The Self-Sufficiency Project

Practice Manual

The National Resource Center
    on Family Based Services
The University of Iowa
School of Social Work
Iowa City, Iowa 52242

June 1992

PRACTICE MANUAL

THE SELF-SUFFICIENCY PROJECT

National Resource Center on Family Based Services
University of Iowa
School of Social Work
112 North Hall
Iowa City, Iowa

in collaboration with

Children's Services Division-Douglas Branch
Roseburg, Oregon

Principal Author: Marcia S. Allen

Contributing Authors:

Lori Allen
Anita Ambrosini
Michael D'Angelo
Miriam Landsman
Kristine Nelson
Jim Nice
Cheryl Owens
Joseph Reiter
Mark Stern
Sandra Zontec

June 1992

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

CHAPTER 1

INTRODUCTION: THE SELF-SUFFICIENCY PROJECT

The Self-Sufficiency Project was a three-year demonstration and evaluation project funded by the Department of Health and Human Services and carried out by the National Resource Center on Family Based Services, University of Iowa School of Social Work (NRC) and the Oregon Children's Services Division, Douglas County Branch (CSD). The NRC was responsible for administering and evaluating the project. The target population for the project was "chronically neglecting" families--families referred repeatedly for allegations of child neglect and regarded as being at high risk of continued neglect.

The primary goal was to intervene in patterns of neglectful behavior through empowerment-based practice. The core component of the Self-Sufficiency Project (SSP) was weekly group meetings consisting of adult groups, children's groups, a shared meal, and multiple-family therapy groups. Additional services such as in-home parenting, parent training classes, substance abuse treatment, and Headstart, were included in individualized service plans at the option of each family. Services were provided from July, 1989 through May, 1991, with additional time for project design and evaluation.

The project site, Douglas County, Oregon, has a population of 92,150. Its principal city is Roseburg, but many families live in isolated rural areas, and transportation is a major problem. The population is largely Caucasian, with very few minorities, and the primary industry is timber. Douglas County has been experiencing economic depression for more than a decade, though it was recovering slightly at the time the project began. Douglas County is also one of the largest producers of methamphetamines in the country, and drug addiction is prevalent.

The Self-Sufficiency Project was evaluated through the collection and analysis of data on each family, including demographic and service history, observational and self-report measures of child well-being, self-esteem, depression, parenting, child development,

1

and family satisfaction. In addition to an analysis of the group data, single-system analysis of selected cases provided an in-depth look at the process of change. Finally, interviews were conducted with project participants to understand and document their perceptions of the project.

The project proved to be highly successful for about half of the 31 participant families, many of them making significant changes in their lives. Founded reports of neglect subsequent to their involvement with SSP were few. This Practice Manual and accompanying Final Report provide more specific information about treatment methods and results.

CHAPTER 2

PROJECT PHILOSOPHY

In developing a model for effective treatment of child neglect, Hartley (1987) identified eight characteristics of neglectful families:

1. <u>Intergenerational legacy of neglect</u>. Studies suggest that there is an intergenerational pattern of neglectful behavior (Polansky et al., 1981, p. 18), but that this pattern is amenable to change (Main and Goldwyn, 1984, p. 214). Because the family of origin strongly influences the next generation of parents, it is important to engage parents in an interaction with or about their family of origin, with the aim of understanding and changing their current family system when this is appropriate.

2. <u>Inadequacy of positive external support</u>. A number of studies have indicated that neglecting families typically lack positive support from their own kin or community (Giovannoni and Billingsley, 1970, p. 199; Polansky and Gaudin, 1983, p. 273) and that neglecting families expect and look for indications of rejection from their neighborhood (Polansky and Gaudin, 1983). A model program must help families develop or enhance a positive support system.

3. <u>Parent/child attachment issues</u>. Infant/parent attachment problems may be particularly prevalent among neglectful families (Egeland and Stroufe, 1981, p. 51). A model program should assess attachment of parents to young children and develop strategies for improving attachment when this is warranted.

4. <u>Low self-esteem</u>. Previous research has found neglectful families to have dominant feelings of futility and emotional numbness, superficial interpersonal relationships, a sense of loneliness and incompetence, passively and aggressively expressed hostility, and a lack of commitment to positive positions; they have been reported to be verbally inaccessible to others and to lack an internal dialogue with themselves (Polansky et al., 1981, pp. 39-40). Improved self-esteem is a much desired outcome with families exhibiting these problems.

3

5. Dependence on social services systems. Improvement, change, maturity, and adequacy appear to be the antithesis of the neglectful family's dependency on external support. The neglectful family system seems perpetually dependent on the social service community, a community that cannot shun them and that demands no reciprocal return of kindness or generosity. Effective services must avoid becoming permanently incorporated into the family system, while at the same time supporting the family and creating change (Hartley, 1987).

6. Developmental deficiencies in children. The effects of neglect on children's development can be devastating, including physiological problems, cognitive deficiencies, and poor self-confidence (Martin, p. 6; Egeland et. al., 1983). Treatment needs to address children's developmental progress.

7. Substance abuse. Parental substance abuse appears as a concomitant problem in many neglecting families (MacMurray, 1979; Wolock and Horowitz, 1979; Zuravin and Greif, 1989). Abuse of alcohol and other addictive drugs is an especially critical problem for pregnant women and their infants. Identifying these problems and engaging the family in substance abuse treatment must be significant elements in an effective family-based treatment model.

8. Symptom contagion. Family-based workers in short-term programs find chronically neglecting families among the most difficult to work with (Nelson, Emlen, Landsman and Hutchinson, 1988). The despair, hopelessness, and helpless behavior characteristic of neglecting families also tend to be experienced by those who attempt to help them. To prevent this, staff need an effective support system and an environment that can strengthen them to help families move beyond this powerful negativism.

In addition to these factors, families reported for neglect of their children often do not have a sense of control over their own lives and this is often reflected in their chaotic lifestyles. These lifestyles are labelled "dysfunctional" by the child welfare system. Other labels applied to these families include "unmotivated," "resistant," "passive-aggressive," "uncaring," "non-compliant," "lazy," and "hopeless." These negative labels

4

affect both families and their workers. Workers expect little change and feel helpless and ineffective in their efforts to assist families. Families also feel helpless and respond to the workers expectations by fulfilling them; they stay the same. It could be said that families are exerting the only control they may feel that they have, the right not to change.

The very name of this project, "Family-Based Treatment for Chronically Neglecting Families," has negative implications for both workers and families. First, the neglect is seen as "chronic," not exactly a term which inspires hope for change. Second, the term "treatment" may imply that it is the worker's responsibility to change the family; it is something that is done to families rather than something that they do for themselves. Therefore, the first intervention of the project was to change its name to the Self-Sufficiency Project (SSP), which more accurately reflects the real desire of these families to be managing their own lives.

Historically, child welfare services have been unsuccessful in helping neglectful families, even though child neglect is a more prevalent problem than either physical abuse or sexual abuse. (In a 1988 study by the National Center on Child Abuse and Neglect, neglect occurred 50% more frequently than abuse.) In the past, services for neglectful families have been determined by caseworkers, courts and other external-to-family sources. It was the goal of the project not to repeat the dominant practice of the agency desiring change more than the families themselves. With SSP it was important to create a system which would be empowering for both families and staff and which would move both groups from a position of "helplessness" to a position of "helpfulness."

The first and most critical element of this change was to give families primary control over their own participation in the project, over defining their own needs, and over determining the project design and identifying which services they would receive. Project staff were seen as facilitators of this process. Responsibilities went with the control: Families were responsible for their behavior and their changes. Staff were responsible for accessing the opportunities and resources which make change possible.

The project was seen as a very real partnership between staff and families and the relationship between these parties was viewed as co-facilitation. Staff, as family advocates, did not claim to have the only specialized knowledge; families were seen as having knowledge of value from another point of view. Staff were cognizant of the relationship process in all interactions and strived to overcome the common historical practice of helpers being seen as experts in a "one-up" position to clients.

Much of the conceptual framework for SSP was derived from work by Michael White and David Epston in their book Narrative Means to Therapeutic Ends (1990). White and Epston view life in narrative form, as a story which we co-create with others in our social environment. As such, each individual and family story has numerous authors which contribute to the product.

> "A case has been made for the notions that persons are rich in lived experience, that only a fraction of this experience can be storied and expressed at any one time, and that a great deal of lived experience inevitable falls outside the dominant stories about the lives and relationships of persons. Those aspects of lived experience that fall outside of the dominant story provide a rich and fertile source for the generation, or re-generation, of alternative stories." (White & Epston, 1990, p. 15)

In SSP, families and staff were co-authoring a new text which was hoped to relieve some of the hopelessness of the former narrative. To do this, SSP focused on the families' strengths and competencies, finding what families had done well in their lives and how they had transcended many tragic experiences. Many times, these successes were forgotten chapters which were restored to the narrative, thereby giving new meaning to old events.

To create an environment for change which would reduce chaos and promote safety, it was initially necessary to give the program some structure. Four groups were established to accommodate parents and children at weekly meetings: the Adult Group, the Teen Group, the Children's Group and the Nursery. Dinner was served following group meetings. At first, staff provided ground rules for meetings and worked with the families to establish project goals. However, this original structure was seen as fluid so that it was capable of adapting to the evolving needs and knowledge of the project. For

example, for families in Phase I, the first group to enter the project, it was several months before Multiple Family Groups were added to each weekly session. Phase II families began Multi-Family Groups within a few weeks.

Other parts of the program were equally flexible. Staff and parents might help prepare and serve the meals or assist with child care if volunteers did not show up. If needs varied in different groups, such as more children showing up for Children's Group on a specific night, staff or parents might be called in to help out.

It was not only important for participants to be open to changes which might improve the program but also to recognize when program adjustments were not working. On occasion, it was necessary to return to what had worked in the past. For example, the Adult Group was de-emphasized with Phase II families and they did not become as engaged in the program. Therefore, the old structure for Adult Group was reinstituted in Phase III.

In summary, key elements of the project philosophy were;

* Providing services in a positive framework which avoided negative labels.

* Creating an empowering system for both staff and families which acknowledged families' control over their own lives and shared project control among all participants.

* Establishing a partnership between families and staff which presumed and utilized competency and knowledge from both.

* Rewriting family stories to build on the strengths and competencies which they had demonstrated in the past and were demonstrating in present.

* Creating an initial structure which had the flexibility to change and develop based on individual, family or project needs.

CHAPTER 3

PROJECT DESIGN

Referral Process

Families were referred to the project by their ongoing case manager in Children's Services Division. The cases were first screened by the supervisor to determine whether they fit project criteria. Project cases were determined to be at high risk for continued neglect on the Alaska Family Services Assessment of the Risk of Subsequent Neglect. In addition to criteria for high risk, families had to meet one of the following conditions: 1) neglect as a pattern of family life over a period of at least 3 months; 2) previous confirmed or multiple allegations of neglect; 3) previous out-of-home placement of a child; or 4) death of a child due to neglect. Families where neglect was seen as situational or a one-time occurrence were not eligible. Having met the criteria for referral to SSP, each case was then staffed by the project team. The case manager was asked to address the following issues in the staffing:

* What is the desired outcome of services? What is the service plan for the family and what are the timelines for goal achievement?

* How is the problem defined? By the family? By the worker? Who is most affected by the problem and what has been tried to remedy it?

* What is the past experience of the family with individual, family and/or group treatment?

* What are the family strengths?

* A brief social history of the family including family composition, a family genogram, a timeline of life crises and significant events and obstacles to treatment.

* A description of the family's support system including friends, relatives, community agencies, etc.

* The worker's assessment of the family's motivation.

9

Thirty-eight families were determined to be eligible and accepted into the project.

Engaging Families

Following the staffing, the family was initially told about the Self-Sufficiency Project by the referring worker, who in most cases continued to be their case manager throughout the project period. A follow-up contact was then made by one of the project staff, either the supervisor, a family therapist, parent trainer or the parent aide. The initial group meeting, which was called a "parenting class," was described to each family along with the project. Terms such as "therapy" were avoided. The family was invited to participate in the project or given the option to continue to receive services as they had in the past. All families entering the project did so by choice, although a few felt compelled by pending court action or the "advice" of their worker.

Engaging families in the project was seen as absolutely critical and this first meeting between project staff and the family was an important opportunity to talk with them in a new way about the services they receive. In the past, most of these families had been told by workers what needed to happen in their lives: what they were doing wrong, what they needed to change and how they should go about doing it (i.e. what services they should receive). They either did as they were told and were therefore "compliant" and "cooperative" or they made different choices and were labelled "non-compliant" and "resistant." Even families who were cooperative by these standards did not feel empowered and may not have been truly motivated to change.

