

Chapter 3 The Core: Family Counseling Services Or "The Preventive Program"

Portions of Chapter 3 were previously reported in Hess, P., McGowan, B., & Botsko, M., (2000), A preventive services model for preserving and supporting families over time, *Child Welfare*, 79, 227-265, and in Hess, P., McGowan, B., & Meyer, C. (1996). Practitioners' perspectives on family and child services. In *Children and their families in big cities*. A. Kahn & S. Kamerman (Eds.), 121-137. New York: Columbia University School of Social Work, and are included here with permission.

A single mother of five, whom we'll call Carmen, had used the Center's preventive services for two years when we first met her. Like a third of the families served by the preventive program, Carmen was not referred by an agency, but rather called the preventive program on her own at the suggestion of a friend. She had completed a drug treatment program and was living with relatives. The father of the older children was uninvolved with the family; the father of the younger children was incarcerated.

Carmen began to describe her experience with this Center program by recalling that *"I knew about the Center, that it was in the area, but when my children were taken away from me [by the public child welfare agency], I had nobody to talk to. A friend recommended that I come here. So I called and made an appointment and talked to Sister Mary Paul."* Like other Sunset Park residents whom we interviewed about the preventive program's services, she emphasized the importance of her open relationship with her worker:

Then I met my worker [in the preventive services program]. I thought I was going to hate her . . . but she is just like a big sister to me, the sister I never had. I could just . . . lay everything on the table and be myself -- I don't have to hide anything -- and from there we discuss and we try to compromise, to find ways to deal with me, the children, any problems that might occur . . . My worker is always here, not to supervise, but kind of help and guide me in how to handle a situation."

The range of services used by Carmen and her children is similar to the range of services used by other families served in this program:

All my kids go to the Center's programs. My daughter goes to a teen group, which I like because she is able to talk with kids her age about how her mom gets on her nerves and mom doesn't understand me and problems that occur in the house with her brothers and sister.

My 11 year old still has the mind of a child, but yet he wants to be grown up. He goes to a semi-teen group and there they help him to find his identity, how to get along with other children because he likes to fight a lot. Through sports at the Center and other activities they help him to share and respect other people's feelings.

My other son is going through changes himself because he was in foster care and when he was returned to me he was very rebellious. He's in a lot of pain and that's very stressful to me. The Center helped me to set one day of the week to spend quality time with him at the Center . . . I needed a space where I could go to spend time with him. I can't do it at home because then the other kids would distract me. That's kind of helped.

I've used the thrift shop. When I had my newborn I had no income at all and I was homeless and I had just got the apartment and was in a very stressful situation where I had nothing at all. The ladies in the support group knew I was going through changes, so they all chipped in and they got me pampers, clothes, crib sheets, a carriage. I got a shopping bag of food from the thrift shop. I got some clothes. And that held me over until

I could stand on my feet.

In addition, Carmen completed her GED, secured a part-time job, and began to attend college. Her reflections upon her own progress during the two-year period she had worked with her preventive program worker convey both her learning and her tenacity: *"I have come a long way in how to deal with my children, but I have three different stages of kids . . . It helps me to learn that there is a different way of parenting without using violence or anger. I was always subjected to that, and I don't want to do that to them because I know how that feels."* She stated emphatically that *"The most important thing I learned in the Center is never, never talk at your children, talk to your children . . . When I go home I practice those skills. It doesn't get easier overnight, but some day."*

Carmen summarized her feelings about the Center's preventive program as follows:

"I believe that you can't keep what you have learned unless you give it away. And I want to do that in turn to a newcomer to the Center, to give her a sense of family, and say, 'Hey, I've been there, I know what it is like. Trust these people. They know what they are doing. Just give them a chance. Don't quit.'"

The purpose of the preventive program. The Center's family counseling program, referred to by staff and families as the "Preventive Program," is designed to prevent the unnecessary placement of children in out-of-home care. It has been a core program component since the Center was established in 1978. In New York City the phrase *preventive services* is widely used to identify services provided by various agencies to prevent unnecessary foster care with the support of city funding and in accordance with the state's Child Welfare Reform Act of 1979.

Soon after the Center was established, Sister Mary Paul wrote about the issues in the use of the term *preventive* to describe such programs: "There is widespread agreement that the term is an unfortunate one, because of the vagueness of the term 'preventive' in relation to the social problems which the services are intended to address" (1981:20). She emphasized the importance of a program's focus upon *both* the psychological and environmental aspects of families' situations as follows:

Whatever the reader's opinion of the comparative values in working with change in the individual vs. change in the conditions which affect individuals, it is here proposed that 'preventive services' should encompass the creation of conditions, psychological and environmental, which promote the well-being of families and protect the capacity of parents to sustain their children. Case management (that is, selection, coordination and integration) of the tasks necessary for this, in situations referred to preventive service programs, will usually consist of certain personal social services directly provided by an agency, along with advocacy, brokering of needed resources, and/or environmental change. (1981:20).

In addition, she stressed that a preventive program must collaborate with other organizations in service delivery and development, "sometimes to stimulate the development of new services in the community. Sometimes too these new 'services' will be informal social arrangements, self-help groups, involvement of college/university internships in developmental activities." (1981:20).

In providing the clinical leadership that has shaped this program since its inception, Sister Mary Paul has been true to her own early prescription regarding the provision of "preventive services." Staff members diligently maintain the program's dual focus upon the psychological and environmental aspects of families' needs and difficulties and actively coordinate services to families with other Center programs as well as with other community resources.

