

PARENTS . . .

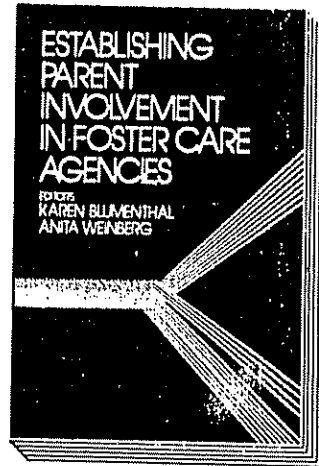
AN UNDER-UTILIZED RESOURCE IN FOSTER CARE AGENCIES

According to ESTABLISHING PARENT INVOLVEMENT IN FOSTER CARE AGENCIES, turning agency practice in new directions takes hard work and planning, but it is not an impossible or unrewarding task. The text offers many useful examples of agencies who have undergone both structural and philosophical changes that alters over a century of practice based on child-centered services.

PARENT INVOLVEMENT discusses the "how-tos" of strengthening and reuniting severed family ties, thus reducing the child's psychological separation from the parent during placement. Agency administrators and their staff who recognize worker-parent teamwork as a critical component of foster care services will find this publication invaluable in achieving permanency goals for children.

PARENT INVOLVEMENT is a product of the Permanent Families for Children Project at the Child Welfare League. The project director, Elizabeth Cole, remarks, "Let's face it, it is easier to leave decisions to the agency, and perhaps, to the foster parents. It is also wrong. It encourages parents to avoid their responsibility to their children and we must not do that. Clearly, here is evidence of the need to retain ties between parent and child when the actual parenting role must be taken on by someone outside the family."

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PROGRAM DEVELOPMENT

Home-Based, Family-Centered Services: The Impact of Training On Worker Attitudes

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After training workers, supervisors, and administrators in intensive in-home family treatment as a means of preventing foster care placement, significant shifts in worker attitudes occurred, particularly in five important areas of case activity.

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As a result of the permanency planning movement, many state social service agencies have reduced the number of children in foster care [Lahti, 1982; Magura 1979; Murray 1984; Stein et al. 1978]. For example, Utah reduced the number of children in foster care from 1,250 in 1980, to approximately 1,100 in 1983, despite large increases in the state's population. As more children are returned home or adopted, child welfare agencies are focusing on service strategies for *preventing* foster care placement. One such promising strategy is intensive home-based family treatment, sometimes known as Home-Based Family-Centered Service (HBFCS) or Services to Children in Their Own Homes (SCOH) [Bryce and Lloyd 1981; Compher 1983; Kinney et al. 1977; Maybanks and Bryce 1979; Overton 1953].

States adopting this approach may need to address worker attitudes toward HBFCS while providing workers with new knowledge and skills [Haapala and Kinney 1979]. After reviewing home-based family-centered services we describe recent pertinent training and the accompanying shifts in worker attitudes.

Home-Based Family-Centered Services

Home-based family-centered service refers to a method of service delivery to children and families in their own homes. The service is as extensive and intensive as required to maintain and strengthen families [Lloyd and Bryce 1980]. Comprehensive home-based programs often include a variety of traditional and nontraditional child welfare service components (e.g., home-maker service, respite care, transportation, emergency child care, cash assistance, alcohol or drug treatment, vocational counseling, family therapy) to provide help with any family need or problem that may be contributing to the need for child placement. The key to this strategy is that the primary site of family work is in the home. Although home-based service programs vary, most models share the following features in some degree:

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

- Small caseloads, staff availability, and the use of a wide variety of helping options are stressed.
- Services are available 24 hours a day to assist clients with crises.
- One or more staff members serve as team members or provide back-up to the primary worker.
- The home is the service setting and maximum use is made of natural helping resources, including the family, the extended family, the neighborhood, and the community.
- The parents remain in charge of and responsible for their family as educators, nurturers, and primary care givers.
- Programs are willing to invest at least as much in a child's own family to prevent placement as society is willing to pay for out-of-home care for that child [Bryce and Lloyd 1980].

There is a growing body of literature on both the service components and cost effectiveness of home-based treatment programs, providing many state administrators with the information necessary to redesign their programs and obtain supplemental appropriations [Lloyd and Bryce 1980; National Clearinghouse for Home-Based Services to Children 1982]. As Horejsi and others have written, however, recent research findings regarding effective practice methods and accompanying technological developments in social services are often insufficient to bring about service delivery change or improve program effectiveness without a supportive ideology [Bronston 1975; Horejsi 1982; Morales and Sheafor 1980; Wolfensberger 1972].