Project staff decided that the element of choice would be an important part of the engagement process. If families were to be empowered, it was seen as important for them to be encouraged to make service decisions for themselves. Their first choice was whether they wanted to participate in SSP or continue receiving services as they had in the past. The second choice was to design the program for themselves. The parents were told that this was a federal research project and that this was a chance for them to make a difference in how services were provided. Not only could they design a service that would meet their own needs, but they could assist others in designing programs

10

nationwide. It was explained that families would first meet together in groups but that, after that, they would begin to make their own decisions about what form the project would take and about what services would suit them on an individual basis. It was assumed that families could make changes and that the project was simply providing them the means to do so. Families were told that there would be meals, child care and transportation so that their participation would be supported in concrete ways. It was also noted that the first meetings would be set from 4 p.m. to 7 p.m. each week so there would be little interference with work or school. (The meeting schedule was later determined by participants.)

Of the 38 eligible families, 31 elected to receive SSP services. This will be referred to as "participants" or "participant families." At least 4 of the 7 who did not participate chose to continue their current service program. One family joined the project but did not receive group services, choosing instead to participate only in family therapy. It was not a requirement of the project that participants attend group meetings; they selected their own services from the array provided.

Project Components

The Self-Sufficiency Project was conducted in three phases based on when different groups of families entered the project. Because of the project design which could accommodate only a limited number of families at a time and because of the need to bring a minimum of 30 families into the project, it was necessary to have each phase be time-limited so that a new group of families could become involved. In Phase I, beginning in August, 1989, 12 families were referred for the project. Only one of these families did not participate. Services included SSP group meetings once a week, services provided by Children's Services Division such as in-home parent training, homemaker services and individual family therapy, and a range of community services including alcohol and drug treatment (ADAPT), the Confidence Clinic, FISH for emergency assistance such as food, Battered Persons Advocacy, the Parents' Relief Nursery, the public health clinic and mental health counseling. Phase II began in January, 1990 with

11

15 families (4 of whom did not participate) and Phase III in September, 1990 with 11 families (2 of whom did not participate). Based on experiences in Phase I, there were program alterations in Phases II and III; these are discussed in the narrative below. In addition, a Parents Support Group was formed after Phase I.

Families were referred to SSP beginning in June, 1989 and services began in July, 1989 continuing until May, 1991. Unlike many family-based programs, the length of service was determined by family need rather than program criteria, with some families receiving up to two years of service. Services were terminated if and when service plan goals were achieved.

The initial project sessions were structured so that all family members could attend, including children in out-of-home care and working parents. Sessions were held late in the afternoon at a local church and transportation was arranged through Volunteer Services for those who needed it. Other families provided their own transportation and were reimbursed for their mileage upon request. Since each session involved as many as 40 people, coordination of transportation was a major effort.

Self-Sufficiency Project sessions, which lasted about 3 to 4 hours, consisted of four meetings running simultaneously: the Adult Group, the Nursery, one or two Children's Groups (ages 6-12) and the Teen Group. Following these group meetings, all participants convened to have dinner together as an informal social gathering. After dinner, there were Multiple Family Group meetings and staff debriefing.

Adult Group

The Adult Group was composed of the children's parents and their spouses or significant others. This produced some controversy in the first group when one mother wanted to bring her boyfriend. The boyfriend was married to another woman and still living with his wife and children. He ultimately was allowed to attend SSP because of his importance to the mother and therefore to the entire family. The Adult Group was co-facilitated by two SSP staff, including at least one family therapist, and had several objectives:

12

1)   To provide the primary forum for adult family members to co-create the project with staff. From the beginning, it was envisioned that families could guide the format of the project as a step toward real self-sufficiency. The group members established an immediate protocol for their meetings; they wanted the following:

*   The agenda to be flexible in order to respond to members' individual needs.

*   Each member to have a chance to speak so it was decided to "check in" with participants at the beginning of each meeting to see if they would like time on the agenda.

*   To have a group meeting rather than a "class" for parenting.

*   To maintain separate groups for children so the adults could continue to have this time for themselves.

*   To begin meeting as multiple family groups after the Adult Group meeting.

*   To have workers in the children's groups spend individual time with the parents to discuss what was observed in their child's group.

*   To keep having dinners and a closing ritual where each group shared their activities with the others.

In addition, Adult Group members generated a list of topics which they wanted to discuss in their meetings (see Appendix A). They then voted on which topics were of most interest to them. In one meeting, subjects ranged from dealing with children who had just returned home from foster care to issues of chemical dependency to the difficulties of being a perfect parent under the watchful eye of the state. As the adults formulated their plans for the project, they were also able to take ownership of their own strengths and needs in parenting.

13

2)   To provide a flexible structure which would enhance the group process and
        promote group members' growth. Clear guidelines for confidentiality were
        established which helped members determine their own boundaries for
        information-sharing.

3)   To create, within a short amount of time, an atmosphere of intimacy and trust
        which would give people an opportunity to tell their family stories. These stories
        could then be rewritten in a hopeful and caring way (White and Epston, 1990).
        For example, one stepfather talked to the group about hearing voices. By
        listening to what he had to say, asking him his understanding of what was
        happening, and discussing this issue in a non-threatening way, the stepfather was
        able to express his fears and sort out his own reality.

4)   To utilize the members' own resources and reinforce their strengths and to help
        the group begin to provide resources to one another. In one meeting, members
        reached out to form a support network when one woman complained that her
        estranged husband was making threats of harm against her. Some members
        suggested that the group should form a "telephone brigade" to call this woman
        regularly to assure her safety. At other times, families took in other project
        families who were moving out of abusive relationships, provided child care for
        one another, and helped each other move.

        What Worked and What Didn't: The Adult Group in Phase I started with a very
loose structure, with the staff taking literally the notion that the families would design
the project. However, the beginnings were confusing and chaotic since the families did
not really know how to proceed and the staff did not know when to intervene. Using
the information gleaned from the Phase I experience, the staff gave a high degree of
structure to the Phase II group. As a possible result, families in Phase II were somewhat
less engaged with the project and were less assertive about their needs. With the Phase
III group, staff tried a middle ground of providing more initial structure, then gradually
reducing their input so that the families were determining the structure by the end.

14

This seemed the best process to meet both staff and family needs for control and planning.

The Phase I group also added families after the group had begun due to the usual difficulties in project start-up. This was very disruptive to the group and in Phases II and III, no new families entered once groups had started. This appeared to facilitate group cohesiveness and trust.

Overall, variables that may have impacted the process of the Adult Group were individual styles of project staff (since group facilitators changed with each phase), group composition and personalities, and staff changes.

Nursery

The Nursery provided child care for children ages one through three while their parents were attending the Adult Group. Originally, there was some consideration of hiring a professional child care provider to oversee the nursery, but fortunately a teacher from the local Parents' Relief Nursery was able to volunteer the time. She began with Phase I and supervised child care assistants throughout the project. The first child care assistants were recruited from a local program for senior citizens called RSVP. However, the RSVP volunteers were not reliable due to frequent illnesses and doctor appointments. Therefore, the project's parent aide contacted the local high school for assistance. The timing was right since the school's Honor Society was looking for a service project. The students proved to be quite dependable and worked in the nursery throughout the project period.

Children's Group

The Children's Group, which ran simultaneously with the Adult Group, consisted of both boys and girls. While Phase I of the project only utilized one group for children, two were used in Phases II and III. One Children's Group was for ages four through six and the other was for ages seven through eleven. The change from one to two groups was necessitated by the large numbers of children and the need to maintain age-appropriate activities. The groups had the following goals:

15

1. To provide child care while parents participated in the Adult Group.

2. To promote social skills and reduce social isolation.

3. To provide children with an opportunity to participate in artistic and creative activities.

4. To provide children with positive adult role modeling.

5. To provide children with structure and consistency.

6. To allow children a place where they could bring up issues for group feedback.

7. To give project staff an opportunity to assess the social and developmental levels of the children.

Groups began with the children laying on the floor in a circle and listening to stories that were intended to stimulate discussion through the use of metaphors. Later activities included making collages, producing skits, making videotapes (such as the children doing their own newscast), seasonal crafts such as holiday cards, body image drawings, Simon Says, role plays/sculpture, art therapy, story telling and musical chairs. The structure of first a group story and discussion followed by creative activities was generally followed with groups in Phases II and III.

What Worked and What Didn't: It was essential to the success of the Children's Group that there were enough staff present consistently to provide the children with one-on-one adult interaction and to maintain structure and order. In general, this was a very active and uncontrolled group of youngsters who badly needed individual attention and instruction. The optimum staff to child ratio was 1:4; this was rarely achieved in SSP.

In retrospect, it would also have been helpful to have a better assessment of each child's needs and abilities before the group began. This would have enabled staff to plan more effectively for the number of staff needed in the groups and to plan activities best suited to the children. Information about the child's developmental level, interests and needs could have been obtained through minimal testing, interviews with parents and individual interviews with the child.

16

There was also substantial feedback from the parents that they thought the groups were helpful for their children. They very much wanted these activities to continue, through the project period and beyond. There were not adequate resources (staff or money) to permit this option.

Teen Group

The Teen Group, for young people ages 12-17, also met simultaneously with the Adult Group and, the Children's Group. Since there were no adolescents in Phase II families, the Teen Group only functioned in Phases I and III. The format focused on group discussion. The facilitators prompted the teens with some of the following types of questions:

* Introductions: (See Appendix B)

* Situational: What's happened over the last week? What's going on for you right now?

* Values clarification: How do you think gender (race, age, etc.) determines what we do in our lives?

* Examination of beliefs: Do your friends agree with what you believe? What about your parents? Teachers? Does everyone agree with you and if not, why not?

* Examination of behavior: When you did that (skipped school, got drunk, got an A on a test), how did your brother feel? Your mom? If you had it to do over, what would you do differently?

* Transitions: What was it like when your family went through this transition (divorce, remarriage, moves, birth of a child)? How did the transition impact relationships within the family and your relationship with other family members?

* Hopes and dreams: What have the major events been in your life (timeline)? What hopes and dreams do you have for your life and are your decisions now leading in the hoped-for direction?

17

The goals for the Teen Group included the following:

1) Putting issues "on the table" that could then be raised in Multi-Family Group sessions. The teens often became catalysts for change in the multi-family groups.

2) Providing mutual support for group participants.

3) Developing socialization skills; helping participants to talk to one another. Discussions here ranged from peer relationships to dating etiquette and interacting with authority figures.

4) Helping teens to examine family roles and, if necessary, finding ways to transcend those that were dysfunctional.

5) Connecting teens with other community resources such as alcohol and drug programs.

What Worked and What Didn't: There were no major issues in the Phase I group; it was very positive and cohesive. The largest difficulties with the Phase III Teen Group arose because the group included siblings involved in incest. (In all instances, these siblings were in separate homes but allowed visitation in this supervised setting.) On occasion, offenders would exhibit offending behaviors in the group and were not responsive to attempts to control that behavior. There was not adequate staffing to do two separate groups but, in retrospect, this might have been wise. The development of trust among group members was seriously impeded when teens were placed in a group with someone whom they felt had betrayed them. In one instance, the group facilitator was the one who had previously reported the sexual abuse in a teen's family and there was an immediate lack of trust which affected the whole group.

More did work than didn't, however. Issues that began in Teen Group were brought successfully to Multiple Family Group sessions and having non-incestuous siblings in the same group was useful both to themselves and the other teens. Beliefs about families were often challenged, offering the teens new options for their families of the future. Collage activities were very helpful in stimulating group participation and discussion. Two siblings in the Phase I group made major changes: The 17-year old

18

boy who had been out of school for two years entered a G.E.D program after researching possibilities with the group facilitators. His 15-year old sister went through in-patient drug treatment after being confronted with her use by the facilitators. (See Family #1)

Meal

Dinner, the opportunity to share food together, was considered a primary project component. It provided a break to the intensity of the group meetings and gave families a social time together both with their individual families and with other project families. Some of these families never had structured time together, so the meal provided an occasion and modeling for family interaction. Staff also socialized with families during this time, reinforcing the partnership between families and staff in this project. Just as important, food was a symbol of nurturing and the project wanted to convey a nurturing attitude toward both families and staff so that parents, in turn, could be reinforced in nurturing their children. The meals were a great motivator; families were always clear that dinner was one of the best parts of the project.

At the end of each project phase, a special dinner was prepared for families and staff to celebrate their accomplishments. This meal was more formal, with tablecloths and place settings and families were served at the table rather than buffet-style. This was a special time for families and staff to review their work together and to relish the changes that had occurred. It was also an opportunity to expand the horizons of many families, where the children might not know why they were given two forks or why they could not just go get their food. It was a rite of passage for families moving on.