An unique approach. Our findings document the program's effectiveness in implementing a coherent philosophy, mission, and approach to preventive services through rigorous adherence to key principles and through creative, flexible social work practice. We believe that these findings provide ample information to suggest that further professional and public attention should be given to the Center's approach to preventive services. As described in Chapters 1 and 2 and reported elsewhere (Hess, McGowan, & Botsko 2000), the Center's preventive services program has combined elements of both

family preservation and family support services to provide a comprehensive yet individualized response to families in need. The Center's preventive program has consistently incorporated program elements that correspond with those typically identified as characterizing family preservation programs, including a family focus and orientation; the development of a client-centered relationship between family and worker, staff accessibility day-to-day, and flexibility in service planning and delivery. Yet, as documented by our findings regarding services to a study sample of 301 caregivers and 423 children in 189 families, the Center's program also is characterized by its service comprehensiveness, flexibility in service duration, and broad and inclusive access to noncategorical services. These characteristics differentiate this program from typical family preservation programs and reflect the program's enactment of family support principles. We found that the Center's program model provides for individualized, comprehensive, often intensive, short- and long-term services that address families' extensive service needs and are associated with identifiable positive changes, particularly in children's problems and behaviors.

Our findings also strongly suggest that the Center's preventive service program model addresses the limitations of current family preservation programs. In contrast to these programs, the Center's program provides "opportunities for ongoing supportive therapy for depressed, maltreating parents" (Dore 1993:552), "coherent and coordinated long-term services to disadvantaged and at-risk families" (Besharov 1994:448), and "a continuum of family and services" that are less narrowly targeted (McGowan 1990:82). It must be noted that the practice principles that are foundational to the Center's preventive service model have long been associated with social work services to families with multiple problems and needs.

Access to the preventive program. In contrast to the other programs at the Center for Family Life, which are accessed by "open enrollment," the preventive program is accessed through an intake interview that is conducted at the Center. Families are scheduled for an interview without regard to the nature of their need or problems either with Sister Mary Paul, who conducts the interviews with English-speaking clients, or with the casework supervisor, who conducts the interviews with Spanish-speaking clients. Sister Mary Paul described the program's approach to scheduling intake appointments:

If a parent were to call me today [a Friday] I would offer an appointment tonight or over the weekend. Sometimes, if there's reluctance, they're not jumping to come in, they'll say, 'I have an appointment, I can't do it until next week.' If they put it off, I do not pressure them. I accept their own timing. If I see that they are uncertain, I would ask if they want to wait. . . When we get a referral call [for preventive services], I don't make an appointment unless I'm in contact with the actual prospective client. My response to a referral source is 'Have them call me'. . . If parents want it, we offer an intake appointment.

Thus, whatever the referral source, preventive program services are not initiated until the clients schedule and complete an intake interview. In the interview the intake interviewer explores a family's needs and problems, explains the services, and confirms the family's willingness to enter voluntarily into a relationship with the program. The limited number of families that are not willing to work voluntarily with the Center are not accepted for service, but are encouraged to contact the Center should family members change their minds. Forms that identify who in the family will be involved with the Center are completed. The intake interviewer explains the only exceptions to confidentiality, e.g., if a family is reported for abuse, or a child is placed in foster care, the Center will have to provide certain information to the New York City and State child welfare agencies. Sister Mary Paul described her intake interviews as follows:

First I hear their problem, and then I tell them, 'Now I have to explain to you more about the Center for Family Life. The counseling is free because we are funded by the city.' I tell them that three-fourths of our funding comes from CWA [the New York City Child Welfare Administration] and that by the city we are classified as a preventive service program. That doesn't mean a lot to some of the families, and I have to explain again that there are certain programs that the city [of New York] funds so that they can help keep the family together and prevent any out of home care or any further breakdown if they step in early.

I tell them that what goes on in this building is just the counseling of families and that families come here with every sort of problem. I tell them about the other services, and then I go back to the preventive service idea. I tell them that I consider counseling an umbrella service. Everything that we encompass here is encompassed in counseling, whether it's advocacy or direct service.

Sister Mary Paul stressed two purposes for the intake interview: *"To get a sense of the problem and what the person's expectations would be about coming here; and to prepare them and motivate them."* She described her intakes as *"fairly skimpy. They're not an intake study by any means. I purposely do not do that. I try not to get too much information because it's hard for families to have to repeat it when they are assigned to a worker. . . [But] you need to get a projected sense of the task before you make an assignment."* Information from the intake interview is routinely recorded by the interviewer on an Intake Recording Form.

Following this interview, families are assigned to a preventive services worker. According to Sister Mary Paul, cases are assigned based on the complexity of the case, worker's experience and current availability, and the client's language fluency. The worker contacts the family immediately to schedule an appointment by telephone, or by letter if the family does not have a telephone. The family and the assigned worker subsequently further explore and define the family members' needs and problems. Together, they develop a service plan. Families' service plans are individualized and vary with regard to service goals, the involvement of family members at different points in time, the treatment approaches used by the worker, and the nature, sequence, and duration of services.

Sources of Information Regarding The Preventive Program

Because the preventive program is viewed by the agency as the "core" of its work, we emphasized this program in our study design. In order to understand the program we gathered extensive case-specific information about services provided to a prospective sample of families whose cases were opened during a thirty-month period. Center co-directors and staff were actively involved in the decisions regarding data collection and instruments to be used (Weiss & Horsch, 1998). In addition, we collected in-depth information from families whose cases had been open in the preventive program for at least two years when our study began. Finally, over a three-year period we met frequently with supervisors and staff to explore their perceptions of the program's philosophy, services, and outcomes, and their own experiences as staff in the program.

