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Improving Service Delivery to High-Risk Families: Home-based Practice

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ABSTRACT: *Practitioners constantly seek innovative ways to improve service delivery to high-risk children and families who are isolated and unlikely to seek help at an agency. Home-based practice is rapidly becoming an alternative to practice in office settings. The authors describe the enhanced assessment and intervention opportunities afforded through home-based practice. Intervention and personal management skills needed to conduct effective home-based practice are described and illustrated.*

PRACTITIONERS CONSTANTLY seek new ways to reach and serve families who face multiple stressors and whose difficulties seem to grow ever more intractable. These families generally have multiple problems requiring intensive intervention in order to make a demonstrable impact (Reid, Kagan, & Schlosberg, 1988). They have been aptly described as "families in perpetual crisis" (Kagan & Schlosberg, 1989). Many families with multiple problems have had extensive but unsuccessful contacts with social service agencies. Agencies label these families as "hard core, deprived, distrustful, unmotivated, hopeless, and difficult, if not impossible, to reach" (Kaplan, 1986). From the family's perspective, agencies seem unresponsive to their needs, inflexible in their approach to problem solving, uncoordinated, and with an inadequate, individual-oriented approach to service. Consequently, families feel angry, antagonistic, and have negative expectations of agencies, given their history of hostile and failed experiences with them (Kaplan, 1986). Family problems are precipitated by a combination of complex environmental and interpersonal family conditions, such as poverty, poor health care, inadequate housing, violent communities, poor nutrition, child-behavior problems, lack of parenting and behavior-management skills, and educational failures, to name several. The combination and severity of these factors place families at risk of separating and increase the chance of children being placed in out-of-home care. Practitioners are challenged to find innovative ways to reach out to these families in crisis.

Although social work has a long and rich history of providing services to families in their home (Hancock & Pelton, 1989; Holbrook, 1983; Leiby, 1978; Richmond, 1917), many voluntary family service agencies (Schreiber, 1987) and child welfare agencies (Edna McConnell Clark Foundation, 1985) continue to offer services primarily in settings outside the home. This article examines the advantages of home-based practice with high-risk children and families, given the improved assessment opportunities and special treatment features home-based services offer. Practice and organi-

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zational skills that enhance home-based practice are discussed.

Home-based Practice for Assessment and Intervention

Home-based intervention offers many advantages and benefits not available in office-based treatment. First, home-based practice enhances assessment because it allows the practitioner to observe the family's natural environment (Woods, 1988; Hodges, Guterman, Blythe, & Bronson, 1989; Lerner & Halpern, 1987). Opportunities to assess family interaction, environmental resources, home-management skills, and social support are increased through home-based intervention (Hancock & Pelton, 1989; Tracy & Whittaker, 1990). A second advantage of home-based practice involves the increased opportunity to work with and within the family's natural environment. Often, interventions that emerge from office-based counseling sessions are difficult or impossible to implement because of environmental obstacles. Working within the family's environment facilitates identification of potential implementation problems, environmental or otherwise, and allows immediate modification of these interventions. Moreover, resources in the family's environment are more easily identified, engaged, and coordinated in home-based work. Finally, home-based services allow practitioners to reach out to isolated families. Many families live in rural areas or are unable to secure child care or transportation and, therefore, find it impossible to meet with a worker in an agency on a regular basis (Woods, 1988; Balgopal, Patchner, & Henderson, 1988). Delivering services in the family's home provides an alternative for those families who would ordinarily not be able to receive regular services.

Home-based Assessment

Home-based services facilitate enhanced assessments because the practitioner is able to interact and observe family members in their natural environment as well as to engage clients who might otherwise be reluctant to participate (Kagan & Schlosberg, 1989; Balgopal et al., 1988; Soreff, 1985; Stroul, 1988). Mary Richmond (1917) spoke of the advantages of conducting initial assessment interviews in the home, noting that workers are able to observe current living conditions and family-interaction patterns that are difficult to assess accurately and fully in an office interview. Examples of observations made during home-based assessment include safety; cleanliness; organization of the home; geographic proximity to public transportation, schools, stores, and place of employment; access to playmates for children living in the home; family interactions; and neighborhood safety. In families in which child sexual maltreatment is a concern, for example, child safety and privacy are more easily evaluated because living and sleeping areas and the availability of doors and locks can be observed and discussed with parents and children. Similarly, during an initial home visit, the practitioner might inquire about photographs or pictures in the family's home. Such inquiries provide opportunities to learn more about family, friends, and possible social supports.

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In addition to observing the family in its natural environment, home-based assessment allows the practitioner to meet and talk with extended-family members, significant others, or neighbors who otherwise might not be present at an assessment interview in an agency (Woods, 1988). These persons can be helpful in providing information about the local school system, neighborhood resources, formal and informal child care, peer groups for children, and other issues that are important for planning family interventions. For instance, long-time neighborhood residents are helpful informants about community safety and neighborhood leadership. Organizing and mobilizing community support for an after-school recreation program might be an important means of providing supervised and meaningful activities for youth who are at risk of being recruited into neighborhood gangs.