Originally, the project had food donated by a local restaurant. That was discontinued after a few months and from then on, food was either donated by stores or purchased with project funds. Volunteer cooks were utilized. The parent aide, who organized and supervised the volunteer services, contacted the local county Extension Office for help. In the previous year, the Extension Office had trained volunteers for a "Home Resource Project" in conjunction with Umpqua Community Action Network. The program had been designed to teach parents basic food preparation skills. Since the

response to their program had been minimal, some of the trained volunteers were eager to share their expertise. Three volunteers worked with SSP and alternated weeks in preparing the meals. At first, the volunteers tried sharing recipes and information on nutrition with the families but the families were not overly receptive. In fact, many felt "put down" by the "I know better than you do" attitude of the volunteers. The information sharing was discontinued. Students from the high school Honor Society assisted in the kitchen and staff and families helped with clean up.

Multiple Family Groups

The Multiple Family Groups were usually the last event of meeting days following dinner. Initially, children under 5 were excluded from the Multi-Family Groups, but eventually that was increased to children under 7 because of the disruption. Child care continued to be provided for those not in groups.

There were a number of considerations in the composition of each Multi-Family Group:

* Each group was to consist of 3 or 4 families.

* The size of the families was taken into account so that each group had a similar number of people.

* As much as possible, families with the same age children were put in each group so that they would be dealing with comparable issues.

* There was an attempt to create a diversity of beliefs and competencies in the group so that, for example, families affected by sexual abuse were not supported by other families in minimizing that abuse. On the other hand, it was possible for families who were successful in one area of functioning to support families who were not so successful in that area. The diversity also allowed families to challenge one another about their behavior.

* Diversity of style was also important. For example, individuals who were outgoing were placed in groups with quieter people.

*	Close friends were separated in the groups, as were individuals in conflict with one another.

Once the group selection was made, there were no changes. On the few occasions when a family joined a group late, the dynamics of the group were altered unfavorably.

Multi-Family Groups had the following goals:

1)	To encourage support from family to family.

2)	To continue the networking process in another form.

3)	To provide an atmosphere where families would confront one another on behavior rather than staff confronting families.

4)	To help families become resources and consultants for one another. (It was just as important for families to <u>be</u> a resource as to <u>receive</u> resources. This was further acknowledgement of their strengths.)

5)	To encourage more immediate feedback on what was occurring between parents and their children. For example, parents could observe and comment on how other parents were dealing with their children.

6)	To give families experience with delivering positive feedback to others. Many participants had only given--and received-- negative feedback, so it was important to help them learn how to encourage rather than criticize.

7)	To help normalize family dilemmas so individuals did not feel alone.

8)	To give children an opportunity to bring out problems in a safe environment where other children and other adults were present.

9)	To provide a forum where issues from other group meetings could be discussed. For example, if teens felt their parents' rules were unfair, the concern could be raised in the Multi-Family Group allowing many different perspectives on the problem.

Each Multi-Family Group had two facilitators from among the project staff. Most often, these were family therapists although the parent trainer was also a co-facilitator.

Since these individuals already worked together on a daily basis, they were easily able to assume roles as co-facilitators for these groups.

The staff carried the project's overall philosophy into these multi-family sessions. They were there to facilitate change, to listen to families' stories and to help co-author new and more helpful descriptions of their lives. As an example, families who, in the past, had presented themselves primarily as victims were asked to remember those times in which they had been effective in their lives. They were then asked to reconstruct how they had shown their inner strength and how they had persevered to overcome their victimization in that circumstance. Families were then able to think differently about life events. Their stories developed new plots where they were able to overcome adversity rather than succumb to it.

What Worked and What Didn't: The rewritten stories developed by families in the group had an immediate audience.

> "The endurance of new stories, as well as their elaboration, can also be enhanced by recruiting an "external" audience. There is a dual aspect to this enhancement. Firstly, in the act of witnessing the performance of a new story, the audience contributes to the writing of new meanings; this has real effects on the audience's interaction with the story's subject. Secondly, when the subject of the story "reads" the audience's experience of the new performance, either through speculation about these experiences or by a more direct identification, he or she engages in revisions and extensions of the new story." (White and Epston, 1990, p. 17).

Accomplishments were noticed and applauded so families felt comfortable proclaiming their changes. Other families became supports, consultants and reality checks on these accomplishments. As families compared their experiences, dilemmas were normalized and networking was enhanced. Since families confronted each other with issues, facilitators were relieved of that responsibility, thereby staying out of a one-up position. Information from the Adult, Teen and Children's Groups were processed in Multi-Family Groups; the relative safety of the "peer" groups carried over so that family members felt protected in bringing up painful issues.

The Multi-Family Groups were difficult to get started. Participants were more awkward in this context and this was a new experience for facilitators as well.

Distraction from the youngest children was the greatest problem; thus the decision to exclude children age 7 and under.

Parent Support Group

The Parent Support Group evolved out of Phase I of the project to provide ongoing contact and support for the families who had been attending group meetings. The families were anxious to continue to meet with one another but there was not adequate staff support for two meetings per week at the level of the Phase I project meetings. Therefore, the parents from Phase I created the following design for the Parent Support Group:

* Continue to meet once a week with some project staff.

* Continue to have some child care provided, but without a formal group process.

* Continue to have meals together.

* Continue to have transportation provided.

* Alternate use of the group time: Use the meeting the first week to talk about adult issues; use the meeting the second week to talk about parenting, the third week back to adult issues and so forth.

The project was able to maintain volunteer and financial support for the child care, transportation and meals and it was decided that the parent aide and the parent trainer would facilitate the group.

As this "new" group began, there were a number of discoveries for both participants and staff:

* The participants were able to maintain their trust with one another and were able to tackle some difficult and painful issues. There were many examples of this: One mother talking about the recent death of a close relative. Another young woman confronting her losses--being adopted and losing her family of origin, losing a child to foster care and then facing

23

the possibility that the birth mother who had "rejected" her might take the child in foster care.

* Participants were able to identify and point out each other's strengths and competencies. They were also able to accept these compliments.

* Participants were willing and able to challenge each other in an assertive way, as when one couple confronted another father about his physical discipline of his children.

* Participants also began to spend more time with one another outside of group meetings and to help each other in an ongoing way. For example, six of the group members helped a mother move. Group members also had a barbecue together and babysat and provided transportation for each other.

* Participants found that they often could not differentiate between "adult" issues and "parenting" issues. If they talked about stress around their children, for instance, it might lead to talk about stress with their parents.

When the time came for the first Parent Support Group to either end or incorporate the Phase II families, it was decided to include the new families. However, the Phase I families recognized the impending change and decided to have a ceremony for closure, a "graduation." The parents planned their own graduation including the invitations to their children, the location, the meal and the structure of the ceremony itself. They also had suggestions for the next Parent Support Group for families from Phases I and II:

* Continue to involve the parent aide and the parent trainer.

* Invite a family therapist to come to every other meeting to help with the personal issues which inevitably came up.

* Extend the meeting length to 2 and 1/2 hours.

* Change the meeting format so that one week was devoted to "personal issues" and the next week covered educational material. As far as the

24

educational component was concerned, the participants picked the topics and helped with obtaining speakers. Some participants volunteered to be speakers on subjects about which they were knowledgeable such as "Stress Management" and "Co-Dependency."

* Renew invitations to Phase I participants who had not continued with the Parent Support Group.

* Continue meals and provide only emergency child care.

At the time the Phase III families were ready for a Parent Support Group, they decided to form their own, separate from Phase I and Phase II families.

To maintain continuity, no new group members were added. There were nutritional snacks but no meals provided because of limited resources. This did not seem to have a negative impact on the group process.

Similar to Phase I parents, Phase III had a high level of cohesiveness, trust, and commitment to their group. As in the other groups, staff decision-making was minimal. In fact, because of this group's open communication with each other, they nicknamed themselves the "Jabber Jaws." Once when the group facilitator arrived late because of a crisis, group members teased her, saying, "We've decided we don't need you anyway; we realize we can run the group ourselves."

What Worked and What Didn't: Since there were three different Parent Support Groups, the first with just Phase I families, the second which incorporated Phase I and Phase II families, and the third with Phase III families, they will be discussed separately.

The first Parent Support Group started well because the families designed the structure and took immediate ownership of the outcome. They had built a significant cohesiveness in their earlier SSP group experiences and had a high degree of trust. The adults were committed to the support group and had a feeling of working well together. At this time, no new families entered the group and none left. Staff involvement in decision-making was minimal and group participants were there because they wanted to be. There was no outside coercion.

Some problems did arise, however, as the group progressed. The parent trainer and parent aide became frustrated because some issues could not be adequately discussed without the professional support of a family therapist. One group member, for example, talked about her past sexual abuse victimization and was left feeling that more processing was necessary both for herself and the group. There were also difficulties for the members in focusing on parenting issues when their own personal or "therapeutic" concerns were more pressing. Again, this pointed to a need for a therapist. Because of the many topics which group members wanted to cover, there were also problems containing the meeting time to its original one hour schedule. A final concern of some staff was that a few of the friendships being formed among group members were not helpful. As an example, some parents expressed beliefs about not being responsible for their children and these were reinforced by other members of the group.

Fortunately, the project was able to correct some of the problems identified by the first Parent Support Group. At the time the Phase II families were added to the group, a family therapist was able to participate in the meetings every other week. This enabled the group to deal more productively with some of the difficult personal issues that they wanted and needed to discuss. The group continued to maintain the support which had been generated in the first Parent Support Group and members were even more empowered by the addition of the educational component. They were pleased to come up with their own topics for each "class" and to, in fact, be able to lead some of the classes themselves because of expertise they had developed. Group members saw their accomplishments being recognized by their peers.

On the down side, the entry of "new" families into the group decreased the trust level the second time around. This was compounded by the loss of time for personal issues every other week when the educational sessions were held. The group simply did not have as much opportunity to develop the trust through personal discussions. Finally, some of the new group members did not see themselves as being there on a voluntary basis because of pressure from the courts or their case manager. These few individuals

then added an element of negativity to the group process.

The Phase III Support Group learned from its predecessors. The group retained the format which included an educational component and a family therapist continued to participate. However, no new families entered the group and a high level of trust was maintained throughout.

Family Initiated Activities

Family Initiated Activities occurred throughout the project period. Although families were instrumental in the design of the project from the beginning, staff provided the structure and process for this to happen. They also provided suggestions as to what might be done. Family Initiated Activities, however, were suggestions coming directly from the families with no staff prompting. Here are some examples:

* Participants suggested the exchange of phone numbers and addresses. Lists were developed and disseminated by the group members.

* At the end of the project, participants from all three Phases were eager to have a group potluck reunion. Families planned the gathering, managed invitations, selected the date and site and brought much of the food. Although this picnic was largely in a shelter in the cold, Oregon rain, the turnout was excellent and everyone had fun.

* Two families initiated a Parent Support Group which ran after the termination of the project period. No staff were involved although SSP was able to help by paying for a meeting room when a free one was not available. Of course, project staff were able to offer advice when it was requested. This group was opened to and advertised for the community-at-large, not just SSP families. This group continued for 4 months.

* One SSP couple who had returned to a community college in a human services program, used the project for a practicum and initiated their own practicum design. (See Family #1)

27

* As previously mentioned, there were numerous instances of families helping each other outside of the project.

Emergency Funds

Emergency funds of up to $345 per family were available to meet needs not covered by other project, CSD or community services. The Adult or Parent Support Group screened requests for use of this fund by group members; participants were asked to bring their request to the group first, where it was then decided if the planned use of the funds was reasonable. With the group's recommendation, project staff made the final decision about whether to grant the request. Through this process, participants gained experience with budgeting and financial management.

Some possible uses for the money included payments for first and last month's rent, food, car repairs or other emergency transportation, telephone installation, and/or child care. This fund was not utilized at the level anticipated because most needed resources were available through the community.

In addition to the services provided directly as part of the Self-Sufficiency Project, families were encouraged to utilize ongoing services provided by Children's Services Division such as case management, parent training, homemaker services, and family therapy for individual families. They were also linked to community services as appropriate.

Services Provided by Children's Services Division

Children's Services Division delivered the following to project families:

* **Case management** services were delivered by the family's ongoing worker at CSD. All families received these services and all case managers were considered part of the project team. They attended staffings and received regular reports from other project staff about the family's progress. They also provided services to children who were in out-of-home care and their caretakers. On the whole, the case managers were a valued support for the other project staff.

28

* **Parent training** services have long been provided at CSD in the form of classes for parents on subjects relating to the age level of their children, anger management, stress management, etc. Twelve project families had received these services prior to entering SSP. For most of the families in the project, however, it was found that in-home parent training was more useful. Since transportation and motivation were often difficulties and since parent-child interaction was best observed in the home, home visits were essential in many cases. The in-home parent training services were provided by the parent aide and the parent trainer who were part of the project staff. They found that it was very effective for families to establish their own goals for the services and that many of these parents had initial difficulty in identifying strengths and competencies in themselves or their children. They were, however, experts at identifying problems. (See Parent Training Report Forms, Appendix C.)

* **Homemaker services** were provided by CSD's Homemaker Program and consisted largely of teaching families housekeeping skills, household management and reinforcing the objectives established in the in-home parent training.