Case-specific information about the 189 study sample families. Extensive case-specific information was collected on 301 caregivers and 423 children in 189 families whose cases were opened for service in the preventive program during the study's data collection phase. Data sources included standardized case data collected at the initiation of services to a prospective sample of families, at six-month intervals, and at case closing. Information was collected from each family's preventive program worker using the Family Assessment Form (McCroskey, Nishimoto, & Subramanian, 1991), preventive services program forms, and a service needs/service utilization instrument developed for the study. Our sampling strategy allowed us to follow all cases for at least one year and up to thirty months subsequent to case initiation. In addition, in 1999 we collected follow-up data regarding the case status of the 189 study sample families.

Cases in the study sample were referred to the preventive program from six sources. Formal social services agencies, including the New York City public child welfare agency, accounted for the largest source of referrals (35.4 percent, 67). Self-referral was the second largest referral source (27 percent, 51). Of the self-referred families, 45.1 percent (23) had previously been served in the Center's preventive program.

Additional sources of case-specific and program data. In addition to the case-specific information gathered about the families in the study sample, we conducted in-depth semi-structured interviews with selected family members and their preventive program workers. These interviews focused on the families' and workers' separate perceptions of the purpose, process, and outcomes of their work together. We also analyzed data from the Center's management information system regarding the total Center service

utilization of almost six hundred families using the preventive program during the twenty-four months between January 1, 1994 and December 31, 1995.

In addition, we conducted in-depth semi-structured interviews with program administrators, supervisors, and practitioners regarding the program's organization, characteristics, service approaches, and desired outcomes, and their professional experiences in the program. Finally, we conducted extensive interviews and program observations with staff and participants in other Center programs in which preventive program families were served.

To identify and understand the service model used in the Center's preventive program, transcripts of interviews and the data from all other sources were analyzed. In interviews concerning the program, staff responses regarding its key characteristics were strikingly consistent. Case-specific interviews with family members and their workers echoed the same themes. These emergent categories and themes were compared with and further confirmed by findings based upon analysis of the case-specific quantitative data. The consistency among the findings derived from the analysis of data from multiple sources provides us with a high degree of confidence regarding the characteristics of the Center's preventive program.

Although these themes are consistent with the Center's commitments, philosophies, and interests as described in Chapter 1, we found that emphases vary somewhat from program to program. For example, in the preventive program, practitioners place great emphasis on the development of a trusting relationship with family members and on engaging the parent(s) and all family members in service use. Thus, while the focus on the family as the unit of attention is an overall Center commitment, this focus is particularly explicit in the preventive program's work.

Key Characteristics of the Preventive Program

Historical and current sources have yielded a coherent image of the characteristics of the Center's preventive services program. Excerpts are provided about several key program characteristics in the following sections, drawing upon the voices of families and staff. Other program characteristics are described in detail in Chapter 3 of Nurturing the One, Supporting the Many. Throughout Chapter 3 we report characteristics of our study sample of 423 children in 189 families and the services they received in the Center's preventive program. This information is selectively provided in the excerpted portions.

Comprehensive, Holistic, Integrated Services Grounded in the Community

Without exception, staff members describe "*counseling, plus*" a range of other within-Center community-based services as comprising the preventive program. They identify as both essential and unique the comprehensive, holistic nature of the services available through the Center's preventive program. This model allows preventive program social workers to reach multiple aspects of each family member's life, and to do so over time as family members develop and their needs change.

The structured linkages between Center programs assure that intra-agency referrals and connections support the work of practitioners and meet the needs of families in a timely way. Through these within-Center service connections, family members have frequent contact both concurrently and sequentially with professional staff in multiple programs and receive services that address their clinical, developmental, educational, and recreational needs. One worker stressed: "*The preventive service program here gives the workers a foundation. I have a whole center to back me up.*"

The information collected about the 189 study sample families confirms the comprehensive nature of the services provided. The families' service needs were extensive. On average, families had 10.6 service needs, ranging from 1 to 29 (i.e., at least one family member had a particular service need). Over 80 percent of the families needed individual and family counseling, and over half (57.7 percent) needed parent education. Caregivers most often had difficulties in the area of emotional problems (77.5 percent). Similarly, over two-thirds (69.2 percent) of the children had an emotional problem, and almost two-thirds (62.8 percent) a behavioral problem. Other specific counseling (i.e., marital and group) and family support service needs (i.e., child recreation, summer day camp, and after-school childcare) were identified for

more than one-third of the families.

In response to these needs, families received a range of 1 to 27 services through the preventive program (mean=9.4 services, SD=5.8). Seventy-five percent of the families received six or more services. It is important to note that the majority of services were provided to study sample families within the Center for Family Life and thus within the neighborhood. Over half received three particular within-Center services: individual counseling (80 percent), family counseling (76 percent), and parent education (53 percent). On average, 4 services per family were provided through referrals to resources outside the Center, including medical and dental care and special education evaluations.

Thus, the extensive case-specific data we collected confirmed staff members' observations regarding the Center's comprehensive approach to preventive service. Two staff members' observations further illustrate:

The preventive services program encompasses a lot of different components. . . There are lots of different ways to engage people, not just the traditional one-on-one counseling. I worked in preventive services before where they only had the counseling component. It was a less effective way of working with families and engaging them. Everybody doesn't get help in the same way. For some counseling's effective and for some it's not.

. . . from one case to the next, it's almost 100% sure that I'm going to be relying on the employment center or I'm going to be calling a Center staff member in the school to work with me with the client. If there's a young mother and an infant, I'm thinking of the infant-toddler program. If she's unemployed and there's no pressure for her to be employed until the child is a little older I encourage her to go to the employment program. Or I suggest the women's group to women who are just beginning a divorce because their peers and social group have changed dramatically. . . Some women are not ready and some are. But if they are saying 'I want' we set up a meeting [with the staff of one of the programs]. It's an intervention. . . Sometimes I feel like I'm writing a prescription: 'This child needs to be in a pre-adolescent girls group.' Then you're working in a team with that group worker.

