERVATIONS

- o Funding through Department of Mental Health
- o A foster home component (maximum stay of 10 days) is maintained for situation when children cannot be served in own home
- o Variety of linkages
- o Admission to program through mental health center

FAMILYSTRENGTH
Concord, New Hampshire
Reg. I
Established: 1985

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Rural/ Small Town	Private nonprofit	100 families 24 FTEs	Infant - 18	45% 13-15 25% 6-12 20% 16-17 10% 0-5	50% Male 50% Female	99% White	76% Behavioral/Conduct 23% Emotional 7% Substance Use Will not accept if: o parent unwilling to participate or if child is in imminent danger of being hurt or endangering others	5 months 8-10 hours/week face to face contact with family

DESCRIPTION

- o Comprehensive in-home family centered services for families with child at risk of out-of-home placement; also works with families on reunification
- o Philosophy: comprehensive approach, flexible timing and array of services, intensive services, low caseload, focus on entire family and its strengths
- o Services: counseling, skills training, community networking, parent support and education groups, child and adolescent groups, and 24-hour crisis coverage

OBSERVATIONS

- o Funding: 75% state, 25% counties
- o Range of linkages with multiple agencies
- o Case management and case advocacy
- o A sole purpose agency designed specifically to support family preservation services

GERARD OF MINNESOTA, INTENSIVE IN-HOME FAMILY TREATMENT PROGRAM
Austin, Minnesota
Reg. V
Established: 1978

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private for-profit	65-75 Families 13 FTEs	Infant - 18	50% 0-12 50% 13-21	50% Male 50% Female	96% White	Acceptance not limited for any family symptom	6 months face to face contact with family initially 4 hours/week varies with child

DESCRIPTION

- o In-home program provided through professional treatment team approach using family systems model
- o Focus on relationship issues, utilizing family strengths, skill building--parenting, communication, conflict resolution, home management, utilizing community resources

OBSERVATIONS

- o Purchase of service agreements with counties
- o Satellite programs
- o Gerard also provides residential treatment services
- o Variety of linkages, including planning, information exchange, referrals
- o Some outcome data

GERARD SCHOOLS OF IOWA, IN-HOME TREATMENT SERVICE
Mason City, Iowa
Reg. VII
Established: 1978

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private for-profit	40 families 5 FTEs	0-21	30% 6-12 30% 13-15 20% 0-5 15% 16-17 5% 18-21	50% Male 50% Female	97% White	70% Behavioral/Conduct 20% Emotional 19% Substance Use	6 months 1 hour/week with child 3 hours/week with family

DESCRIPTION

- o Provides short-term intense services in the home
- o 2-3 contacts weekly with total family or subsystems
- o Provide family therapy, parenting intervention, couple counseling, custody mediation
- o Goal is to prevent out-of-home placement or aid children in returning earlier and to strengthen and maintain family
- o Family systems approach

OBSERVATIONS

- o 95% purchase of service from Iowa Department of Human Services
- o Agency also provides day treatment, In-Home Diagnostic and Evaluation services, residential treatment
- o For 8 years, 80-85% of families have remained intact upon termination of services
- o In-Home Diagnostic and Evaluation program offers in-depth, multi-disciplinary evaluation with report and recommendations within 45 days
- o Provides case management and advocacy through membership in organizations including Home-Based Family Services Association

KALEIDOSCOPE, SATELLITE FAMILY OUTREACH
Chicago, Illinois
Reg. V
Established: 1973

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Urban	Private nonprofit	55 families 30 FTEs	0-21	--	--	80% Black 15% White 5% Hispanic	40% Child Abuse and Neglect 30% Behavioral/Conduct 20% Schizophrenic and Other Psychotic Disorders 10% Emotional Admits any family regardless of multiple needs or severe pathology	18 months 20 hours/week with family

DESCRIPTION

- o Provides intensive services to families in their own homes to avert out-of-home placement or to reunite children who have been in residential placements with their families
- o Provides parent training, role modeling, family counseling and therapy, homemaking, crisis intervention, and helping to meet the family's basic needs for food, clothing, jobs, medical care, etc.