Home-based assessments also allow practitioners to observe and learn about the cultural practices of families, particularly ethnic-minority families. For example, home-based practice can provide workers with insight into cultural values and beliefs (Mokuau, 1990; Derezotes & Snowden, 1990), religious practices and rituals, home governance and leadership, spoken and unspoken family rules, and child-rearing practices. Knowledge of a family's ethnic identity and cultural traditions helps practitioners plan interventions that are culturally consistent with the family's beliefs and practices. For example, in African American single-parent families, the oldest child is often given responsibility for assisting with the care and upbringing of younger siblings. The oldest child might help with supervising, clothing, feeding, preparing meals, and organizing recreation. Single parents depend on older children to assist with caretaking functions that are generally considered parental responsibilities by other families. Observing the actual performance and rewards of these roles prevents practitioners from quickly judging that a mother, for example, is placing unfair burdens and responsibilities on a child or that the child is ill-equipped for the tasks.

These assessment issues are illustrated in the following case example.

> M, a 10-year-old, resided in a low-income housing community with his mother. He was referred to the school social worker for attendance problems.
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> During the home-based assessment, the school social worker learned that M's mother left for work at 6:00 A.M. M was responsible for waking up, preparing his own breakfast, and catching the bus by 8:30 A.M. He had an alarm clock but reported staying up late at night and ignoring the alarm in the morning. M's mother was very concerned about his attendance problem but noted that she had no other option but to arrive at work by 6:30 A.M. However, she had left a note each morning reminding M to eat breakfast and get to the bus stop by 8:30. She believed that he was old enough to be responsible for his morning routine.
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> During the home assessment, the worker noted that the apartment was clean and modestly furnished. M had his own bedroom and toys. The worker also noted a walker in the living room. When she inquired about the walker, she was told that M's maternal grandmother lived nearby and used the walker when she visited.
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> The worker also observed several arguments in which M's mother would ask her son to do something (get plates for dinner, get ready for bedtime) but would not follow through with encouragement, reminders, or disciplinary consequences to make him follow her instructions. Because the initial visit lasted well past 9:00 P.M., the worker witnessed M's successful attempts at staying up late to watch movies, a major contribution to his oversleeping.
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> During the home visit, the social worker also learned that most of M's friends were considerably older—14- and 15-year-old boys. These boys frequently skipped school and persuaded M to join them. M's next-door neighbor shared her concern that M and his friends would often return home soon after 9:00 A.M. and would remain in the house until 3:00 P.M., when his mother returned home from work.

The home-based assessment helped the worker uncover several environmental factors that were contributing to the school-attendance problem. The worker learned that M's mother worked the first shift and therefore M was responsible for completing his morning routine and departing for school without supervision. The next-door neighbor volunteered to the worker that on some occasions older boys in the neighborhood persuaded M not to attend school. Finally, the worker was able to observe M persuade his mother to ignore his regular bedtime. Aided by the additional information provided by the home-based assessment, the practitioner developed an intervention plan that targeted both the mother's enforcement of bedtime rules and routines as well as M's temptation to skip school with the older boys

Home-based Intervention

Intervention strategies used in the home closely resemble techniques used in agency settings. For example, practitioners employ skills in relationship building, skills development (e.g., parenting, anger management, assertiveness), counseling to resolve interpersonal or intrapersonal conflict, advocacy, and/or the provision of concrete services (e.g., transportation, child care), depending on the needs of the family. Home-based treatment, however, has the added advantage of increasing the likelihood of working with all family members, engaging isolated families (Soreff, 1985), and tailoring interventions to respond to the particular environmental obstacles in individual family homes.

To begin, home-based services are more likely to promote the participation of all family members in assessment and treatment. Although a problem may be "assigned" to one family member, several or all members may contribute to the problem and thus could play a role in ameliorating it. Family members may inadvertently reinforce behaviors of one member that the worker is trying to change, reduce, or eliminate. Working with other family members can be crucial in resolving the target problem. For example,

> a mother was trying to be more consistent in managing the behavior of her two-year-old daughter through rewards and punishments, but was frustrated at the apparent lack of improvement in the child's temper tantrums. During a home meeting, the worker discovered that the grandmother, who also lived in the home, gave the child considerable attention and whatever she asked for when the child had a tantrum. The opportunity to learn about the grandmother's behavior would not have been possible without the home session. The worker was able to include the grandmother in subsequent sessions, thereby helping her to understand the importance of responding consistently to the child.