Workers particularly value being able to access the services that families need without having to "refer out to a whole other agency where we might lose touch with what's going on." They described the importance of integrating a family's services through teamwork with staff in different Center programs: "You know who they are, and you can talk to them and be open. You know what to expect from them, and that's a real security."

Workers consistently emphasized that the Center's comprehensive services model attracted them to the Center's preventive program and keeps them there. For example, a worker stressed: "**The support systems for the families I see -- groups, the after-school program, the employment program -- are one of the most important pieces of the work. . . That is what draws me here -- the model itself. Without the other services so many of my cases wouldn't be moving. It gives such a roundness to the worker.**" As illustrated by the single mother's statement at the beginning of this chapter, families similarly acknowledged the importance of the wide range of services they receive as clients in the preventive program.

The preventive program staff members clearly value their professional relationships with others in the community and the program's goal of connecting families more positively with the community. Many of these connections are forged through helping families become involved with Center community-based services, such as the after-school childcare program. One staff member emphasized: "**We serve one community as opposed to being scattered across the borough. You get to know the community well and they get to know you.**"

Family Focus and Orientation

The preventive program staff members identify a family-centered orientation as essential to their work and

consistently apply a family-centered approach to assessment and to intervention. The multiple services provided to both caregivers and children reflect the program's emphases on 1. meeting the needs of all family members and 2. viewing the family as a system. We found that, from the first contact, the majority of study sample family members participated in identifying the family's needs and problems and in establishing an intervention plan. Intake interviews were attended by 70 percent of the 301 study sample caregivers and over half (54.5 percent) of the 423 children.

Staff members articulated the importance of engaging all family members, understanding family systems, and identifying and supporting each family's strengths. Sister Geraldine, who served families in the preventive program in addition to her other responsibilities, reflected on the importance of helping families recognize their strengths: "*There is a strain here that is very strong, that there is something in every family that you meet that has something to get from the Center and something to give. In the early days we would always say 'in the assessment you are responsible for looking for the strength as well as what the presenting problem might be,' looking at the whole person.*" She further stressed: "*I find that the hardest thing to get clients to do with you is to recognize their own strengths*".

Both workers and families described interventions with multiple family members individually, in dyads, and with the family as a whole. Staff members identified positive changes in family relationships and preserving families as important case outcomes. The following are illustrative of staff observations:

You can work on different aspects of the family. Depending on the situation, you'll see different pieces in different ways. For example, if the largest stressor is the marital relationship, then maybe what you would work on is the marital relationship. Depending on how the kids were reacting or if they needed extra support, you might see them individually or the siblings together. Or for a time you might work on the marital piece and then switch to something else like the parent-child relationship, depending on where the client's at and where they want to move.

[I try to provide] as many opportunities as I can for family members to be able to reflect on who they are, to do that with each other as a family. That's what family counseling will do, just getting that open communication of feelings and forming those attachments to each other. . .

Clients similarly both understand and value the family-centered nature of their work with the preventive program staff. For example, three different single mothers described their families' problems as follows:

Development of a Client-Centered Relationship Between Family and Worker

Program staff and clients also view the development of a client-centered helping relationship between the worker and family members as an essential program characteristic. Important relationship dimensions include the expectation that clients voluntarily enter the helping relationship and remain active over time in determining the treatment goals, the services that are needed, the outcomes desired, and the point at which services will end. Workers noted that the concept of shared parenting (Gabinet 1983), in which the agency partially assumes some parental tasks, often shapes their relationships with parents, particularly those who have severe difficulties in maintaining their children at home.

Relational components particularly valued by families include the focus on family members' strengths as well as difficulties, the experience of being respected, the frequency of worker-family contact, and the sense of worker-family partnership. In their interviews with us, clients conveyed strong positive feelings about the mutuality they experience as participants in this process. Family members consistently described staff members' accessibility, responsiveness, sensitivity, and trustworthiness as integral to their positive experiences with the program. They emphasized that they feel free to communicate their thoughts and feelings without being judged. As one mother commented: "*I don't have to hide anything.*" From the clients' perspective, feeling respected is perhaps the most important dimension of their experience.

Others described the ways in which they felt they were partners in the relationship from the beginning and

the ways in which they were encouraged or permitted to shape the experience. For example, "[At intake] Sister Mary Paul really wanted to make sure I wasn't being forced to come. . . She wanted to make sure that this is what me and my daughter wanted to do." Clients also described a relationship in which they felt accepted and equal with their counselor.

The importance of this relationship to the clients' willingness and ability to persevere with the work when it became difficult was also articulated. For example, one single mother described her ambivalence about discussing certain topics and, periodically, about continuing with counseling generally. She stressed that her worker taught her about and helped her stay with the process:

My worker will say 'How are you doing?' And I'll say 'OK.' And then she'll say 'You are not talking to me.' And then she'll say 'Do you want to talk about anything specific?' and I'll explain to her the situation. Right now we are going to start on a log I've been writing about my childhood, being a victim of abuse. So it's hard for me to talk. . . I have the sense that she understands where I'm coming from and what I'm trying to tell her . . . she says 'I know you have a feeling, can you tell me what kind of feeling? I see it in your eyes' . . . sometimes I want to run out the door, and she says 'No, that's not the way to go about it. Running away is not going to solve anything.'

But sometimes I've said 'Why am I doing this? Why am I going for counseling? Why am I putting these kids through counseling? . . . I wanted to see results right away. I would say 'I'm going to stop going.' And then I would stop coming, I wouldn't call. My worker would call me 'What's going on? Why aren't you coming? Do you want to stop coming? Why do you want to stop coming?' I said 'I don't feel like talking right now, I just want to be left alone.' So I just kind of listened, and after I talked with her that same day I came back...