* **Family therapy**, in-home or in the office, was provided as part of CSD's Intensive Family Services program which works with families who have a child at the risk of placement. Again, ten families had already received these services prior to their SSP referral and others began services while in the project.

* Group and individual counseling for **juvenile sex offenders** was provided through CSD.

Services Provided by the Community

The community services provided to project families included the following resources:

29

* **Sexual abuse treatment** was coordinated and delivered by a team of community providers. Services included groups for victims, offenders and non-abusing spouses. As part of this community effort, CSD did provide counseling to some victims. The parent trainer for SSP was Douglas County CSD's Sex Abuse Treatment Specialist during the project period and did work with victims in some of the project families.

* **ADAPT:** Delivered both in-patient and out-patient alcohol and drug treatment services.

* **The Umpqua Community Action Network** included three services utilized by project families: **The Confidence Clinic** assisted women with self-care, assertiveness training, developing resumes, educational and job counseling and groups for parenting, stress management, anger management and economic self-sufficiency. **Headstart** provided pre-school services to disadvantaged children and UCAN also maintained a **food bank** for Douglas County residents.

* **Project Pride:** Provided educational alternatives, including GED preparation, to young people.

* **Mental Health Clinic:** Provided the usual range of mental health services but was primarily used for individual therapy by SSP participants.

* **Battered Persons Advocacy:** Provided a hotline, shelter, crisis counseling, legal services, a Men's Anger Group, a Women's Support Group and information and referral for families affected by battering.

* **FISH:** Provided emergency assistance with food and clothing and medical screening for children.

* **Public Health Clinic:** Provided health care screening and treatment for low income families.

* **Parents' Relief Nursery:** Provided up to four hours of respite care four times a week for families at risk of child abuse.

30

* **Early Intervention Program:** Provided parent education services, physical therapy, speech therapy, vision and hearing training and case management for families with children with disabilities.

* **HUD (Housing and Urban Development):** Provided housing for low-income families.

* **WIC (Women, Infants and Children):** Provided nutritional supplements for pregnant women, mothers and their children.

Ongoing Progress Review

The progress of each family was reviewed quarterly in a staffing with the SSP team and service providers who wished to attend. The Family Systems Change Scale was completed at that time and an outline was followed similar to that in the initial referral process to see if changes had occurred over the 3-month period (see Referral Process).

CHAPTER 4

PROJECT STAFF

All staff for the Self-Sufficiency Project were employees of Children's Services Division (CSD) in Douglas County, Oregon. CSD is the state child welfare agency charged with investigating reports of child abuse and neglect and providing appropriate services to those families. As noted above, CSD has a number of in-house programs for treating child abuse and neglect. There were several reasons for establishing the project in CSD. First, CSD staff had strong expertise in working with neglectful families and were also qualified professionals in many of the service areas deemed critical to the project: case management, family therapy, parent training, and homemaker services. Also, given the project design, it was important to have access to a number of staff on a part-time basis rather than hiring 3 or 4 project staff. CSD had that staffing capability. Third, it was believed that coordination of services would be improved if the project was located in the same agency as the ongoing child protection worker. And finally, it was desirable to demonstrate a model for working with neglectful families which would alter the child protection view that these families were not capable of change. The project matched our expectations in all of these areas. Ongoing workers/case managers became invaluable resources as part of the project team and their decisions about these families were directly influenced by reports from other project staff and their own observations of the change in families.

The project staff included six family therapists on a part-time basis (1 FTE equivalent), one half-time parent trainer, one full-time parent aide, one quarter-time supervisor and ongoing case managers for each family. They were responsible for facilitating and coordinating project services as well as obtaining required research data. In keeping with the overall flexibility of the project, however, staff roles often changed to meet project needs. For example, case managers did the dishes; the parent aide and parent trainer provided co-therapy; the family therapists did parent training and

homemaking; and all staff assisted with child care. (Although roles for co-facilitation shifted, trained staff were always present.) Staff simply pitched in and did the job that was needed at the time. The result was a true team effort, with the good of the whole clearly exceeding the sum of the parts. The philosophy of partnerships not only applied to staff relationships with families, but also to staff relationships with each other.

The Parent Aide position proved to be the glue that held the project together. She was the only full-time project staff and she coordinated all activities. Her role included:

* Most often, provide the initial project contact with families. She would visit homes with the case manager, explain the project and invite families to join.

* Monitor attendance at group meetings and visit those families regularly who did not appear to be engaged. She maintained personal contact with families who seemed peripheral.

* Locate, solicit, monitor and train the volunteers who provided meals, transportation, and child care. The parent aide was instrumental in finding creative solutions to the project's volunteer needs and supervised volunteer performance once they were on the job.

* Contact churches as group meeting sites and serve as liaison with the churches on an ongoing basis once the project utilized their space.

* Plan meals and shop for groceries. This was needed for two meetings per week from Phase II on.

* Provide in-home parent training services, including the initial consultation and ongoing training.

* Attend all staffings, planning meetings and evaluations.

* Co-facilitate the Parent Support Group with the parent trainer.

* Arrange for speakers for the Parent Support Group.

* Assist with the Children's Group when needed.

* Link families with other CSD and community resources.

* Complete research instruments (Childhood Level of Living, Child Well-Being Scales, AAPI, General Contentment Inventory, Developmental Profile II)

The Parent Trainer worked for the project half-time. The other half of her time was devoted to sexual abuse treatment activities for CSD. Her SSP responsibilities included:

* Design and coordinate in-home parent training services with the parent aide. This included the design of both initial and weekly consultation forms (Appendix C).

* Provide in-home parent training to voluntary families who had established some goals for change. These services included regular staffings with the case manager and ongoing evaluation and restructuring of goals.

* Provide parent education classes which involved some project participants. Subject areas included stress management, child development, discipline, health care and self-care for parents.

* Provide initial project contact with families.

* Work with parent aide to coordinate meals, child care and transportation.

* Participate in all staffings, planning and evaluation meetings.

* Co-facilitate Adult Group, Children's Group and Teen Group as needed.

* Co-facilitate the Parent Support Group.

* Assist the parent aide with recruiting speakers for the educational component of the Parent Support Group.

* Administer the Adult-Adolescent Parenting Inventory to project families.

Initially, six **Family Therapists** worked in SSP on a part-time basis. By the end of the project, only four therapists were involved. Therapists also continued to carry out other responsibilities with CSD as part of the Intensive Family Services program. Their functions with SSP included the following:

* Co-facilitate all SSP groups: Adult Group, Teen Group, Children's Group, and Multiple Family Group.

* Co-facilitate Parent Support Group with combined Phase I and II families and with Phase III families.

* Provide initial project contact with families.

* Attend all staffings, planning and evaluation meetings.

* Administer the Index of Self-Esteem and Generalized Contentment Scale.

* Supervise practicum of project participants.

* Coordinate services with case managers, community providers and families.

Case managers were involved with each project family. They were most often the ongoing child protection worker in CSD and they played the following role in SSP:

* Provide initial referral to SSP and present the project to the family with SSP staff. Complete original Alaska Risk Assessment.

* Attend all relevant staffings.

* Link families with community resources when necessary and coordinate those services.

* Provide services to children in out-of-home care and to their care providers.

* Complete all necessary court work with the family.

* Conduct child abuse/neglect investigations when new referrals were received.

* Maintain agency case records and participate in administrative reviews where applicable.

* Contribute ideas to the development of SSP.

The Supervisor was the "main keeper of the ever-changing vision." He assured that staff ideas and plans fit with the goals of the project and he worked to maintain the balance of flexibility and structure which was necessary for successful outcomes. To do this, he carried out the following functions:

* Act as a buffer between project staff and administrative layers of the project, while keeping staff informed of changes which might affect project operation. (As a note, there were five levels of administration involved: the local CSD branch manager, the CSD regional manager, CSD central office administration, the National Resource Center, and the consortium leaders.)

* Supervise and coordinate staff activities regarding project design and family treatment. This included problem-solving with staff and assisting them with treatment goals.

* Oversee the project budget.

* Coordinate reports, research instruments, and staff meetings.

* Intervene to prevent staff burnout and/or sense of hopelessness. This was done by pointing out the positive growth and changes in families, even when the change was small.

* Delegate responsibilities for indirect service activities.

* Provide direct services if time allows.

* Hire project staff.

Volunteers were responsible for transportation, meals and child care:

Drivers:

* Pick up and return families who had no other transportation to group meetings.

Cooks:

* Assist with meal planning.

* Cook meals.

* Supervise clean-up.

Child Care Monitor:

* Supervised child care in the nursery.

Honor Students:

* Provide child care in the nursery.

* Assist with Children's Group.

* Assist cook in meal preparation.

* Assist with clean-up.

CHAPTER 5

DISCUSSION

Results

Of the 38 families who were determined to be eligible for the Self-Sufficiency Project, 7 were never actively involved. At least 4 of these 7 chose to continue to receive services as they had in the past, some because they did not like the groups, some because of schedule conflicts and some because they did not want to interrupt services with their current providers. Thirty-one families participated in the project for at least several sessions. Fourteen (45%) of the 31 families were successful in making significant changes as measured by the Child Well Being Scales (Magura and Moses, 1986), the Childhood Level of Living Scale (Polansky, 1972), the Index of Self-Esteem and the Generalized Contentment Scale (Hudson, 1982), and the Adult-Adolescent Parenting Inventory (Bavolek, 1984). An additional eight families (26%) remained stable, eight families (26%) showed some negative change and there is no data for one family. (For more detailed report on project evaluation, please refer to The Self-Sufficiency Project Final Report published in another volume.)

Since 31 families out of 38 (82%) did join the project, it is reasonable to conclude that SSP was successful in its first objective, to engage families in the services. It is believed that the voluntary nature of the project (i.e. the option to join), the opportunity to co-design project services, the option to choose which services best met family needs and the tangible benefits of food, child care and transportation were primary motivating factors for family participation. Unfortunately, some case managers were so anxious to use the project for their families that they applied pressure and even used court leverage to get families involved. Approximately four families cited coercion as a factor in joining SSP. Since the project was founded on the principle of giving families a choice about participation, most of those who had been pressured into attending made little progress and, on occasion, exerted a destructive influence. It is likely that coercion was

38

a factor among those families who dropped out, did not change or showed some negative change.

In comparing the participant group of 31 families with the non-participant group of 7 families, there were several prominent differences. The non-participant group contained a higher percentage of families with child placements due to abuse (83.3% compared to 58.6% in the participant group), a higher percentage of families with placements due to neglect (100% vs. 70%), a higher percentage of families with drug problems (75% vs. 50%) and a higher percentage of families where the primary caregiver had a drug problem (75% vs. 38.6%). The participant group did have a higher rate of alcohol problems (69% vs. 50%), however. Given the small sample, these differences were not significant but they may indicate that the non-participants as a group were experiencing more difficulties with parent/child separation due to out-of-home placements and more difficulties with drugs than those who participated.

Although most families participated in project services, a number (16) did not appear to respond with positive change. So, although most families were engaged in services, some did not become engaged in a process of change. This is not surprising given the nature of the population served. Among the families served, 33% of the children were living out of the home of the primary caretaker: 18 in foster care, 6 in the home of another parent or relative, 3 in adoptive homes and others in shelter care, incarceration or residential treatment. Sixty-three percent of the families had 3 or more prior referrals for neglect and 70% had had at least one prior out-of-home placement due to neglect. Seventy-two percent of the SSP families also had at least three prior reports of abuse and 59%, at least one prior placement of a child due to abuse.

In an overwhelming majority of SSP families, one or both caregivers had themselves experienced neglect (92.6%) or abuse (88%) as children, and in 76% of the families, one or both caretakers had a history of drug and alcohol problems. Fifty percent of the families had a caretaker with a history of significant, long-term depression and an additional 14% had a caretaker who attempted suicide. In 36% of the

39

families, a caretaker had been convicted of a felony.

On the whole, families were also quite poor. Seventy-two percent had incomes no higher than $10,000 annually and, on average, four people were supported by this income. About 71% of the families received food stamps and AFDC and 43% did not have a working telephone in their homes. On the whole, referring workers expressed extreme skepticism about the potential for change among these families.
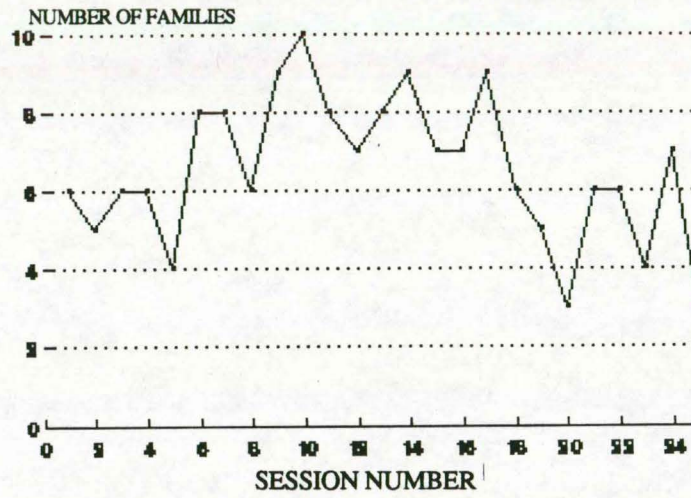
Given that most project families were experiencing both child abuse and neglect and had demonstrated multiple needs over an extensive period of time, it was a hopeful sign that nearly half were able to make substantive changes in the course of the project. The number of group sessions attended and the average number of monthly hours of parent aide service were correlated with positive change on various scales. It would appear that the families who benefitted most from the project were those who most utilized the services available. This does not mean that they utilized more services than other families, just that they were more involved with the services they did receive. (Refer to the Final Report for more detail.)