Home-based treatment also allows workers to engage hard-to-reach, isolated families. Home-based assessment and treatment services demonstrate practitioners' willingness to extend themselves beyond usual practice settings to reach out to these families. Outreach efforts are especially important to isolated families and families with problems so severe that agency contact is unlikely to occur (Kagan & Schlosberg, 1989; Olds & Kitzman, 1990). Families become isolated for many reasons, including inter- and intrapersonal conflict as well as environmental and physical obstacles such as lack of transportation or adequate child care. Some families may be in a state of crisis or overwhelmed by stressors in their environment and thus unable to make weekly visits to an agency. Engaging these clients in office-based programs is extremely difficult. Family routines need to be stabilized and transportation and child care arranged. Moreover, many families have had negative experiences with social service agencies. Balgopal et al. (1988) supported the use of home-based practice to treat families who show a general reluctance to receive any type of social service assistance. The potential for client engagement and follow-through is increased when the social worker makes an effort to meet the family on "their turf."

Home-based treatment may be particularly appropriate for adolescents and their families. Children and adolescents may feel more relaxed in their own environments. Schlacter (1975) indicated that home treatment was useful when teenagers were involved because the home environment allowed the teenager the freedom to relax, dress comfortably, and generally feel more at ease. Home-based services are often termed "treatment in the family setting." Treatment can also occur in other areas of the family or community environment, such as the worker's car (while providing transportation for a family member), at school (while working to increase parental involvement with the school), or even at a local fast-food restaurant. Staff at Homebuilders, an agency that provides home-based services exclusively, have noted the success of "McDonald's therapy" and the greater ease with which teenagers can discuss personal issues while looking straight ahead in a moving car, as opposed to during face-to-face office meetings (Kinney, Madsen, Fleming, & Haapala, 1977; Kinney, Haapala, Booth, & Leavit, 1988).

Finally, home-based treatment facilitates environmental modification. Frequently, interventions that are suggested in family treatment are difficult to implement because of environmental obstacles, both within and outside the family. The ability to work with environmental resources and constraints increases the chances that the intervention will be implemented as intended. For example,

> a social worker developed a goal to increase the percentage of homework completion for an adolescent girl. The teenager was at risk of being retained in her current grade because of lack of progress. Her teachers felt that her failure to complete homework was largely responsible for her school problem. The practitioner helped the family develop a behavioral contract in which the daughter was rewarded each night for completing homework. The parents were in close contact with the teacher and assumed an active role in monitoring homework completion. During a home visit, however, the worker observed the daughter working on her homework in the living room. She was distracted by the television and the conversation of other family members. The contract had been in

effect for three nights, yet the daughter had earned a reward for only one night. The social worker suggested that the teenager study in the kitchen or her bedroom, where she would not be disturbed. This simple environmental modification increased the homework completion rate to 60% the following week and 80% the third week. In addition, the amount of time spent on homework decreased as the distractions decreased. The teenager was able to spend some time with her friends after completing her studies. The homework distractions might not have been discovered and the contracting might have failed had the worker not made the home visit.

Practice Skills for Providing Home-based Services

Because home-based practice is carried out in a less structured setting and in a family setting that may be unfamiliar to the worker, it is important to develop and refine skills in diplomatic assertiveness, organization and planning, and personal and professional flexibility.

In home-based practice, social workers must practice diplomatic assertiveness to structure the time during home sessions. Assertiveness helps workers deal with issues related to control and to working in the family's space. For example, social workers might occasionally find that families are distracted by stimuli in the home environment (telephones, radio and television, neighbors, and other visitors). Instead of asking a family member to turn off the television or radio or to lower the volume during the home meeting, the worker might make an "I" statement regarding his or her inability to hear someone. Or the worker might speak in a softer tone of voice to highlight the interference from the TV or radio. In another case, the worker might find visitors in the home when he or she arrives for a regularly scheduled meeting. Rather than asking the visitors to excuse themselves from the room during the meeting, the worker should check with the mother or authority figure in the family to see if she or he feels comfortable with the visitor as a form of social support and/or potential participant in the session.

During a recent home visit, the first author encountered a mother who was unable to remain engaged in the meeting for more than five minutes. She constantly left the room to go to the kitchen or to find cigarettes or coffee. The worker stated that she had a difficult time following the conversation and asked that the mother try to attend to the meeting for at least 15 minutes at a time. The mother was given the opportunity to gather cigarettes and coffee before the meeting began and then every 15 minutes afterward. Thus, the social worker's assertive comment clarified her expectations for the visit and enabled the parent to work actively toward accomplishing agreed-upon treatment goals.

Organizational and planning skills are also helpful in home-based practice. These skills include the ability to plan effectively and realistically in scheduling activities so that time and energy are used efficiently (Norris-Shortle & Cohen, 1987; Stroul, 1988; Wasik, Bryant, & Lyons, 1990). Social workers delivering in-home treatment must be skilled in planning individual sessions, because such in-home treatment occurs in the midst of the family's daily life and thus is subject to numerous distractions and crises.