I got into the habit if something scares me I don't want to face it, and my worker doesn't allow me to do it. She says 'No, you have to face your problems, you cannot hide. You are teaching your kids to face responsibility, not to hide, you have to do the same thing. If the kids see you doing that, then they'll do it.'

A secure base for exploration. Bowlby describes therapeutic relationships in which the characteristics above are achieved as providing a "secure base from which he [the client] can explore the various unhappy and painful aspects of his life, past and present, many of which he finds it difficult or perhaps impossible to think about and reconsider without a trusted companion to provide support, encouragement, sympathy, and, on occasion, guidance" (1988:138). The concept of a child's attachment to a parent as a secure base for exploration was first introduced by Mary Ainsworth (1967:345-346). Bowlby emphasizes that the practitioner's role is "analogous to that of a mother who provides her child with a secure base from which to explore the world" (1988:140).

Bowlby further stresses, "Throughout adult life the availability of a responsive attachment figure remains the source of a person's feeling secure. All of us, from the cradle to the grave, are happiest when life is organized as a series of excursions, long or short, from the secure base provided by our attachment figure(s)" (1988:62). Ainsworth similarly describes affectional bonds that develop throughout the life span (1991) including attachments to parents, surrogate parent figures, intimate partners, mentors, and therapists.

We believe that the concept of a secure relational base from which to explore is very useful for understanding the centrality of family members' relationships with preventive program practitioners in their ongoing development and change over time. Workers' and clients' descriptions of their work together amply illustrate the characteristics of accessibility, individualized responsiveness, and sensitivity identified by Bowlby as essential to providing a secure base for therapeutic exploration. From this relational base, family members explore developmental and/or therapeutic tasks, issues, and problems. Practitioners extend themselves as resources that may be used by families for a brief period, over the children's childhood and adolescence, or periodically over time as needed.

Shared parenting: Lightening the load. Program practitioners described developing close relationships with children's parents and other caregivers as a goal of the work. This goal is consistent with the recognition that the emotional support, or lack of it, that caregivers receive, affects the quality of their parenting (Bowlby 1988:126). Program staff members also often referenced Gabinet's concept of "shared parenting." Gabinet (1983) proposed a model that extends the notion of emotional support of parents to include ongoing supportive neighborhood services to parents and their children, a "series of services which could be offered to protect rather than disrupt family functioning" (p. 405). She elaborates:

Shared parenting is the term which describes a new kind of service designed to compensate for parental inadequacy and at the same time to prevent the child abuse that in many instances results from these inadequacies. . . families need facilities within walking distance of their homes, where they can feel they belong, can find trustworthy friends and can receive assistance when necessary. . . what is new in these recommendations is the basic concept: that institutions would be viewed as vehicles for improving the parenting experience of children, that where parents are inadequate, parental responsibilities would be shared or augmented but not supplanted by the institutions. These facilities would also be viewed as providing supportive services to parents because these supports will relieve some of the parental stresses, which increase the risk of abuse and neglect of children. (pp.405-406)

The benefits of a parent's therapeutic attachment to a Center preventive program practitioner and the related experience of "shared parenting" were frequently identified. To illustrate, one worker described her relationship with a chronically depressed mother and her five children, four of whom have serious special education needs. The family had been referred to the Center by the city public child welfare agency. Although an allegation of sexual abuse of one of the children by another was unsubstantiated, the child welfare agency felt the family could benefit from Center services. At the time of our interviews with the worker and the family, the family had been receiving multiple Center services for over three years. The mother, whom we will call Marla, had been hospitalized as an adolescent for over a year following a suicide attempt. The worker observed:

Her contact at the Center over the past three years has been really important in keeping her level of depression from overwhelming her. She usually walks in like the weight of the world is on her shoulders and you can see it sitting there. Sometimes it takes a while for us to get into an issue in any kind of depth or length. . . You have to ask a lot of questions, you have to be more active . . . She was evaluated here by our psychiatrist and he thinks her limitations are much greater than we had thought.

Marla's responsibilities as a mother are central in her life. The worker stressed: "*She really tries, she really struggles in wanting something better for her kids although not always knowing what to do about that. I have a real sense that life has always been a struggle for her, and yet she still manages. I have a lot of respect for that.*" The worker described changes that she had observed in Marla and their shared success in maintaining the children at home: "*She's now able to look at a problem and think it through a little bit more, to better trust herself and her ability to make the right choices. The struggle is always whether she is able to follow through. We have been able to keep the kids in school and make sure that they are safe in the family.*"

Like many immigrants in Sunset Park, Marla has limited contact with her family in another country. She relies heavily upon her relationship with her preventive program worker for emotional support and for assistance with her own and the children's relationships with special education, health, and legal professionals and with connections to other Center services and staff. The worker emphasized Marla's isolation and the necessity for shared parenting: "*She doesn't have anybody in her life that believes in her, that understands her -- her family is far away, she has no friends. . . Her husband refuses to work with us on her problems. She tried to separate from him a few years ago and he told her that he would go to court, prove her incompetent, and keep the children.*" The worker described the way in which Marla perceives their relationship and some of the ways in which they share parenting:

She sees me as somebody like one of her sisters who she would be able to go to and discuss things that she wouldn't discuss with other people, somebody that she would trust, like family. She knows the distinction between me being a friend or family member and somebody from the helping profession. She and her children can engage with me and utilize our work effectively. The relationship has been significant to her even though there have been so many referrals to other resources. The negotiation of the systems has been an ongoing task for both of us -- school, legal, camp, employment or training programs for the children. At some point I've had to intervene or help her make the connections with all the systems that impact upon the family.