In many instances, new staff attitudes as well as service priorities must be established if the technological or practice innovation is to succeed. For example, adoption changes, state or federal adoption subsidies, and placement of special-needs or minority children would not have been achievable if significant shifts in worker attitudes had not occurred with respect to the adoptability of certain children and the importance of a "forever home" [Churchill et al. 1979].

Administrators and supervisors have been discovering that attitudinal as well as technical program shifts may be necessary to implement home-based services. For example, the following treatment principles used by the Homebuilders program in Washington State may be different from or conflict with certain more traditional child welfare service approaches or family therapy models:

- deemphasizing previous diagnoses

- emphasizing an understanding of the client's present situation
- providing "hard services" such as moving, cleaning, and grocery shopping with clients
- giving out therapist and supervisor home phone numbers
- routinely working nights and weekends
- never insisting that all family members participate in the treatment sessions
- seeing clients in their homes whenever possible rather than at the agency office
- minimizing the use of labels or professional jargon
- allowing clients, at least initially, to set service priorities with casework directed at the client's top priority [Haapala and Kinney 1979; Kinney et al. 1977, 1981]

When attitudes as well as skills must change for a program model to succeed, one way to accomplish this is through staff development programs that focus on attitude change through skill building and review of innovative program models. Following are the results of a workshop evaluation of such a training program.

Method

Description of the Training

During May 1984, staff members from the Utah Department of Social Services and four voluntary child welfare agencies attended 2-day training sessions on home-based service, involving three sessions for 22 to 27 participants. The training was provided by the staff of the Homebuilders program of the Behavioral Science Institute, a HBFC service agency located in Washington State.

Training topics and learning objectives were determined mainly by a needs assessment conducted with child welfare supervisors at a supervisory skills workshop held in January 1984. The training was directed to six principal topics:

1. Strategies of In-Home Service: Homebuilder's Model
 - values and beliefs
 - role of the worker
 - program structure

2. Stress Management
 - worker self-awareness
 - worker stress reduction
 - application to families
3. Structuring to Prevent Crisis Recurrence
 - structuring before going out on a family visit
 - structuring during visits
 - structuring between visits
4. Defusing, Engaging, and Confronting Family Members
 - handling unmotivated and resistant families
5. Assessment and Goal-Setting
 - a model for assessment
 - helping families set priorities
 - goal-setting and evaluation
 - cultural values and treatment goals
 - strategies for coping with a lack of progress
6. Client Transfer and Continuity

Sample

A total of 72 staff members participated in the training—59 workers and 13 supervisors/administrators. Most of the participants were child protective supervision workers who focus on improving family functioning to prevent child placement in cases of child abuse or neglect. A slight majority of participants (37, 51%) held a graduate degree in social work, with a greater percentage of the supervisors (32%) holding an M.S.W. degree. The second most frequent educational category was a bachelor's degree in one of the social sciences. Most (42, 60%) of the participants had over 5 years of experience in child welfare, indicating that this group as a whole is roughly comparable to child welfare staff members nationally in that line staff generally have less than 5 years of experience, and supervisors have about 10 [Vinokur 1983, 7].

Procedure

As part of the workshop, an assessment form was administered to each participant at the beginning and the end of training. On a 7-point Likert scale, participants were asked to rate their degree of agreement with specific practices or attitudes related to the Homebuilder philosophy of home-based care. Two items relating to release of home phone numbers and client labeling