OBSERVATIONS

- o Funded 80% by Illinois Department of Children and Family Services, 20% by Department of Mental Health
- o Philosophy is normalization and investing as much as possible in keeping families together
- o Kaleidoscope also provides Youth Development Program (independent living), therapeutic foster homes
- o Provides case management and advocacy
- o Founded Illinois Alliance for Family-Based Services

LA GRANGE AREA DEPARTMENT OF SPECIAL EDUCATION, PREVENTIVE INTERVENTION PROGRAM (PIP)
La Grange, Illinois
Reg. V
Established: 1984

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Suburban	Public	16 children 2 FTEs	14-21	60% 16-17 30% 18-21 10% 13-15	80% Male 20% Female	94% White 5% Black	90% Behavioral/Conduct Will not accept if: o profound retardation precludes service provision	3 months 3 hours/week with child 2 hours/week with family

DESCRIPTION

- o Consists of four major components: in-home crisis intervention; in-home parent training; community linkage and liaison; and a feasibility study of short-term alternative living arrangements
- o Establishes organizational capacity to deliver adjunctive or supportive services to SED students in LADSE Cooperative

OBSERVATIONS

- o Funding - 100% P.L. 94-142 discretionary funds
- o Special education department provides full continuum of special education services; PIP is adjunctive
- o Variety of linkages

LUTHERAN SOCIAL SERVICE OF IOWA
Des Moine, Iowa
Reg. VII
Established: 1978

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	350+ families 30 FTEs	0-18	38% 6-12 31% 0-5 20% 13-15 9% 16-17	55% Male 45% Female	97% White	97% Dual Diagnosis 3% Mental Retardation Child in danger of being removed from home because of suspected abuse or emotional disorders Will not accept if: o psychotic o violent behavior	6 months Intensity varies with need 1 or more hours/ week with child and family

DESCRIPTION

- o Provides diagnostic and evaluation services, interventions including therapy and parent skill development, and leisure and recreation services
- o Provides supervision through in-home monitoring with goal of preventing out-of-home placement

OBSERVATIONS

- o Funded 83% by Iowa Department of Human Services
- o Agency provides continuum of services including therapy, in-home services, foster care, group care and residential treatment
- o Have paid lobbyist for advocacy activities
- o Direct care ratio 1 staff - 8 children

LUTHERAN SOCIAL SERVICES, FOCUS HOME INTERVENTION PROGRAM (HIP)
Washington, D.C.
Reg. III
Established: 1984

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Urban	Private nonprofit	4 families 6 FTEs	21 months - 17	41.7% 6-12 41.6% 13-15 8.3% 0-5 8.3% 16-17	71% Female 29% Male	100% Black	50% Behavioral/Conduct 50% Emotional Will not accept if: o not in danger of out-of-home placement o not residing with parent or guardian o parent or guardian do not agree to service	4-6 weeks As many hours per week as necessary with family

DESCRIPTION

- o 24-hour 7-day a week home-based program
- o Philosophy based on family systems theory
- o Each family has therapist and resource worker
- o Services include parent support, self-esteem building, parenting skills training, school stabilization, crisis intervention, individual and family therapy, advocacy, and information and referral

OBSERVATIONS

- o Contract with D.C. government constitutes 100% of funding
- o Makes referrals to variety of providers
- o Team provides case management and advocacy

MENDOTA MENTAL HEALTH INSTITUTE, HOME AND COMMUNITY TREATMENT
Madison, Wisconsin
Reg. V
Established: 1969

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Public and families	15 children 3.8 FTEs	3-10	90% 6-12 10% 0-5	67% Male 33% Female	85% White 10% Black Remainder Hispanic and Native American	50% Emotional Disorders 50% Dual Diagnosis (Attention deficit and emotionally disturbed)	52 weeks 4-6 hours/week with family during first 6 months

DESCRIPTION

- Core team provides family treatment and child management process which serves as an alternative to residential treatment
- Sessions focus on demonstration and practice of skills including staff modeling and coaching

OBSERVATIONS

- Funding: 80% state general revenue, 20% third party payment
- Variety of linkages, case management, advocacy
- Been in existence for 17 years with same staff nucleus
- Agency also provides in-patient care