Marla: Now she is strong. In a separate interview, Marla and one of her daughters described the significance of the worker-client relationship and the three-year connection with Center services. The mother related that a typical meeting with her worker would include talking about her problems, outlining steps to solve the problems, and then talking again about whether she could take the steps and what supports she would need to take them. She noted that at the beginning of a meeting, the *"weight is heavy. When I leave the weight is light."* Marla openly described her thoughts about suicide and that with her worker's help she has been able to tell herself to *"hold on, be strong, hold your ground."* Her daughter interjected that *"my mother was weak, now she is strong. We used to walk all over her. Now she is strong. What [my mother's worker] does for mom, mom now does for me."* Both mother and daughter commented that they could not imagine a time in life when they would not need the Center's services.

Some will read this and other case descriptions throughout this volume and express concern about the Center's "encouragement" of a family's "dependency" upon a worker and upon the Center's services. It is here that we find the concepts of attachment and of shared parenting to be particularly useful. In her initial description of the concept of a relational secure base, Ainsworth wrote that when babies are able to crawl, rather than staying close to the mother they make "little excursions" to explore other objects and interact with other people, returning to the mother "from time to time. The mother seems to provide a secure base from which these excursions may be made without anxiety" (p. 345). Developmental theorists consistently stress that continuous close relationships across the life span are essential to the development and maintenance of autonomous functioning, competence, and positive self-esteem. "Dependence" upon such relationships is recognized as integral to the development of the abilities that are required for successful interpersonal relationships, including those of parent, partner/spouse, and employee. Thus, through close relationships with Center practitioners, family members are able to explore, plan, and carry out "excursions" with increasing degrees of autonomy and confidence. As they do so, they rely on Center staff and programs for emotional support and nurturing, role modeling and learning, problem solving, and advice.

This approach to practice is consistent with the implications for child welfare drawn from studies of the helping alliance by Dore and Alexander (1996), who stress that "for families with significantly impaired psychosocial functioning alliance formation should become an end in itself, at least in the beginning phase of treatment" (p. 357). They suggest, in instances when clients' difficulties in interpersonal functioning are serious, that the initial focus should be "developing relational capacity in the client" rather than on changes related to the presenting problem (ibid).

Flexibility to Individualize Services

Essential to the preventive services program is flexibility to vary the work in ways that respond to families' needs over time. This permits highly individualized, client-centered service. Staff greatly value this flexibility. For example, one worker stated: *"Here there is a great level of freedom to do what you think needs to be done with the family. There are certain basic requirements related to home visits and contacts, those kinds of things. But if a family needs you to be in the home much more, that's fine. I feel trusted to do what I think would meet their needs. There are different ways you can become involved in their lives."* Another preventive service social worker similarly states: *"We have the goal of trying to keep families together, but we don't have a strict guideline that says I must see the child, I must see the mother, or I must see the family together. We can use any kind of intervention that we feel comfortable with to achieve that goal."*

Therefore, although similarities can be identified in services provided to different families, workers develop an unique service plan with each family, providing services in the family's home, the worker's office, and elsewhere in the community. Service plans also vary in the frequency of meetings with family members, which family members are included in sessions at various points in time, and which additional services are accessed both within the Center (i.e. after-school, employment center, emergency food, etc.) and outside the Center (i.e., preschool childcare, medical care, psychotropic medication, etc.).

Flexibility in Service Duration and Access to Services over Time

One characteristic that distinguishes family preservation services currently provided throughout the country from other services to families is their brief nature, typically limited in duration from one to five months (Fraser, Nelson, & Rivard, 1997). Thus, in using such programs families are not empowered to access them over time in ways that would be consistent with their problems and needs. Due to the definition of service as time limited, a family with chronic problems that require continuous or episodic service over time, such as a parent's or child's severe mental illness, would not be eligible for extended services.

The limitations of a brief service model in addressing many families' needs have been described (McGowan 1990; Dore 1993, Dore and Alexander 1996; Besharov 1994). For example, Dore has stressed that "current family preservation programs are unlikely to succeed with families whose characteristics typify depressed, maltreating families living in poverty" (p. 551) and states, "It is imperative that family preservation services include opportunities for ongoing supportive therapy for depressed, maltreating parents" (p. 552). Consistent with others' recognition of these limitations, the authors of a recent review of studies of family preservation programs raised as a question for further study "Can a brief intervention be expected to offer protection against complex problems like child maltreatment [child abuse or neglect]? . . . Should the duration of service be extended?" (Fraser, Nelson & Rivard 1997:150). The Center's answer to this second question is a definite "yes."

Flexible service duration. Findings regarding the Center's preventive program's provision of both short- and long-term service emerged early in our study from in-depth interviews with preventive program workers. When asked whether case "types" or "categories" could be identified in the program's client population, workers primarily identified types of cases based on service duration. A "*short-term*" case was described by workers as a "*higher functioning family with specific needs or problems.*" In contrast, a "*long-term*" or "*maintenance*" case was defined as ". . . *someone who for years will need that constant support in order to make it. Most of my clients live on the edge of a lot things, and they are dealing with very bread-and-butter issues. There are some clients where there will always be an immediate issue that's too much for them to solve on their own.*" The worker then illustrated this definition by describing a family that needed and used a number of concrete, therapeutic, recreational, and other supportive services over time:

For example, I have a client who had her children in foster care multiple times, an alcoholic, she has three children at home, one in a residential treatment facility. I've referred her to the women's group here so she's attempting to build other supports besides myself. She greatly depends on the other [Center for Family Life] resources like after-school childcare and summer camp. Those things are definitely crucial to help her to survive daily. . . . Meanwhile, while she's getting this together, the kids still have their feelings about foster care. Two are in special education. They have a lot of needs themselves that mom isn't ready to meet. She's ready to meet their basic physical needs in her own way. She needed basic things -- how to manage a budget, how to buy food -- those were the issues for a long time. Now we've kind of moved beyond that to relationship issues. But it's very hard for her because she doesn't have supports, her judgment is poor, and her own capacity to deal with the kids and with her feelings is limited.