TABLE 1 Pre- and Post-Training Attitude Ratings^a
N = 56

	<i>Median</i>	<i>Median</i>	<i>Z Score^b</i>
	<i>Pre-Training</i>	<i>Post-Training</i>	
	<i>Rating</i>	<i>Rating</i>	
1 Usually disregard previous diagnoses	2.8	4.3	-4.44 ***
2 Spend little time focusing on understanding the past.	3.0	5.2	-4.55 ***
3 Provide "hard services," including moving, cleaning, and grocery shopping with clients.	4.1	5.8	-4.82 ***
4 Ask clients to set and prioritize their own goals	6.0	6.3	-2.75 **
5 Never insist that all family members participate	2.3	5.0	-4.53 ***
6 Focus on dynamics or personalities rather than teach skills	3.0	2.3	-1.74 NS
7 Actively pursue reluctant clients through repeated calls, letters, and visits	4.7	5.2	-0.35 NS
8 Rarely "confront" clients	2.4	3.0	-3.684 ***
9 Never give out home phone number	4.1	3.3	-2.79 **
10 Rotate to be on call and to be available for emergency visits to clients 24 hours/day, including holidays	5.0	5.1	-0.89 NS
11 Routinely work nights and weekends	3.0	4.5	-3.68 ***
12 Deliver most services in the home environment	6.1	6.5	-2.62 **
13 Schedule appointments at the convenience and preference of clients, not workers.	4.7	5.9	-4.21 ***
14 Ask clients to evaluate workers	5.0	5.2	-2.45 *
15 See clients within 24 hours	5.9	6.2	-3.06 ***
16 Limit in-home services to a 4-6 week period	4.1	5.2	-4.02 ***
17 Therapists can do as much harm as they can do good	5.5	6.1	-2.96 **

TABLE 1 Pre- and Post-Training Attitude Ratings^a
N = 56 (continued)

	<i>Median</i>	<i>Median</i>	<i>Z Score^b</i>
	<i>Pre-Training</i>	<i>Post-Training</i>	
	<i>Rating</i>	<i>Rating</i>	
18 Labeling is productive in working with families.	2.6	1.7	-2.22 *
19. It's our job to motivate clients	5.1	5.3	-0.27 NS
20. There are more similarities than differences between clients and workers.	5.2	5.9	-3.31 ***
21 People are doing the best they can.	3.5	6.0	-5.31 ***
22. The term "family therapy" has very little meaning when used in a case plan	2.9	3.8	-2.95 **
23 Most kids are better off in their own homes	6.4	6.8	-2.52 *
24 It is important to minimize barriers to clients receiving services	6.2	6.6	-3.33 ***
25 Clients have better information about their situation than professionals do	5.5	6.4	-4.65 ***
26 If a worker never consults with other staff, something is wrong	5.9	6.4	-2.81 **
27 There are few "right" answers in our casework with individuals and families; only options, with pros and cons	5.9	6.6	-3.86 ***

^a Agreement with each of the attitude items was rated on a 7-point Likert scale with the following scale anchors: (1) disagree strongly; (4) neutral; and (7) agree strongly.

^b Shifts in attitudes were tested using Wilcoxon Sign Test of Significance

* $p < .05$

** $p < .01$

*** $p < .001$

were phrased in reverse of Homebuilders practices to encourage individualized rating of each item. The assessment form was developed by Homebuilder staff members for this evaluation and represents many of the essential "practice principles" or attitudes of the program. With few exceptions, training participants found the items to be clear. However, no formal tests of reliability or validity were conducted (see "study limitations" section). The

assessment form was administered at the end of the training to determine the extent to which worker attitudes shifted as a result of the training. (See table 1 for a complete list of the practice attitudes used in the pre- and post-training assessment forms.)

Results

Attitude Ratings

Of the 72 participants who attended the workshop, 56 completed both the pre- and post-measures. To determine if significant shifts in worker attitudes had occurred, the Wilcoxon Sign Test was used to analyze the data statistically. The Wilcoxon test was employed because an ordinal rating scale was used, and the distribution of the data was skewed. Attitudinal ratings are presented in table 1.

Statistically significant differences in worker attitudes were noted in 23 of the 27 items. Some of the most significant shifts occurred in the area of disregarding previous diagnoses, focusing on the present experiences of the family, participation of available family members in therapy, the advantages of time-limited treatment, allowing clients to set their own treatment goals, and the advantage of delivering services in the home environment.

Workers responded on the pre-assessment with fairly traditional casework attitudes. After the training the ratings shifted toward agreement with Homebuilder beliefs about practice. For example, in the pre-training condition, workers strongly disagreed that previous diagnoses should be disregarded. By the end of training most workers believed that previous diagnostic labels should be minimized in assessing family situations. Before training, participants strongly disagreed that little time should be spent focusing on the past. At the end of training, strong agreement to *not* focus on the past was expressed by the majority of workers.

Similarly, workers initially insisted that all family members participate. At the conclusion of training workers strongly agreed that it may not be possible to involve all family members and therefore it is more effective to work with the family members who are available for each session. On the pre-assessment, workers were not convinced that family members are doing the best they can. On the post-assessment, workers' attitudes shifted significantly toward agreeing that family members are doing the best they can, given current family circumstances and the family's current repertoire of skills.