NORTHERN PINES UNIFIED SERVICES CENTER, INTENSIVE HOME INTERVENTION PROGRAM
Cumberland, Wisconsin
Reg. V
Established: 1980

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Rural	Public	5-6 families 1 FTE	0-18	Primarily adolescents	--	99.4% White .6% Native American	Emotional Substance Use Mental Retardation Developmental Disabilities Children at high risk for institutional placement	Ongoing services

DESCRIPTION

- o Family specialist works intensively with 4-6 families in their homes with other community agencies to prevent institutional placement
- o Provides family counseling, consultation to schools and other agencies, and back-up psychiatric-psychological services of the clinic
- o Judge has ordered families to participate in the program as an alternative to residential care

OBSERVATIONS

- o Funded 90% by state, 5% by county
- o Provides case management and advocacy
- o Joint effort between psychiatric clinic and Burnett County Department of Social Services
- o Progress and outcome and cost-effectiveness evaluation using Global Assessment Scale for children
- o Agency also provides outpatient services, inpatient services, group home, alcohol and drug abuse prevention program, in-home infant stimulation program, family incest treatment program and attention deficit disorder clinic

NORTHERN RHODE ISLAND COMMUNITY MENTAL HEALTH CENTER, HOME BASED COUNSELING
Woonsocket, Rhode Island
Reg. I
Established: 1981

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Public	36 children in combination of day treatment and home-based counseling 1 FTE plus a 2 20-hour consultants	13-18	40% 13-15 40% 16-17	80% Male 20% Female	90% White 10% Minority	80% Behavioral/Conduct	3 hours/day per 45 day period with child Daily phone contact with families 5 - 10 sessions home-based counseling with child and family

DESCRIPTION

- o A home-based outreach intervention program which is a collaborative venture involving a CMHC and three LEAs.
- o Program provides "affective education" and adjunct therapeutic intervention to behaviorally handicapped children in their home environment
- o Three hour/day program for 180 school days plus intensive case management and home-based counseling

OBSERVATIONS

- o Program clinical cost funded by schools through P.L. 94-142
- o Also has day treatment program

NORTHSIDE CENTERS, INTENSIVE CRISIS COUNSELING PROGRAM (ICCP)
Tampa, Florida
Reg. IV
Established: 1982

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	14 children 3.5 FTEs	0-18	--	57% Male 43% Female	83% White 12% Black 5% Hispanic	45% Behavioral/Conduct 30% Substance Use 25% Physical/Sexual Abuse Will not accept if: o clear, serious risk of danger initially	5 weeks (6 weeks maximum) 3-12 hours/week with child and family

DESCRIPTION

- o Uses crisis intervention approach with families where child is in imminent danger of removal from home
- o One responsible adult must be willing to work to keep the family together
- o Provides family crisis intervention and social service linking/case management

OBSERVATIONS

- o 100% state funded
- o 1984-85 "success" rate was 89% at 12 month follow-up. (Have 3, 6 and 12 month follow-up data)
- o Center also has case management and other services

NORTHWEST FLORIDA MENTAL HEALTH CENTER, INTENSIVE CRISIS COUNSELING PROGRAM (ICCP)
Panama City, Florida
Reg. IV
Established: 1981

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed/Rural	Private nonprofit	16 families 3.5 FTEs	0-18	40% 13-15 30% 16-17 15% 6-12 15% 0-5	60% Female 40% Male	85% White 15% Black	50% Behavioral/Conduct 40% Abuse/Neglect Victims 10% Emotional Will not accept if: o strong suicidal ideation o extremely violent behavior o acute psychosis	5 weeks (max. 6 weeks) 6 hours/week with child and/or family (2-4 visits/ week)

DESCRIPTION

- o Provides home-based crisis intervention for families in which there is a danger of out-of-home placement for a child due to abuse, neglect or status offense behavior
- o Provides intensive intervention, 24 hour availability
- o Employs behavioral programming, family therapy, parent training, crisis intervention, transportation liaison and referrals to community services