There were some differences in group participation among the three cohorts of families who entered in the various phases of the project (Figure 1). Twelve families were referred for Phase I of the project (7/19/89 until 2/8/90) and 11 families participated. Participants met for the original group sessions 26 times. This does not count the meetings of the Parent Support Group which followed. The average attendance for families in this cohort was 6.5 (59%) participant families per session, with attendance at its peak between the sixth and seventeenth sessions. Attendance may have increased after the sixth session because several families entered the program after it had started. The decrease in attendance began shortly after Thanksgiving and resumed only sporadically until Phase I ended on February 8. The holidays may have interrupted the continuity of the meetings and the total duration of Phase I may simply have been too long to retain family interest.
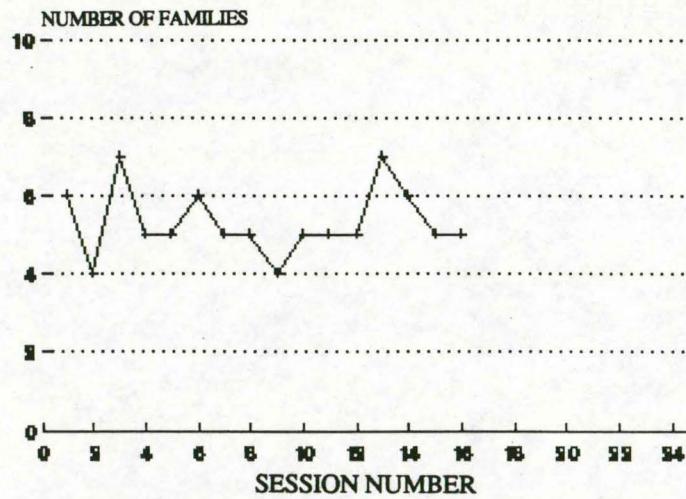
In Phase II (3/1/90 through 6/28/90), 15 families were referred for the project
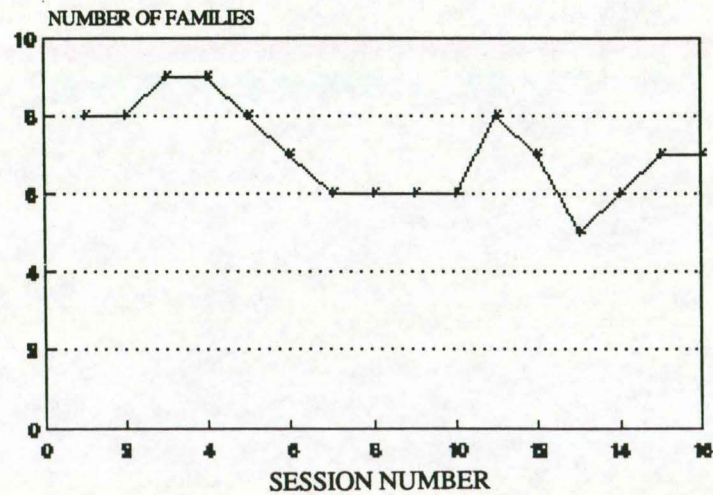
GROUP SESSIONS ATTENDED

PHASE I (7/89 - 2/90)

NUMBER OF FAMILIES / SESSION NUMBER

PHASE II (3/90 - 6/90)

NUMBER OF FAMILIES / SESSION NUMBER

PHASE III (10/90 - 2/91)

NUMBER OF FAMILIES / SESSION NUMBER

with 11 continuing to participate. Average meeting attendance was only 5.3 families (48% of participants) with 7 families being the largest number to attend any one meeting. It would appear that several families may have dropped out at this stage of the project. The Phase II groups met for 16 sessions and attendance was relatively constant throughout, indicating a core group of involved families.

Eleven families were referred for the project in Phase III (10/4/90 through 2/28/91) and 9 participated. These groups also met 16 times with an average attendance of 7.1 families (79% of participants). Peak attendance occurred in the first 5 or 6 sessions, showing that those families who did leave may have done so after a few meetings, with the group remaining fairly stable from that point on.

It would appear that Phase III was the most successful in retaining families in project groups and that Phase II was the least successful. This coincides with reports from project staff who have characterized the three phases in the following ways:

* Phase I had a chaotic beginning with confusion and disorganization for both staff and families. Several families started late and because of this and requests from some participants, the number of sessions were extended possibly beyond their usefulness. However, a core group of families who stuck with the project in this phase were instrumental in planning services and maintaining project momentum.

* In response to the chaos of Phase I, the staff presented a more structured model of service in Phase II. Families had less input in project design and there was less emphasis on the Adult Group process. It is possible that this restriction of choice resulted in families disengaging from SSP.

* In Phase III, "we got it right." While some initial structure was provided by staff, the Adult Group moved quickly to involve families in the decision-making process. However, it should be noted that families in Phase III only had the option to be in the project for 8 months because services were discontinued in May, 1991. By contrast, families in Phase I

41

had the potential of nearly two years in SSP.

Staff also had observations about the types of families for whom the project was most successful:

* Families who recognized at some level that their lives were not working for them and were therefore open to new options.

* Families who felt respected as they were and families who were, in fact, accepted by the staff unconditionally. In other words, success may not only have been a function of the family's perception but also of the staff's perception of the family. This acknowledges that staff attitudes may affect outcomes.

* Families who actively sought help from the project.

* Families who had already started on some path of change (e.g. alcohol/drug treatment, parent training).

* Families who had previously been involved with services from some of the project staff.

In keeping with the theoretical framework of the project, the staff also recognized the importance of outside views in helping families rewrite their stories. They noted that successful families, although entrenched in old ways, had a certain readiness for authoring a new version of their lives because:

* They had other important people in their lives who saw them in a positive way.

* The project staff and participants were the only significant people in their lives so the positive SSP view had influence with the family.

* During the project, some of the important members of the family's support system began to see them differently.

* The family did not have a significant number of people supporting the negative story.

In short, families did well when significant others, in or outside the project, could

42

believe in their potential for change. However, the beliefs of project staff and participants could not overcome a dominant negative image from a family's major support system.

Implications for Replication

Overall, SSP staff believed that, by Phase III, the project design was both well-conceptualized and well-implemented. They would recommend that the following components be maintained in a replicated program:

1)   **The Philosophy:** All elements of the SSP philosophy were considered key to helping families create successful outcomes for themselves. These included:

* A positive framework for the program founded on the belief that all families have the capacity to change.

* An empowering system for both staff and families which allows them to share control over program design. It also allows families a choice about which services they receive.

* A partnership between families and staff which presumes and utilizes competency and knowledge from both.

* A theoretical base which provides for creativity in rewriting family stories from members' strengths and competencies. The focus on strengths was as important for staff as for families. It was often easy for staff to become disheartened when reading case records or forms about these families. However, when they reviewed family strengths, they were able to maintain a more balanced perspective about the progress of the families and the effectiveness of their own work. Staff suggest that all agency forms be revised to include a focus on strengths rather than deficiencies.

* An initial structure with the flexibility to change and develop based on individual, family and project needs.

2)   **An Array of Services:** It was important for families to have options about which services they receive. This implies having a array of services available and giving

families a true choice about which they utilize. Those services deemed most critical include the following:

* Group meetings which focus on adult, child and family needs. To enable maximum group participation, child care and transportation are essential. A nutritious meal is a great motivator. (See "Design" below.)

* Family therapy for individual families which promotes the resolution of such issues as marital conflict, intergenerational legacies of abuse and neglect, and family communication.

* In-home parent training which helps families identify specific parenting goals and develop the skills to achieve them.

* In-home parent aide services which keep families connected to the project and motivated to use the services available to them. The parent aide can also link families with needed resources.

* Sexual abuse treatment for adult survivors, victims, adult offenders, non-abusing spouses and juvenile offenders. While all participant families in this project had experienced child neglect, many had also experienced sexual abuse, either in the current family or in the previous generation.

* The availability of both in-patient and out-patient alcohol and drug treatment programs. Nearly 80% of participant families were affected by alcohol and/or drugs.

* Homemaker services to assist families with housekeeping and household management skills. Nearly half of participant families had received these services prior to joining SSP, which indicates both that the services were needed and that, by themselves, they were not sufficient to produce change. If they had been sufficient, families would not have been referred to SSP.

* Services for battered persons such as hotlines, crisis counseling, shelter and legal services. At least four of the families were experiencing domestic

violence.

* Emergency assistance with food, shelter, clothing and transportation. Since most of these families are dealing with issues of extreme poverty, resources need either to be accessible in the community or through flexible funds.

Other important services include health care, Headstart, AFDC and WIC.

3)   **The Design:** The group component of SSP was both the core service and the one newly created under this funding. While Phases I and II of the project were largely experimental, Phase III appears to represent the best ideas resulting from earlier trial and error. Elements from Phase III groups which should be considered for replication are:

* Weekly meetings of approximately 3 hours in duration with additional time allowed for staff debriefing. Participant attendance is dependent on the availability of child care and transportation. Sixteen such sessions appeared to meet both staff and family needs.

* Participation of all family members, including children in out-of-home care and employed parents. This means meetings must be scheduled when parents are available. The meetings can also serve as supervised visitation when a child is in foster care so the connections between children and parents are strengthened and parents have an opportunity to interact with their children in a constructive environment.

* The provision of a meal which conveys important messages about nurturing, nutrition, family rituals and socializing. It also allows families to attend meetings in late afternoon and early evening when they would otherwise be concerned about eating. As a rule, staff suggest "keep it simple," both from the standpoint of food preparation for such a large number of people and so that families can see that cooking need not be complicated.

* Having "peer" group meetings in conjunction with multiple family groups.

The peer group meetings permit the free discussion of issues most relevant to family members in a specific role (i.e. parents, children and teens) and support role development for individuals. The multi-family groups give another perspective on these roles so that families are exploring the same issues in an entirely new context. They allow families as a whole to exchange points of view with other families. The peer groups appear to be a catalyst for the multi-family groups and it is therefore recommended that they be held first. The interaction between peer and multi-family groups was considered to be the most valuable aspect of the project.

*   The provision of an initial structure for the Adult and Multi-Family Group meetings which is gradually replaced by the participants' own protocol. For example, an initial structure might consist of checking in with each of the group participants (individuals or families) to see if they have something to discuss and/or the generation of certain topics for discussion. Participants should be invited to make suggestions about group structure and format and their suggestions should be implemented as quickly as possible. The Parent Support Group was one such suggestion in the Self-Sufficiency Project.

Beyond what was implemented during the project, SSP staff recommend consideration of the following additions:

*   It would have been helpful in the beginning to have an assessment of each parent's skills with regard to food preparation, budgeting and shopping. Many families could have benefitted from participating in these project activities with staff and volunteers had their level of need for such skills been recognized.

*   With regard to the food preparation, it might be possible to prepare a short book of recipes for the meals served during the group sessions. This "recipe book" could then be given as a gift to families during the closing

46

dinner ceremonial after each phase.

* Have facilitators consistently work with the same group if the program plans to run for more than one "phase." In SSP, facilitators worked with different groups in each phase. For example, a family therapist might have worked with the Children's Group in Phase I and moved to the Adult Group in Phase II. They then had to learn new skills which somewhat delayed the group process. By staying with the same group in the next phase, the facilitator would have been able to use his/her skills more effectively.

* Involve parents as "co-facilitators" in the Children's Group and in providing child care in the Nursery. This would enable the parents to learn new skills and help the program simultaneously. This was not done because parents zealously guarded their time for themselves in the Adult Group.

* Videotape families when the first round of group sessions ends; ask for families' impressions of the process and what has changed for them. This was done in SSP with families at the end of the project but might have provided a more useful reference had it been done at an earlier juncture and then repeated periodically. This would be a good way for families to review their own progress.

4)   **Staff Roles:** At a minimum, a project such as SSP should have a supervisor, a parent aide, a parent trainer and family therapists on staff. Case management services, including services to children in out-of-home care, are vital but it is not necessary to have them provided in the same agency as the program itself. However, if they are provided by another agency, greater staff time will likely be necessary for service coordination. Additional staff support should include clerical, bookkeeping, and volunteer services.