Another worker further elaborated that in long-term cases

the progress may be very minimal, and you're really just trying to maintain the family in

some way or support the functioning of the children until they grow up. There's not necessarily the expectation that things are going to improve dramatically -- there might be very small progress here and there -- but it's really to allow the children and the family to have the support that it needs to maintain its level -- to not get worse.

However, long-term services are provided only with a clear rationale. Each case is regularly reviewed by a clinical supervisor to determine whether the case should remain open. In addition, at least every six months the Center's preventive program is required to account to the New York City public child welfare agency for service goals, goal attainment, and the need for continued services in each case. If family members believe that continued services are necessary and the practitioner's and clinical supervisor's assessment differs, the family members' concerns are thoroughly reviewed. Then either extended service is provided, with the objectives for continued service clearly defined, or a "trial" termination is attempted, with periodic meetings for ongoing review.

Previously reported case-specific findings regarding the duration of services to the study families (Hess, McGowan, & Botsko 2000) support the program staff's conceptualization of general types of families whose presenting problems can be addressed more immediately and those for whom lengthy and extensive service efforts are necessary to assist the family in reaching and maintaining an adequate level of functioning. In examining the length of service to study sample families, we found that of the 182 cases closed by summer 1999, service duration ranged from less than six months (25 percent of the study sample) to over 3.5 years (6 percent), with an average service duration of 17.5 months (SD=13.5 months). Greater service duration was associated with a higher number of presenting problems at intake, a higher mean service need, and the identification of children's health/mental health problems, parent's health/mental health problems, and children's needs, problems, and behaviors that were identified by the family's worker as sufficiently severe to place the child at high risk of out-of-home care. An open-ended approach to establishing service duration permits the Center's preventive program to serve differentially clients with problems that vary in nature, number, and severity.

Other Key Preventive Program Characteristics Discussed in Chapter 3 of the Book
Other characteristics discussed in depth in Chapter 3 of Nurturing the One, Supporting the Many include multiple service episodes over time, possible effects of flexible service duration on workers' satisfaction, staff accessibility, inclusive access to noncategorical services (i.e., continuous voluntary accessibility to all Center services over time, not labeling clients or services), and a supportive professional community.

The Preventive Program Staff

Staff Characteristics and Responsibilities

Throughout the research project and since, the number and responsibilities of the staff in the preventive program have remained fairly constant. Most staff members are assigned to the preventive program exclusively; some also carry assignments in other Center programs. In late 2000, twenty-one practitioners (eighteen females and three males) serve families in the preventive program, with a full-time equivalent of nineteen staff. Nine workers are bi-lingual (seven in Spanish and English and two in Chinese and English). Seventy-six percent (sixteen) of the preventive program staff members have served families in the program for over three years, and twelve of these for over six years. Eighteen have master's degrees in social work, and one is completing an MSW, one has a master's in divinity, and two have BSW degrees, one of whom is entering an MSW program. Each year, from September through May, the staff expands to include approximately six social work interns, completing the final year of a master's degree education.

Full-time preventive program staff serve an average caseload of sixteen to eighteen families at any point in time. Because of the long-term nature of the service to many families, the average annual caseload is only slightly higher. Staff work a minimum of seventy hours in a two-week period, thirty-five hours per week. Most report working several more hours per week, particularly during the school year (September - June) when the caseloads are higher, client groups are meeting regularly, and family members are available. Workers report that their time is allocated primarily to direct service with families. Supervision, staff meetings, and other collateral meetings require four to eight hours per week. Clinical case

supervision is provided by Sister Mary Paul, who has a doctorate in social work and who conducts intake interviews but does not carry a caseload, and by three M.S.W. supervisors who are also assigned cases. Paperwork requires two hours to one day per week or more, depending on the cycle of forms due.

To better understand the staff members' experiences with the preventive program, we asked them to identify what drew them to and retains them in the program, the characteristics that enhance effectiveness as a CFL preventive service worker, and their responsibilities, stresses, and supports.

Preventive Program Workers Are Drawn to the Program By . . .

As illustrated in previously cited excerpts from workers' interviews, the philosophy, model, and services available through the Center for Family Life's preventive program both draw social workers to and retain them in the program. In addition, preventive program workers greatly value the opportunities for professional development, the administrative support for autonomous professional practice, and, as described above, the supportive relationships with Center colleagues.

The program's staff members emphasize the strong appeal of both the community-based, comprehensive, holistic services model and the program's focus on the family as the unit of attention. Many commented that the model contributes to their being and feeling effective and emphasized the congruity of the Center's philosophy with their own values and beliefs.

Preventive program workers also consistently identified being drawn to the opportunities for professional guidance, support, and learning balanced with a respect for their competence, a respect that translates into a comfortable degree of staff autonomy. An experienced staff member elaborated:

They [Sister Mary Paul and Sister Geraldine] let you do your job. You don't have anybody on your back telling you what to do or checking on you. They know that you're doing the best you can. When I encounter situations where I feel I have to consult, I go and do it. I think the sisters particularly trust that I would never go overboard. . . The bottom line is that you're on your own, but not on your own, because you have supervision but they trust your judgment, and that's a great feeling. That's why I love this place.

Another, in describing her professional growth since joining the program staff, identified the multiple benefits derived from the relationship with her supervisor Sister Mary Paul:

I have never had a learning experience with a supervisor before this. . . She provides very strong guidance and support. And she is a resource. She has the power connection to say 'I know someone, I'll make a phone call for you.' Probably in almost every case I have, she's intervened in a way that has really helped move things along or she's put in a good word or she's signed her name to a letter. . . you know your back is always covered. I think sometimes in this profession you can feel very isolated. I feel very secure with her.