OBSERVATIONS

- o 100% funded by Florida Division of Children, Youth and Families
- o Based on philosophy that every family has strengths to build on and deserves opportunity to maintain the family unit
- o Case management provided by Department of HRS
- o While limited to 6 weeks by contract with HRS, find it would be helpful and appropriate to have flexibility to extend services on a less intensive basis
- o Mental health center also provides outpatient services, therapeutic parenting program, child abuse prevention and counseling, vocational services, day treatment, case management, etc.
- o Family Enrichment Program provides in-home services to teen mothers to prevent abuse and neglect

PROGRESSIVE LIFE CENTER'S, COMMUNITY SERVICES PROGRAM
Washington, D.C.
Reg. III
Established: 1984

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Urban	Private nonprofit	50 children 7 FTEs	14-18	50% 16-17 40% 13-15 5% 6-12 5% 18-21	90% Male 10% Female	90% Black 5% White 5% Hispanic	80% Behavioral/Conduct 10% Emotional 10% Substance Use Will not accept if: o active psychosis o severe substance abuse	6 months 2 hours with child and 2 hours with family on weekly basis

DESCRIPTION

- o Alternative sentencing program for juvenile offenders
- o Philosophy and approach is Afrocentric, which has a spiritual basis
- o Progressive Life Center provides in-home family, group and individual counseling and therapy component
- o Other services include parent training, multi-family retreat and an adolescent therapy group

OBSERVATIONS

- o Funded through DC government
- o Information exchange and referrals occur with a variety of providers
- o Progressive Life Center provides similar services to other agencies and funding services

QUAKERDALE FAMILY SUPPORT TEAM
Waterloo, Iowa
Reg. VII
Established: 1978

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	300 children/ year 7 FTEs	Infant - 18	40% 13-15 30% 6-12 20% 0-5 10% 16-17	60% Male 40% Female	95% White Remainder Black and Hispanic	Behavioral/Conduct Emotional Developmental Disabilities Substance Use Will not accept if: o actively psychotic adult or child	6-8 months 5 hours/week face to face contact with family, 2 hours/ week with child

DESCRIPTION

- o Provides in-home treatment services to families in 11 counties in Iowa
- o Approach focuses on family as primary caretaker; general systems theory model used by therapists
- o Services include family therapy, parent skill development, community assistance and supervision

OBSERVATIONS

- o Funding: 98% state department of human services, 2% county funds
- o Variety of agency linkages, advocacy, case management
- o Serves rural areas
- o Evaluation component

ST. CLOUD CHILDREN'S HOME, IN-HOME FAMILY SERVICE
St. Cloud, Minnesota
Reg. V
Established: 1984

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	22 families 4 FTEs	Infant - 21	--	--	98% White 2% Native American	44% Behavioral/Conduct 34% Mental Retardation 22% Emotional All referrals are accepted for an initial evaluation	6 months 5 hours/week with child and family

DESCRIPTION

- Provides intensive, comprehensive continuum of therapy and crisis intervention services
- Staff includes in-home therapists and specialists who provide a supportive and educational focus
- Services include systems oriented family assessment, therapy, crisis intervention, liaison with community resources
- Family systems approach

OBSERVATIONS

- Funding: hourly rate charged to agency making referral; sometimes families contribute
- St. Cloud's also a residential treatment center
- Uses Kiresuk and Sherman Goal Attainment Scaling Procedure to evaluate program
- Associated with St. Cloud's, a residential treatment center under Catholic Charities

ST. MICHAEL'S CENTER, HOME BASED FAMILY SERVICE PROGRAM
Bangor, Maine
Reg. I
Established: 1981

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	9 families 5.5 FTEs	Infant - 18	50% 13-15 30% 6-12 20% 16-17	60% Male 40% Female	99% White 1% Native American	70% Behavioral/Conduct 20% Substance Abuse 10% Emotional Will not accept if: o family lacks commitment o full caseload	13 weeks 4 hours/week with family

DESCRIPTION

- o Short-term intensive, in-home family assessment, counseling and referral
- o Family systems approach
- o Teams of two-family workers
- o Development of a network of community services for each family
- o Joint planning and collaboration with other agencies

OBSERVATIONS

- o Funding: 50% Department of Human Services, 40% Department of Mental Health, 10% local
- o Offers emergency foster care or respite for families
- o 6 month and 1 year follow-up visits