Home-based assessment and treatment services demonstrate practitioners' willingness to extend themselves beyond usual practice settings to reach out to families. Outreach efforts are especially important to isolated families and families with problems so severe that agency contact is unlikely to occur.

Developing an informal client contract can be a useful tool for general case planning. The contract specifies goals and objectives of treatment in small, achievable steps and delineates who will be involved in the change effort. The contract helps workers plan short-term, focused intervention as well as predict the length of treatment (Gambrill, 1977; Gambrill, 1983). Both long- and short-term contracts are helpful intervention tools. For example, short-term contracts with clearly stipulated contingencies are especially useful for working with children and adolescents who have short attention spans and require immediate reinforcers. For example, a short-term contract was used with a teenager who was skipping school to be with his girl friend. The conditions of the contract were simple. If the teen attended school each day for one

week, he could earn money to buy a T-shirt he had been wanting for several weeks. In some cases, a longer, more formal, contract may be useful. For example, contracting was helpful in providing court-ordered aftercare services to a child recently discharged from residential care. The contract specified the goals of the court, parent, aftercare worker, and child. It also delineated tasks and responsibilities for each goal, expected outcomes, and the anticipated time frame for completing individual goals as well as terminating services. This contract was especially helpful to the parent, who was hesitant to participate in treatment due to her anxiety regarding the specific purpose and length of the intervention.

An agenda is another helpful planning tool for keeping workers and families on task during home meetings. In organizing a home session, a worker might suggest that the family develop a list of items that they would like to discuss during the next home meeting. The worker could also develop a similar list. When all parties present their agenda at the beginning of the next home meeting, the worker and the family can then structure the session so that all agenda items are discussed. For example,

> in counseling the parent of a developmentally disabled child, one worker found that an agenda helped to organize home-treatment sessions. The mother tended to persist in discussions of the child's poor self-help skills while finding it difficult to identify any improvements in the child's academic and social development. To elicit a more balanced discussion of both parental concern and child progress, the worker suggested that the mother outline items to discuss at the next home session. The mother was instructed to include self-care problems as well as improvements in other areas. The worker also suggested that the mother prioritize agenda items and specify the time needed to discuss each item. By organizing the meetings around the mother's agenda, the worker was able to address all of the parent's concerns as well as encourage the mother to acknowledge some improvements and implement additional treatment activities during each session.

Although diplomatic assertiveness, organization, and planning help avoid distractions and allow the worker and family to adhere to a treatment plan, sometimes clients' crises or other needs demand immediate attention. Thus, successful home-based practice requires flexibility, the ability to adapt easily to change. Workers need to be flexible in scheduling, selecting treatment approaches, and implementing treatment goals. For example, home-based workers often schedule meetings with family members on weekends and evenings. Virtually all agencies with this type of program offer staff flextime to enable workers to adjust their schedules so that they are available to families when needs arise, not only when the agency is open. If the family is in the midst of a crisis when the worker arrives, the worker must be flexible in intervention planning and implementation and prepared to help the family respond to the crisis (Stroul, 1988). Whether the response is direct help in resolving the precipitating problem or teaching the family coping behaviors to avert a future crisis, practitioners need to be flexible. Flexibility is required in other circumstances as well. For instance, it may be necessary to carry on family work while a soap opera is on TV if having it on seems to reduce a family member's anxiety or enhance relationship building. In short, practitioners must be able to make decisions quickly as new information becomes available.

Conclusion

The search for more accountable and effective social work services has challenged workers to examine many aspects of practice. Home-based practice offers an innovative way to reach out to high-risk children and families who are unwilling or unlikely to engage in agency-based treatment (Lerner & Halpern, 1987; Holliday & Cronin, 1990). The growth in the number of home-based programs over the past 10 years indicates that service delivery in the family's home is effective (Bryce & Lloyd, 1981; Compher, 1983; Frankel, 1987; Maybanks & Bryce, 1979; Stein, 1985).

Home-based practice offers many advantages over agency-based services. Workers are able to observe family interactions and dynamics, to make more accurate assessments of target problems, and to plan interventions designed to address the specific needs and conditions of the family. Many of these objectives are difficult, sometimes impossible, to accomplish in an agency setting. More research is needed to evaluate the limitations and liabilities of this mode of

practice. For example, does home-based practice put practitioners at increased risk of personal injury? Do the intensity and crisis potential of home-based practice accelerate problems of burnout among practitioners? These and other questions need to be studied.

Home-based intervention programs operate in various settings (Maybanks & Bryce, 1979). Although these efforts are commended, practitioners need to consider how they might incorporate and refine home-based services in their practice with high-risk children and families.

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