Role flexibility and teamwork among staff promoted both staff empowerment and

efficiency in delivering services. It would not have been helpful to have staff saying, "I only deal with therapeutic issues; you see that the family gets some food." If the program is to assure a real partnership between families and staff, it cannot be governed by rigid hierarchical relationships and roles among the staff themselves. The concept of parallel process dictates that what occurs at one level of the system is replicated at other levels. Role differentiation must exist, of course, but it must also be adaptable to the ongoing needs of the families and the program.

Areas of Difficulty

While the above factors were seen as essential to the success of the Self-Sufficiency Project, a few elements did pose difficulties. The project experienced tremendous staff change during the two years of service provision and each time a change occurred, the project was forced to make significant adjustments. The changes included the move of the Project Consultant from a position in Oregon near the project site to a position in Iowa at the National Resource Center; the leave-of-absence of the Project Director for one year; a change in the Branch Manager for the Douglas County CSD office; the departure of two family therapists in the first six months of the project and the addition of two new therapists; the departure of one of the new therapists after only 3 months and the addition of another person, who only stayed one month before moving to a new job; the subsequent loss of one and then two of the family therapy positions; and in the last few months of the project, a change of jobs for the supervisor and parent aide. The losses in the last few months were the most problematic, because new personnel were not in a position to maintain all the responsibilities of their predecessors. As a result, project staff, with two less family therapy positions, also had to pick up some of functions previously carried out by the supervisor and parent aide. This left all staff exhausted by the end. It is a credit to the staff of this project that they were able to manage the changes as well as they did and to maintain their enthusiasm for the work with these families. It is a credit to the project design that role flexibility was built in and allowed for coverage of all functions. It is also a credit to

the adaptability of the families that they were able to deal with these losses and move forward on their own paths.

One of the difficulties in retaining staff was the limited duration of the project. As soon as stable full-time jobs became available, people moved on. This is, of course, the nature of grant-funded programs where the future is uncertain. Replicating programs would do well to consider in advance how they would handle similar changes among their staff and to assure that quality services to families would be maintained.

Staff also had to contend with some administrative confusion in this project. As was mentioned earlier, there were five levels of administration, three within CSD and two more through the project. While communication about SSP monies and accessing the emergency fund were problems within CSD, there were also problems related to the evaluation that came from the consortium leaders and the National Resource Center. New instruments were added by the consortium and there were frequent requests for new data. This was an added burden on project staff.

It is suggested for future programs that there be clear guidelines about the evaluation process at the beginning of the program and that those requirements are stable throughout the project. It is also suggested that financial matters be handled at the lowest possible level and that emergency funds be immediately available for use at the local level. In SSP, funds had to be requested from CSD's Central Office; because of the time lag involved in such a request, the funds were virtually unusable in an emergency.

CHAPTER 6

CONCLUSIONS AND SUMMARY

In reviewing Hartley's (1987) original considerations for designing programs to help neglectful families, project staff find the Self-Sufficiency Project to have been quite successful (Refer to Final Report for greater detail.)

Social Support and Reduced Dependence on Social Service Systems

One of the most successful achievements of the Self-Sufficiency Project was the development of strong peer support networks. Many instances have been cited in this report of families helping one another. This high level of networking among SSP families expanded their own positive social support system at the same time as it reduced reliance on the more formal support provided by social services. From the outset, SSP had sought to establish a positive, less dependent relationship with agencies and workers. The name change from "Chronic Neglect" to "Self-Sufficiency" is symbolic of this approach. Families were encouraged to co-design the project and to choose which services to use. This approach seems to have been effective for the participant families, as they established friendlier, less conflictual relationships with CSD staff and developed more confidence in their ability to solve their own problems.

Self-Esteem

Many of the participant family members showed significant improvements in self-esteem as indicated both in outcome measures and in more assertive and active behavior. (See Families #1 and #2 Moreover, participants themselves talked about having achieved greater confidence during the course of the project. Self-esteem itself is a developmental construct, gained not through teaching or modeling but through personal experiences. The Self-Sufficiency Project provided a space for individuals to create opportunities for their own growth and development, whether this consisted of achieving career goals, helping other families, re-entering school, or maintaining sobriety.

Parent/Child Attachment and Developmental Deficiencies in Children

Because parents were able to meet their own needs in a more satisfactory way, they became more cognizant of the needs of their children. It was clear to staff that parents were more attentive to their children and more active in both nurture and discipline. Parents became involved with schools, medical providers, and Children's Services Division and saw themselves as advocates for their families. With time, it is expected that these factors will impact the any developmental deficiencies the children have, and that the increased interaction will promote parent/child attachment.

Intergenerational Issues

Hartley noted intergenerational issues as a factor in neglectful families. While the intergenerational hypothesis and the existence of overlapping patterns of abuse with recurring neglect find support in this study, the small and specifically rural sample preclude drawing conclusions about these issues. However, SSP was very active in helping families to confront their histories and to give new endings to old tales. The Adult Groups, Parent Support Groups, Multiple Family Groups and individual family therapy all addressed intergenerational factors.

Substance Abuse

Staff report that many of the families with identified substance abuse problems were either in treatment or sought treatment during the course of the project. There were other families, however, who were not ready to deal with the problem and/or where the substance abuse was not addressed adequately. Since a number of SSP families were in recovery, however, they were very active in confronting substance abusing behavior among other families when it appeared to be an issue.

Symptom Contagion

Finally, staff were extremely successful in avoiding symptom contagion, that is not becoming caught in the environment of negativism surrounding these families. Staff enjoyed their work, they enjoyed the families and they continued to enjoy each other. To quote one of the Self-Sufficiency Project staff, "It was fun to be part of this."

Summary

Beyond the above considerations, there are some observations about the families who improved their lives while in SSP. The families who were successful in creating change were those families who recognized that some change was necessary and who were able to accept a positive view of their ability to change. They were families who were engaged in the project by the opportunity to participate in and create their own program and by tangible offerings such as food, child care and transportation. They were also families who utilized the services they had chosen and who probably received a strong combination of family therapy, parent aide services and group support early in their project participation.

In many ways, the Self-Sufficiency Project was like a wonderful stew: It contained many nutritious ingredients which contributed to its flavor and its capacity to satisfy needs. However, any one or two of those ingredients alone, while meeting some of the need, would not have been as appealing and would not have provided an equally balanced diet for the consumer. SSP services were comprehensive and flexible to meet a wide range of family needs. Staff roles matched this variety and flexibility by including a team with an assortment of expertise who were willing to do what needed to be done. And the core service, the weekly group sessions, were created in partnership with the families who participated. The project itself was always governed by a belief in the families' capacity the change and the willingness to provide them with every opportunity to do so. Half of the families participating in SSP took this chance to rewrite their stories with new hope for the future.

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FAMILY #1
SUCCESSFUL COMPLETION OF THE PROGRAM

When this family first entered the Self-Sufficiency Project in 1989, the members included Joanne, a single mother, age 37, her new husband, Matt, age 34, and Joanne's six children by four different fathers: Jim, age 19, John, age 17, Andrea, age 15, Connie, age 11, Ricky, age 2, and Kelly, age 1. At that time, three of these children were out of the home. The oldest boy, Jim, was in prison for burglary and both Ricky and Kelly were in foster care, where they had been placed following a drug bust in the family's home. Of the other children, Andrea had lived on the streets of Portland for long periods and supported herself through panhandling, John was involved with drugs and Connie had been raised primarily by her paternal grandparents. Neither Andrea nor John was in school. Over the years, the family had had over 20 referrals to Children's Services Division for child abuse and neglect.

Joanne came from a family where she had suffered both physical and sexual abuse and neglect. She also had a long history of criminal behavior related to drugs. Joanne met Matt in a drug treatment program. He was a volatile heroine addict who also had a history of criminal behavior. Together, Joanne and Matt violated the rules of the drug program and eventually dropped out.

At the time of referral to SSP, there was strong consideration of terminating parental rights on Ricky and Kelly, the latter of whom had been away from her mother for nearly a year and had very little attachment to the family. As a whole, family members were described as "depressed, suffering from extremely low self-esteem and being very street-wise."

Just prior to entering SSP, Joanne and Matt had started an out-patient drug treatment program and began attending meetings of Alcoholics and Narcotics Anonymous. In the SSP Adult Group, they talked openly about the recovery process and the transitions their family was going through as a result of their decision to lead a clean and sober lifestyle. Matt related to the group more easily than Joanne and self-

55

esteem remained a significant issue for her for some months. A first sign that Joanne was able to value herself came when she announced to the group that she had bought herself a new pair of shoes. Since entering recovery, she had been unwilling to spend money on her own needs, always giving to others first.

Joanne and Matt gradually moved to a position of leadership in the Adult Group and their children were some of the most outspoken participants in the Teen and Children's Group. Seeing that their opinions in group were both acknowledged and valued prompted Matt and Joanne to enter the local community college as full-time students working toward a degree in human services. The Self-Sufficiency Project then functioned as their practicum. They attended all of the project's Adult Group meetings and acted as guides for the project and mentors for new participants. They were also instrumental in organizing the Family Support Groups which followed the first phase of the project.
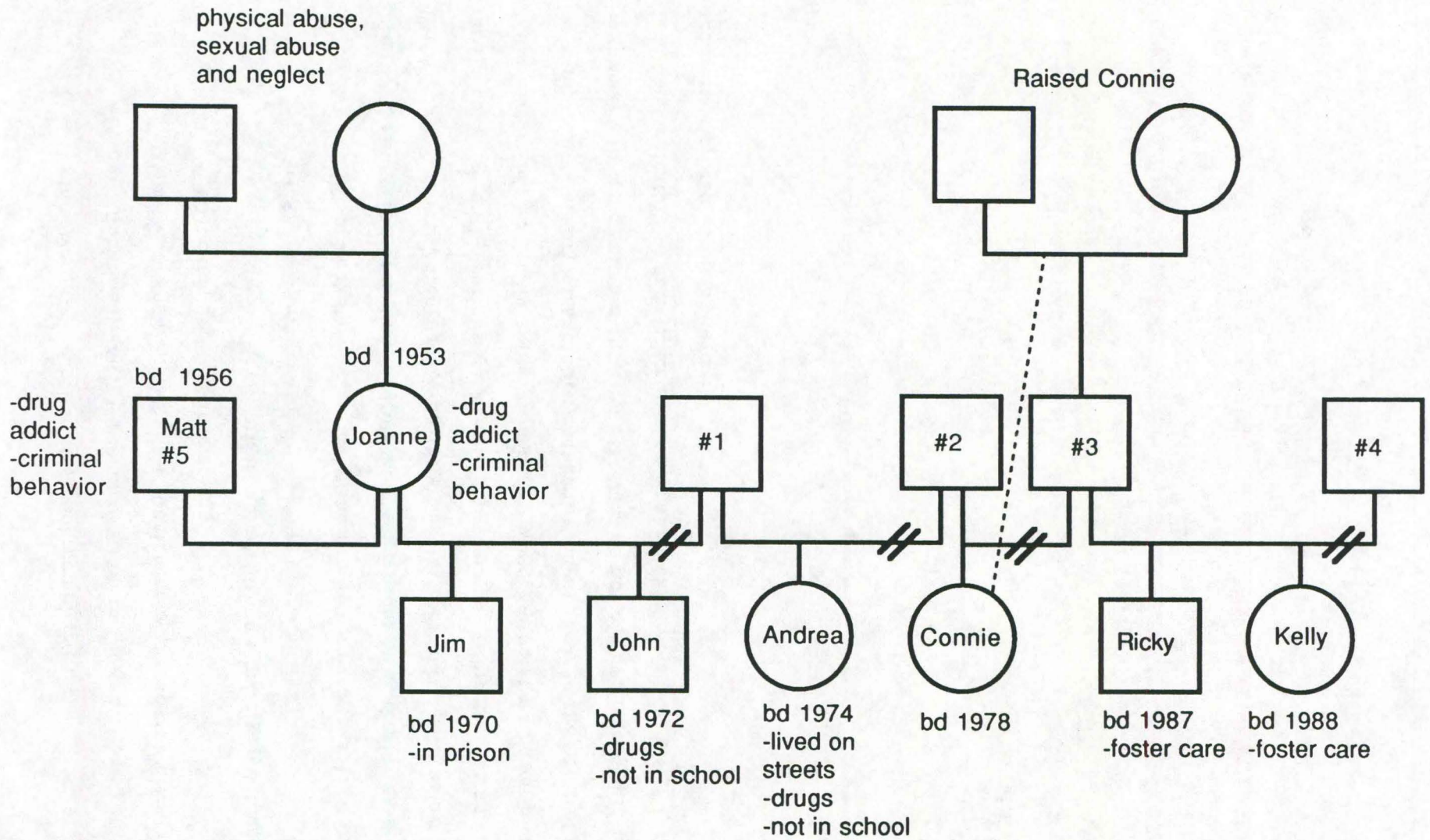
Within two years, Joanne and Matt had both completed their Associate Degrees at the community college, Joanne with honors, and both had enrolled in the University of Oregon to complete a Bachelor's program. Matt was also working part-time at the local drug counseling agency. For the children, equally important changes occurred:

* Out of love for her child, Joanne released Kelly for adoption to the foster adopt home where she had been living since infancy.