SWEETSER CHILDREN'S HOME, FAMILY PRESERVATION SERVICES PROGRAM
Saco, Maine
Reg. I
Established: 1984

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	8 families 6 FTEs	Infant - 18	--	--	100% White	Diagnostic labeling not used. Will not accept if: o life of child is threatened o child is not in danger of removal from home	9 weeks 3-6 hours/week with family

DESCRIPTION

- o Nine-week intensive, in-home treatment program
- o Team of 2 family workers meet with a family 2-4 times a week
- o Therapeutic approaches include family systems treatment, brief problem solving techniques, educational and psychodynamic approaches
- o Services include family focused treatment, education, community liaison and advocacy

OBSERVATIONS

- o Funding: 80% state, 20% agency contribution
- o Sweetser Children's Home also offers residential, day treatment and evaluation services, therapeutic foster homes, therapeutic group homes prevocational programming, and neuropsychological evaluation services.

VENTURA COUNTY MENTAL HEALTH SERVICES, VENTURA COUNTY CHILDREN'S MENTAL HEALTH DEMONSTRATION PROJECT, IN-HOME INTERVENTION PROGRAM COMPONENT (INTERFACE)
Ventura, California
Reg. IX
Established: 1985

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Public	6 children 3 FTEs	6-17	40% 13-15 40% 16-17 20% 6-12	60% Male 4 % Female	75% White 20% Hispanic 2% Black 2% Asian 1% Native American	45% Emotional 40% Behavioral/Conduct 15% Schizophrenic/Psychotic Will not accept if: o mental retardation o active psychosis o violent behavior o acute medical illness o not at risk of separation from family o not likely to return home within 10 days	4-6 weeks 5-10 hours/ week with child 5-10 hours/ week with family

DESCRIPTION

- o Program based on Homebuilders model
- o Goals are to prevent child in crisis from being separated from family and to facilitate successful reunification of child and family after placement
- o Provides assessment, crisis intervention, parent training, individual and family therapy, community referral and liaison

OBSERVATIONS

- o 100% state funded (special legislation)
- o Part of Ventura County Demonstration project with comprehensive system of children's mental health services
- o County has 10.5 FTE case managers ("brokers") to coordinate full continuum of services as part of an integrated intergency network
- o Have 2 research psychologists for systems evaluation of program outcome and costs over time and across agencies
- o Other services provided in county include enriched foster care, emergency services, residential treatment for juvenile offenders and court dependents, crisis intervention in Juvenile Hall, case management, day treatment on a school site, outpatient services, group homes, prevention, etc.
- o County has interagency policy council, interagency case management council, written interagency agreements and is working toward an interagency service system

WAKE COUNTY JUVENILE SYSTEM, OUTREACH
Raleigh, North Carolina
Reg. IV
Established: 1981

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Public	50 children 7 FTEs	6-18	40% 13-15 40% 16-17 20% 6-12	75% Male 25% Female	50% White 50% Black	75% Behavioral/Conduct 15% Emotional 5% Mental Retardation 5% Development Disabilities Will not accept if: o child presently dangerous to self or others such that hospitalization is required	1-12 years 1-25 hours/week with child 1-25 hours/week with family

DESCRIPTION

- o Provides in-home services from minor support services to intensive family therapy, depending on the need
- o Provides supportive counseling, parent education, individual and family therapy, behavior management, role modeling for parents and children, family functioning assessments, help with household management, accessing, linking with community services

OBSERVATIONS

- o 100% state funded
- o Soon to be merged with the Clinical Team of the Juvenile Treatment System
- o Services provided according to client need, following philosophy of Willie M. consent decree
- o Part of Juvenile Treatment System which provides case management, individual habilitation planning team, secure residential treatment, high management group homes, moderate supervision group homes, supervised apartment living, therapeutic foster homes, day treatment, individual, group and family therapy and vocational services
- o Families must accept service. Emphasis on family involvement in service planning
- o State-wide evaluation of Willie M. programs

APPENDIX

LIST OF PROGRAMS RESPONDING TO SURVEY

Appalachian Mental Health Center
Family Services Network
P.O. Box 215
Beverly, West Virginia 26253