Perceptions of Characteristics That Enhance Practitioners' Effectiveness

We also asked the preventive program practitioners to describe the characteristics of social workers who are effective in the Center's preventive services program. Not surprisingly, the characteristic most frequently identified was flexibility -- particularly with regard to using multiple practice approaches and being open to differences: "*Flexibility -- being able to adapt and pitch in and change -- from the concrete to the more abstract. Being willing to look at things from different angles -- people's behavior and expectations.*"

Workers also consistently identified the importance of a practitioner's commitment to the Center's mission and comprehensive services model, to the program's clients, and to the family as the unit of attention. Respect for clients and a non-judgmental attitude were also stressed. For example, one worker explained: "*The cases run the gamut, and you really have to have a broadness of scope. You have to be constantly willing to learn about a variety of things and expect to hear a variety of things and be willing to want to try to understand.*" Professional knowledge and skill were also frequently reported to be important worker characteristics. Workers emphasized the necessity of sophisticated assessment skills, clear

professional and personal boundaries, and skills in the professional use of self, in working with children, and as a team member.

In addition, numerous personal qualities were identified as important. These included having strength, problem-solving ability, helpfulness, "*not being fazed by different kinds of things that come up*," compassion, "*a thick skin*," energy, independence, sensitivity, and consistency.

Stresses

As one would expect, the preventive program workers identified a number of stresses associated with their work. In reflecting upon these, three words were spoken again and again: "*responsibility*," "*ambiguity*," and "*unpredictability*." Practitioners described the stress associated with the responsibility conferred upon them by referring sources in cases where child abuse or neglect had occurred and recurrence was to be prevented, and by parents and children who desperately want for their difficulties to be resolved quickly. They also described the obligations they placed on themselves in making professional decisions associated with serving families and children who are at risk daily for suicide, family and street violence, teen pregnancy, dropping out of school, and other serious problems with life-long consequences.

Practitioners also identified as stressful what they described as an inherent ambiguity and unpredictability in implementing a service approach that involves continual interactions with family members and others in many community settings -- in families' homes, in practitioners' offices, in schools, on the streets. Cases in which family members are seriously depressed or angry were noted as particularly stressful because of the amount of energy required to manage one's own reactions to the client's emotions and behaviors when with them.

Practitioners also underscored the burden related to the enormity of many families' needs. For example, one worker explained: "*There are some days when you feel like you can never meet this family's needs. It is so overwhelming because there is so much to do and you only can do this much. It isn't even possible to do all that you could do if you spent every single hour.*" The quantity of paperwork also was identified as a stress, as were difficulties in accessing resources needed to help families, personal safety, and low salaries.

Supports and Benefits

As illustrated by interview excerpts in this chapter, workers identified the Center's preventive program model and the resources of the Center as major sources of support and security: "*I have the whole Center to help me.*" Workers stressed that the structured linkages to comprehensive services available within the Center itself were critical to their own effectiveness with clients. Accessible supervision was also consistently identified as very important, providing guidance, emotional support, options, and power - "*My supervisor opens doors for me.*"

Workers reflected upon the importance of "*not being alone with it*" in managing the case-related stresses. It is noteworthy that the workers' description of supports are echoed in a comment made by Sister Mary Paul as she discussed what helped her, as a clinical supervisor, manage the risk in a difficult case carried by one of the social workers she supervises: "*I think partly in this agency it's our joint and aggregate involvement in it [managing risks], it's not myself taking risks. It's others making contributions to the management of that risk. . . Everybody is a part of this client's care. It's an aggregate situation. I don't bear it on my shoulders alone.*"

As discussed earlier, the preventive program social workers also are supported by a "*community of colleagues*." In describing resources essential to managing the stress, several phrases repeatedly emerged: "*Collegial support*," "*a sense of community*," "*camaraderie*," and "*friendship*." From colleagues, practitioners reported receiving respect, acceptance, validation, ideas, and encouragement.

Practitioners emphasized that the opportunities for their own professional growth are among the benefits of staying with the program. For example, one noted: "*I've had some satisfaction from a sense that there have been sessions I've had with [a new client] that I know that when I first came here I wouldn't have*

been able to have because I would have been too shocked by the level of hostility in her. I feel pleased that I see some growth on my part."

Through the analysis of the qualitative data we have collected, we have found striking parallels in the experiences described by the clients served in the Center's preventive program and the experiences described by their workers. The parallels include their experiences of feeling respected, of finding the family focus and the flexibility valuable, and of being supported as they grow and change. Thus, the Center's preventive program philosophy and model not only meet the needs of clients, but also support the staff who serve them.

See Chapter 3 for Discussion of . . .

Chapter 3 in Nurturing the One, Supporting the Many also provides an extensive discussion of preventive program results for the children and caregivers in the study sample in three areas: The extent to which families' service needs were addressed; changes in final Family Assessment Form (FAF) Scores, a form developed by the Children's Bureau of Los Angeles (McCroskey et al. 1991; McCroskey & Meezan 1997); and study sample children placed outside the home. In addition, the study findings regarding the Center for Family Life's preventive program are examined in depth, both in terms of the relationship identified by program staff between the services model and their sense of effectiveness, work satisfaction, and retention with the program and with regard to the ways in which key characteristics of the preventive services model echo the methods used in the Minneapolis-St. Paul Family Centered Project over forty years ago (Overton & Tinker, 1957; Compton, 1981). The authors underline both the feasibility and the productive nature of serving families through a program with these key characteristics.