* Ricky was returned home from foster care and court wardship was terminated. He continues to do well at home.

* Connie challenged the family with her non-compliant behavior but she began working constructively with a school counselor whom she liked. Joanne maintained regular contact with the counselor.

* Andrea returned to school in the mornings, got a part-time job and entered drug treatment. Later, at age 17, she became pregnant and gave birth to a healthy baby named Kelly.

*   John, who had been out of school, completed the program at Project Pride, an educational and vocational program to facilitate youth in getting their G.E.D. and/or a job. At last contact, he was readying himself to take the G.E.D. exam and was in recovery.

*   Jim was paroled from prison, returned home briefly and then moved out on his own.

One of the project staff summed up the family's progress: Joanne and Matt have been ". . . asking for, receiving, and utilizing suggestions on parenting skills that they can use with their children; following through with personal as well as professional 'assignments' given by various staff; utilizing resources within the community to help in reunification of the family and also in their recovery process; and continually working on the previous history of addiction that had brought them to the point of having to be involved with the agency in the first place." Another of the project staff added, "Their love and dedication to each other as they go through the many trials of a family in recovery has been inspiring to me."

Family #1 Circa 1989

physical abuse, sexual abuse and neglect

Raised Connie

bd 1953

bd 1956

-drug addict -criminal behavior

Matt #5

Joanne

-drug addict -criminal behavior

#1

#2

#3

#4

Jim

John

Andrea

Connie

Ricky

Kelly

bd 1970 -in prison

bd 1972 -drugs -not in school

bd 1974 -lived on streets -drugs -not in school

bd 1978

bd 1987 -foster care

bd 1988 -foster care

58

- Over 20 referrals to Children's Services Division for child abuse/neglect

SUCCESSFUL COMPLETION OF THE PROGRAM

Sally's family initially came to the attention of Children's Services Division following the sexual abuse of her daughters by their father. The family included Sally, her husband and their three children, Susan, age 10, Melanie, age 7, and Janey, age 5. Sally had a long history of involvement with the child welfare agency in her home state of Virginia, including the death of one child allegedly due to a beating by her boyfriend. The boyfriend was not convicted and remained in the home until he injured another of the children. Reports indicate that Sally was not emotionally available to her children, failed to protect them from harm and neglected their medical needs.

Immediately following the report of the sexual abuse, Sally was cooperative with CSD in seeking help for her children. However, as Sally later recalled, her husband "had total power over my life" and she continued to let him visit the children, contrary to a court order. She also began minimizing the abuse of the children and it was clear that she was not able or willing to protect them. The girls were placed in foster care. At the time of placement, Susan was very vocal and manipulative while Melanie and Janey were quiet and unable to talk about their feelings.

At the time she entered the Self-Sufficiency Project, Sally was in individual therapy and had stated that she "did not want to be in abusive relationships." For most of her adult life, she had been in relationships with men who had physically and sexually abused her children and she, herself, was a victim of sexual abuse. Sally became pregnant with her first child at age 17, got married and was then able to leave home. Following the birth of her second child, she left her husband and moved in with a boyfriend. This boyfriend was abusive and was purported to have killed the baby. Following his abuse of her daughter, Sally relinquished custody of this girl to her parents. That child remains in Virginia. Subsequently Sally remarried and moved to Oregon. At the beginning of SSP, Sally said that she wanted to rewrite her story and that of her children so that they were "survivors instead of victims."
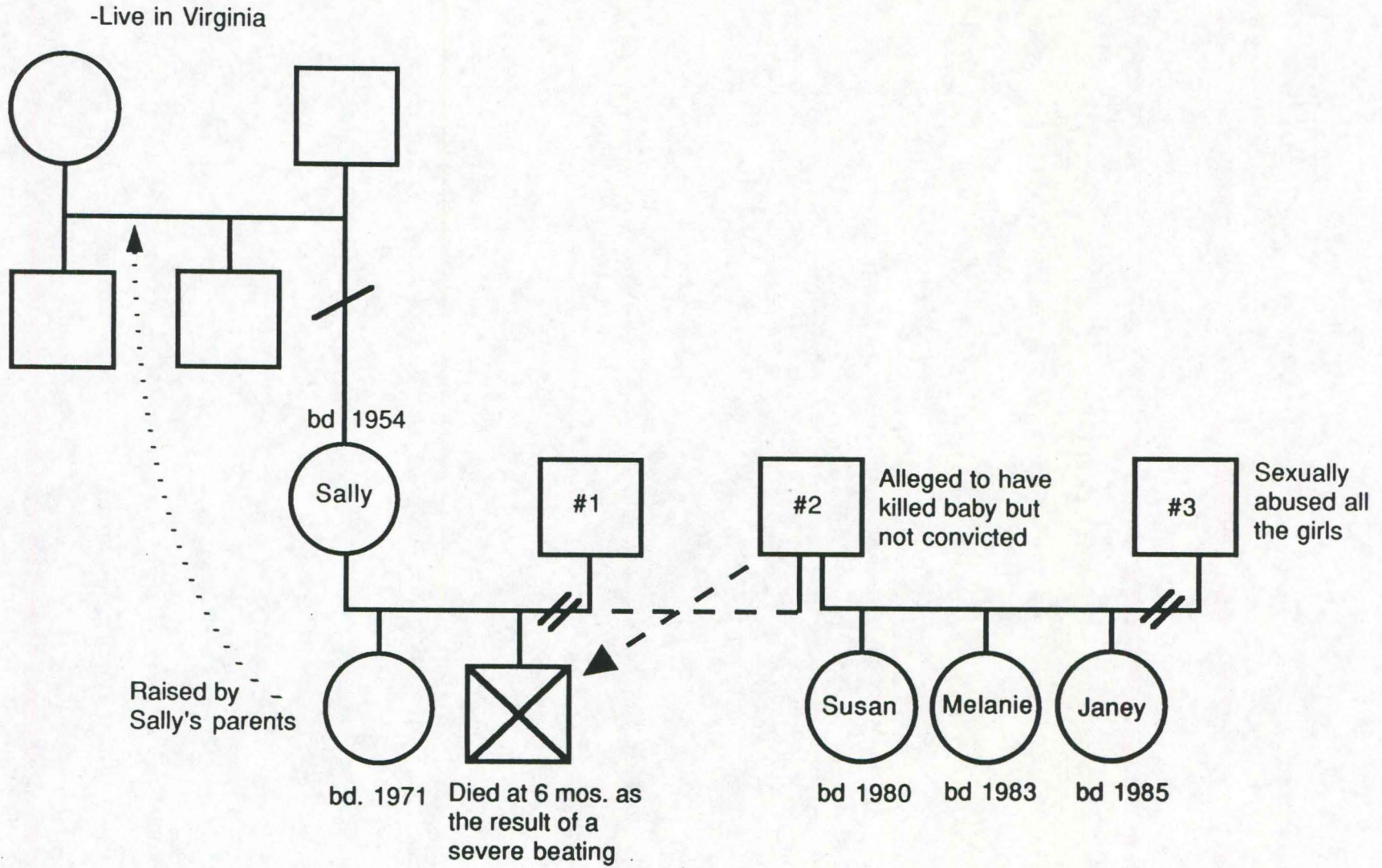
Still, Sally was very angry with CSD for forcing her to separate from her husband and for taking away her children but she could not express her feelings and wishes about having the children returned to her care. She wanted to blame everyone for her loss: her husband, her friends, her past, and, of course, CSD. Members of SSP's Adult Group, however, began "calling" Sally on this blaming behavior and inviting her to take charge of her own life. She was questioned on what she wanted to see happen in her life and the lives of her children. As Sally began to take "healing steps," the group praised her progress and she gained confidence and strength.

The family utilized many resources in their movement toward change: Sally participated in SSP's Adult Group and Parent Support Group along with continuing her individual therapy and receiving in-home parent training services. The children were in the SSP Children's Group and the two oldest were involved in sexual abuse treatment. Sally and her daughters received individual family therapy as well as participating in the multiple family therapy groups. This is a good example of how the Self-Sufficiency Project supported all resources necessary to help the family: The individual therapy and in-home parent training were provided by the project's parent trainer and the family therapy was provided by the project's family therapists. In addition, Sally utilized community resources such as Sexual Abuse Treatment, Battered Persons Advocacy, and FISH (emergency assistance).

Through her involvement with SSP, Sally became less fearful of her husband and was able to confront him on his offending behavior. As she became more assertive in relationships, she regained her authority as a parent and was able to help move her "parentified" daughter into a more appropriate familial role. Sally was also more assertive about regaining custody of her children; she requested a meeting with her worker's supervisor, described the changes she was making and asked that her children be returned. They went home during the project period. Through the parent training, Sally was able to establish clear goals for herself and her children and she endured the transitional behaviors that the children exhibited when they returned home. She was

able to empathize with their anger at her for not having protected them and for allowing them to be removed from her care. Sally began to see how her actions affected her children and was able to give them the support and comfort they required. Project staff said, "Sally showed a great deal of strength and courage in her struggle to gain control of her life."

Family #2 Circa 1990

-Live in Virginia

bd 1954

Sally

#1

#2 Alleged to have killed baby but not convicted

#3 Sexually abused all the girls

Raised by Sally's parents

bd. 1971

Died at 6 mos. as the result of a severe beating

Susan   Melanie   Janey

bd 1980   bd 1983   bd 1985

Ellen's family was referred to the Self-Sufficiency Project as a probable "last resort" at family reunification. The oldest child, Ron, age 10, lived with his father and had very little connection to his mother. The two daughters, Margaret, age 8, and Karen, age 5, had been placed in out-of-home care due to long-term neglect and sexual abuse of Karen by Ellen's boyfriends. Ellen, who was developmentally disabled, lived in a small apartment and supported herself through welfare payments and SSI. The apartment was very dirty and disorganized and Ellen was extremely isolated, her main connection being with various boyfriends. The relationships she did have often had a negative impact on her life; these included conflictual relationships with her mother and sister. Ellen also seemed depressed since she rarely left the house and spent most of her time watching television. She was known to keep rodents for pets. Ellen repeatedly denied that her daughter had been sexually abused.

It is probable that Ellen herself was a victim of neglect as a child. Her parents were divorced and her two brothers and sister were also developmentally disabled. Sometime during her childhood, Ellen and her brothers and sister were simply "dropped off" at Fairview School, the state institution for the mentally retarded, where they remained for several years.
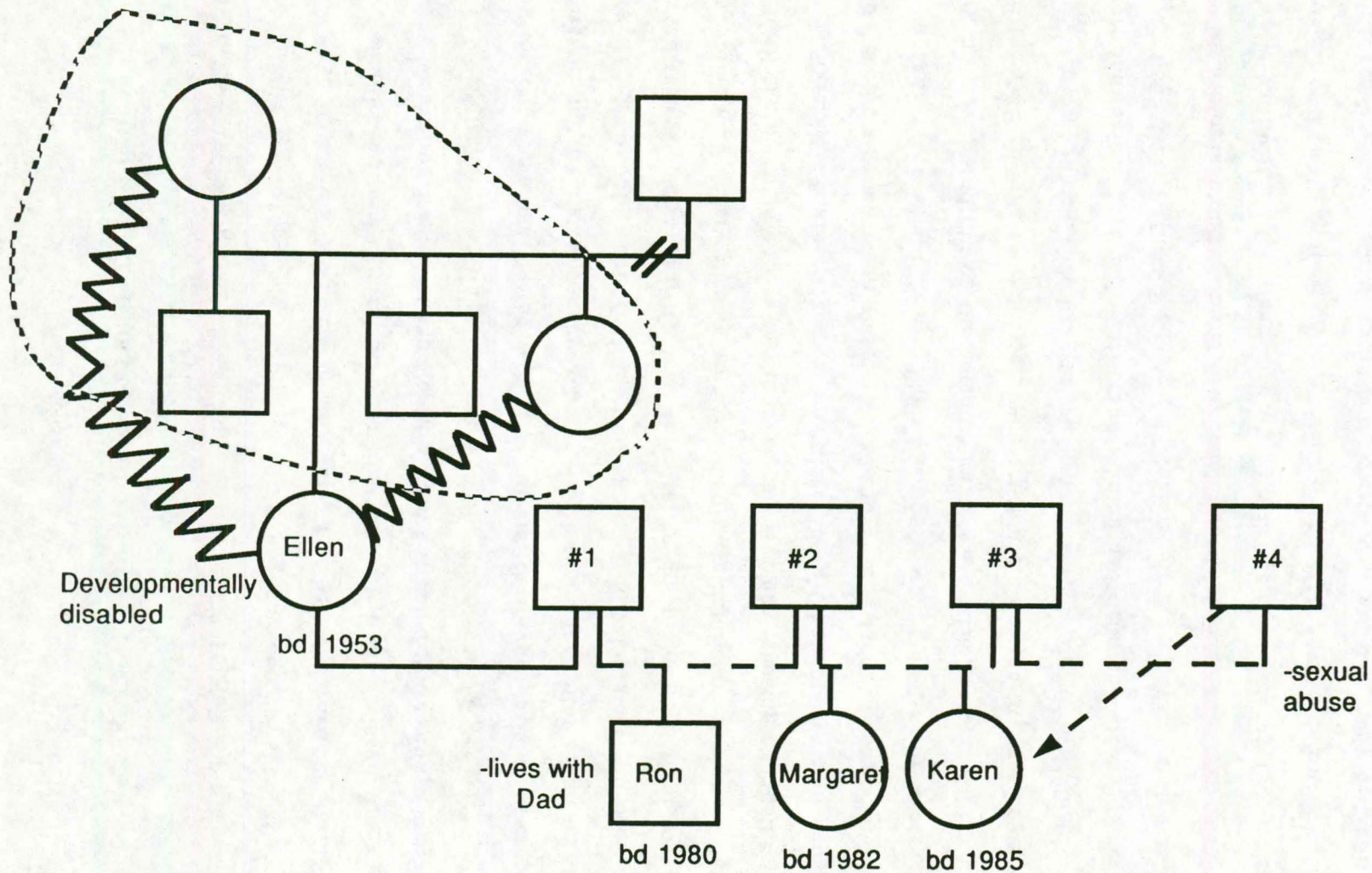
Shortly after Ellen began working with SSP, she did begin to make some changes. She was not with a boyfriend at the time and made some connections with other group members. The children were returned to her home and in-home parent training services were initiated. Ellen was able to focus some attention on the children and made efforts to parent them directly. Previously, she had often let Margaret parent Karen or let boyfriends parent them both.