In addition, workers became more convinced that services should be delivered in the home, perhaps as a result of a discussion of the assessment

and skill-building advantages of in-home treatment. Another shift occurred regarding phone contacts with staff members. Workers were at first quite uncomfortable with the idea of providing clients with their home telephone numbers. After the sessions the most frequent response was "strongly agree," although wide variation in worker attitudes remained for this item.

In four areas there were no statistically significant attitude shifts because workers felt from the beginning that (1) the staff should focus on teaching skills rather than on dynamics or personalities; (2) reluctant clients should be actively pursued through repeated calls, letters, and visits; (3) in-home treatment staff should rotate on-call and be available for visits to clients 24 hours per day, including holidays; and (4) home-based service staff should try to motivate their clients.

Study Limitations

Because no reliability analyses were conducted for the survey, the attitude change data must be viewed with caution. One of the limitations in the assessment form was some ambiguity on a few of the items, such as item 8—(workers should rarely confront clients), and item 22—(the term "family therapy" has very little meaning when used in a case plan). Although both items yielded significant results, there was some concern about the clarity of these statements, and only limited inferences can be made about the degree of attitude change for these items.

Continued worker interest in the HBFCS concept and subsequent staff support for starting three new pilot projects in the state of Utah offer some evidence that attitudes toward HBFCS did actually change. It is possible, however, that many worker attitudes were close enough to those of the trainers before training that active support of this concept by the trainers and the state administrator during the workshops gave the trainees "permission" to express their beliefs.

Another limitation in the study concerns predicting the duration of the attitude shifts. Without follow-up research it is difficult to ascertain what attitudes workers will use in their practice and whether workers will maintain these attitudes over a longer period of time. As workers incorporate new attitudes and skills into their practice, will their attitudes be modified because of caseload, administrative, supervisory, or co-worker factors?

Discussion

Shifts in attitudes following the training that has been described may be important at three different organizational levels.

Referring Workers

Even if workers who receive training are only going to refer cases, an attitude more supportive of home-based services may help substantially in identifying appropriate cases, giving an initial description of home-based services to the family, and coordinating the referral to the home-based worker. Trained referring workers are more likely to support efforts to keep children in their homes when they recognize the financial and family integrity advantages associated with home-based care.

Home-Based Family Workers

Building a certain set of attitudes may reduce the on-the-job-training necessary to raise new workers to the standard expected of an experienced home-based staff member. These attitudes may also encourage workers to engage in more supportive behaviors, including the offering of concrete services and the use of a flexible intervention style with families—all of which increase the chances of successful treatment with difficult or reluctant clients [Haapala and Fraser 1984; Hartman and Laird 1983; Polansky et al. 1981].

Policy Makers

The results of this study also have important implications for policy makers. Many public agency administrators and juvenile court judges are only now struggling with implementing the section of Public Law 96-272 that requires that states document in the case records of children being placed what services were provided in an attempt to *prevent* out-of-home placement. In the past, state policies often discouraged pre-placement preventive services because of misdirected federal funding incentives [Children's Defense Fund 1978]. New federal fiscal incentives in Public Law 96-272 may increase the support of policy makers for a home-based perspective.

Research Suggestions

Further research is necessary to test the hypothesis that there is a relationship between a "pro-home-based services attitude" and "pro-home-based worker behavior." Another research question concerns the minimum amount of training time necessary to change worker attitudes toward various aspects of home-based services. It is also important to study the duration and intensity of worker attitude change and what factors strengthen or weaken a worker's perception of the importance of family preservation through home-based

Assuming that actual changes in worker attitudes occurred, what accounted for the shifts of these staff members? A number of factors may have been operating, all of which need further examination: one factor implies that attitude changes were accomplished through exposure to two experienced trainers/workers who shared their beliefs and attitudes about effective home-based services. A second is the effect of using as trainers two out-of-state "experts" who came with credible evidence of HBFC effectiveness. Third, the issue of "social desirability" may bring about shifts because trainees wish to please trainers. A fourth factor might have been the combination of skill development and attitude shaping that was used; trainees learned new concrete skills and also discussed beliefs that undergird them.

The answers to such questions may further our appreciation of the role and function of beliefs and perceptions upon worker behavior, as well as provide practical information that could be used to more effectively influence worker attitudes and behavior regarding HBFC service. ♦

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