Baird Center for Children and Families
Community Based Services
1110 Pine Street
Burlington, Vermont 05401

Behavioral Sciences Institute
Homebuilders
34004 9th Avenue South, Suite 8
Federal Way, Washington 98003

Bringing It All Back Home Study Center
Appalachian State University
Home Remedies
204 Avery Avenue
Morganton, North Carolina 28655

Children's Center of Wayne County
In-Home Treatment
101 Alexandrine East
Detroit, Michigan 48201

Community Commitment, Inc.
P.O. Box 307
Point Pleasant, Pennsylvania 18950

Community Service Providers, Inc.
251-A Welsh Pool Road
Lionville, Pennsylvania 19353

Counseling Service of Addison County
Family Advocate Project
89 Main Street
Middlebury, Vermont 05753

CPC Mental Health Services
Therapeutic Community Alternatives Program
59 Broad Street
Eatontown, New Jersey 07724

Dauphin County Juvenile Probation
In-Home Detention Program
Dauphin County Human Services Building
Seventh Floor
Harrisburg, Pennsylvania 17101-2025

Denver Department of Social Services
Operation Home Base (HBO)
2200 W. Alameda
Denver, Colorado 80223

Eastfield Ming Quong
Adolescent In-Home Treatment Program
251 Llewellyn Avenue
Campbell, California 95008

FamiliesFirst
Family Preservation Services
502 Mace Boulevard, Suite 8
Davis, California 95616

Family & Children's Services of the
Kalamazoo Area
Home-Community Intervention Program
1608 Lake Street
Kalamazoo, Michigan 49001

Family Service Association of Greater Fall
River, Inc.
151 Rock Street
Fall River, Massachusetts 02720

Family Strength
72 North Main Street
Concord, New Hampshire 03301

Gerard of Minnesota
Intensive In-Home Family Treatment
P.O. Box 715
Austin, Minnesota 55912

Gerard Schools of Iowa
In-Home Treatment Service
P.O. Box 1353
Mason City, Iowa 50401

Kaleidoscope, Inc.
Satellite Family Outreach
1279 North Milwaukee
Chicago, Illinois 60622

La Grange Area Department of Special Education
Preventive Intervention Program
1301 W. Cossitt Avenue
La Grange, Illinois 60525

Life Management Center of N.W. Florida, Inc.
Intensive Crisis Counseling Program (ICCP)
525 East 15th Street
Panama City, Florida 32405

Lutheran Social Service of Iowa
In-Home Treatment
3116 University Avenue
Des Moines, Iowa 50311

Lutheran Social Services of the National Capital Area
Focus In-Home Crisis Program
3319 Alabama Avenue, S.E.
Washington, D.C. 20020

Mendota Mental Health Institute
Home & Community Treatment Program
301 Troy Drive
Madison, Wisconsin 53704

Northern Pines - Burnett County
Intensive Home Intervention Program
Burnett County Government Center
Route 1 Box 300-117
Siren, Wisconsin 54872

Northern Rhode Island Community Mental Health Center, Inc.
Home-Based Counseling
1 Cumberland Plaza
Woonsocket, Rhode Island 02895

Northside Centers
Intensive Crisis Counseling Program (ICCP)
13301 Bruce B. Downs Boulevard
Tampa, Florida 33612

Progressive Life Center
Community Services Program
1123 11th Street, N.W.
Washington, D.C. 20001

Quakerdale Family Support Team
140 South Barclay
Waterloo, Iowa 50703

St. Cloud Children's Home
In-Home Family Services
1726 South 7th Avenue
St. Cloud, Minnesota 56301

St. Michael's Center
Home-Based Family Service Program
1066 Kenduskeag Avenue
Bangor, Maine 04401

Sweetser Children's Home
Family Preservation Services Program
50 Moody Street
Saco, Maine 04072

Ventura County Mental Health Services
Demonstration Project
In-Home Intervention Progam/Interface
300 Hillmont Avenue
Ventura, California 93003

Wake County Child and Family Services
Outreach
2321 Crabtree Boulevard
Raleigh, North Carolina 27604