After these initial gains, Ellen reconnected with an old boyfriend; her attention once again focused on the man in her life. While Ellen attended all Adult Group meetings, she never actively participated. She continued with the in-home parent

training but found it difficult to motivate herself to deal with the children's behavior, even when it clearly distressed her. The atmosphere in the home was characterized by fighting, "cussing," and arguing. Typically, Karen would get angry, scream that she was running away and then slap her mother. Ellen would slap her back, and her boyfriend, Ralph would also hit the children. The parent trainer observed a gradual deterioration in the care of the home and in Ellen's ability to handle the children. The odor and clutter in the house both became worse and the girls appeared to be totally out-of-control, with Ellen's attempts at parenting largely ignored. Ellen quit attending the Parent Support Group because she needed to be home "to cook for Ralph" and she later admitted to being bored and not wanting to return. At the time that family therapy was introduced, several months after the beginning of SSP services, Ellen discontinued parent training. She did not want to do both at the same time.

It is probable that Ellen's limited abilities along with some depression, made it difficult for her to understand and engage with many of the services being offered. Her extreme dependence on men to guide her life and her decisions further complicated the situation. Had services engaged Ralph earlier in the process, it is possible that Ellen might have taken a greater interest but it is difficult to say that more could have been done. After the end of the project, Ellen's daughters were again removed; there is now a strong likelihood that parental rights will be terminated. At least, with the multiple and intensive interventions of SSP, workers were better able to determine the likelihood of change within the family and to move quickly toward a permanent plan for the children.

Family #3 Circa 1990

Ellen
Developmentally
disabled
bd 1953

#1
#2
#3
#4

-sexual
abuse

-lives with
Dad

Ron
bd 1980

Margaret
bd 1982

Karen
bd 1985

FAMILY #4
DID NOT COMPLETE PROGRAM; NOT SUCCESSFUL

In the year before Kathy's family entered the Self-Sufficiency Project, her youngest child, Maria, age 2, had been placed in foster care because she was failing to thrive. By the time the SSP services began, Maria had been returned but the family remained chaotic and new medical problems had been identified. Jason, age 7, had giardia and was being treated at the Health Clinic but could not attend school. Maria now had tuberculosis. Jason was also demonstrating out-of-control behavior such as throwing the puppy up against the wall and Patricia, the oldest child at 8 years old, was often missing school for questionable reasons. Kathy had not followed through with necessary medical appointments for the children and medical neglect had been documented. The house was filthy, with feces rolled up in sheets on the floor, and the children were equally dirty. Jason, who was medically handicapped, had not been toilet trained until the age of 6 and, with the giardia, was again refusing to use the toilet. Kathy's behavior was characterized as "impulsive," with frequent moves in and out of the state. People also moved in and out of her home on a frequent basis.

The family consisted of Kathy, Maria, Jason, Patricia, and Kathy's boyfriend, Manuel, who was in and out of the home. Manuel was Maria's father; Kathy had divorced the father of Patty and Jason, who continued to reside in New England where the family had originated. Manuel was an illegal alien who spoke little English and there were indications that both Kathy and Manuel had drug and alcohol issues. Manuel was in jail briefly for Driving Under the Influence and Kathy was arrested as an accessory to a burglary and required to do community service.
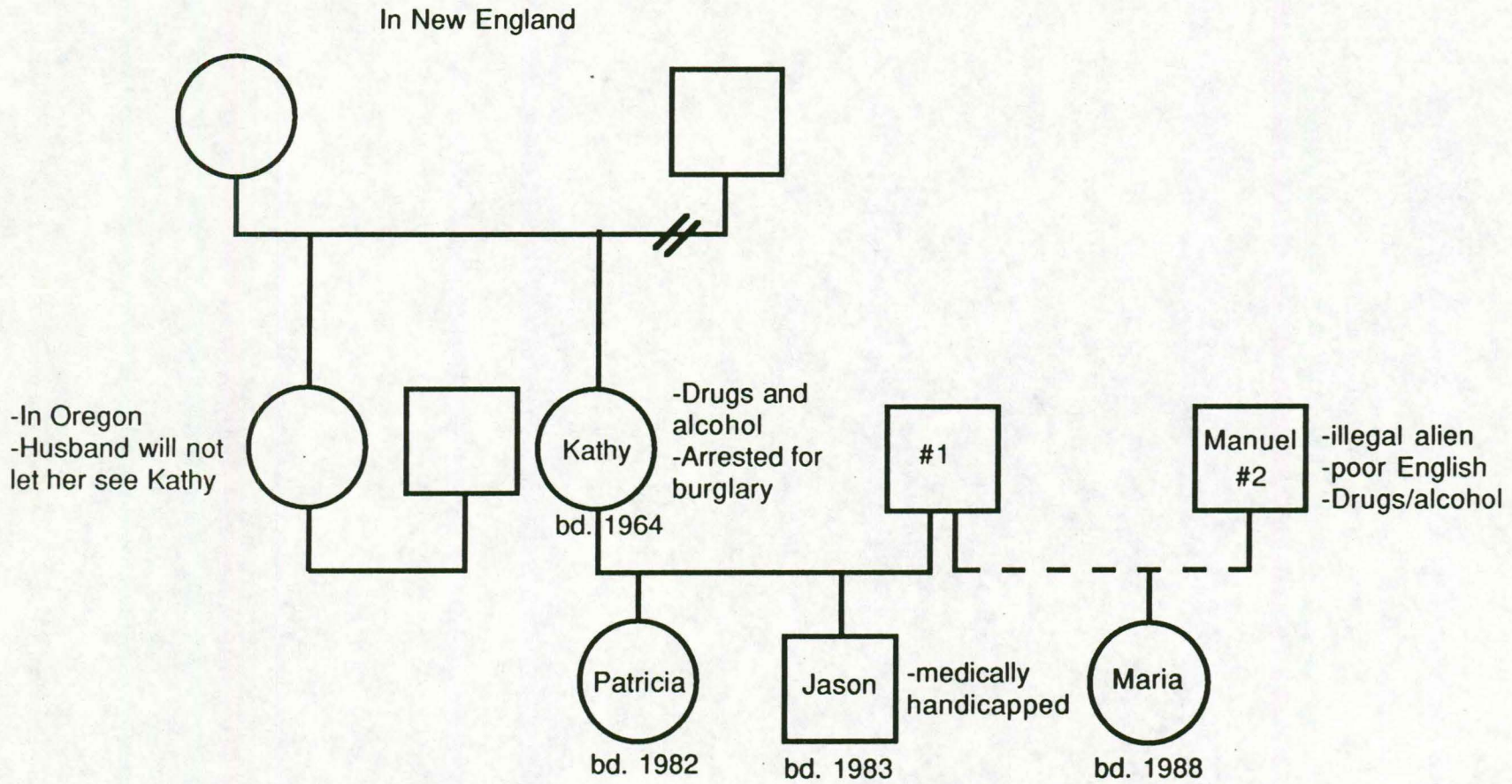
While Kathy initially agreed to work with the Self-Sufficiency Project, she attended just two or three of the group meetings and Manuel attended only one. Manuel was never seen by project staff during home visits so it was extremely difficult to engage him in the program. The family did receive in-home parent training services for several months but there was little change in behavior. Kathy did not follow through on

plans developed with the parent aide and often failed to show up for scheduled home visits. Most critically, she did not deliver Jason's stool samples to the Health Department so that he could be cleared of giardia and return to school.

Kathy and Manuel separated toward the end of their contact with project staff and Kathy abruptly moved the family back to New England to reconcile with her former husband. At last check, she was again in Roseburg with the strong probability of renewed involvement with Children's Services Division. While Kathy was always verbalized a willingness to work with SSP, it is clear that she never saw the project as being of value to her. It is possible that drug and alcohol issues were more of a concern than originally supposed and that dealing with this more directly might have been helpful.

Family #4 Circa 1990

In New England

-In Oregon
-Husband will not
let her see Kathy

Kathy
bd. 1964

-Drugs and
alcohol
-Arrested for
burglary

#1

Manuel
#2

-illegal alien
-poor English
-Drugs/alcohol

Patricia
bd. 1982

Jason
bd. 1983

-medically
handicapped

Maria
bd. 1988

68

APPENDIX A

POSSIBLE ISSUES TO COVER IN ADULT GROUP

POSSIBLE ISSUES TO COVER IN ADULT GROUP

1. Blending families and/or step-parenting _____
2. Emotions--how to recognize them and what to do with them _____
3. Self-care _____
4. Coping/stress management _____
5. Communication skills (general) _____
6. How to deal with children's questions _____
7. How to recognize when children have problems _____
8. How to deal with destruction from children _____
9. Realistic expectations for children _____
10. Parental roles, who should do what _____
11. Discuss what happens from week to week _____
12. Discuss problems families have in common _____
13. Discuss our childhood and what was lost, etc. _____
14. How to recognize successes in your life _____
15. Family activities that don't cost money _____
16. The difference between discipline and punishment _____
17. How to answer your children's questions about sex _____
18. How to create a support system _____
19. How to get your child to do what you want them to _____
20. How to deal with depression _____
21. How to get along with caseworker _____
22. How to deal with divorce _____
23. Boyfriends as parental aids _____
24. Battering _____
25. Sex Abuse _____
26. Self-esteem and how to give to a child when your own self-esteem is low _____
27. Teenage issues _____
28. Drug and alcohol issues _____

The lines after each item were used to indicate the number of families voting for that item.

APPENDIX B

SELF-SUFFICIENCY PROJECT

TEEN GROUP: INTRODUCTORY QUESTIONS

SELF-SUFFICIENCY PROJECT

Teen Group: Introductory Questions

1.   What is your name?

2.   If you could be anyone in the world, who would you be and
     why?

3.   What is the best thing about being a teenager in a family?
     What is the worst thing about being a teenager in a family?

4.   If you could live anywhere in the world, where would you live
     and why?

5.   What is your favorite thing to do?

APPENDIX C

SELF-SUFFICIENCY PROJECT: IN-HOME PARENTING COMPONENT

INITIAL ASSESSMENT AND
IN-HOME CONSULTATION REPORTS

SELF-SUFFICIENCY PROJECT: IN-HOME PARENTING COMPONENT

Family:_____Start Date:_____

Caseworker:_____End Date:_____

INITIAL ASSESSMENT FOR IN-HOME CONSULTATION

1. Family members and ages:_____

    _____

2. Children's Services Division involvement (Include approximate length of time you
    have worked with the family and Children's Services Division services used):____

    _____

    _____

3. Brief family history:_____

    _____

    _____

    _____

4. Family dynamics:_____

    _____

    _____

5. Present lifestyle and financial situation:_____

    _____

    _____

    _____

6. Community resources:_____

    _____

    _____

7. Family support system (positive and/or negative)_____

    _____

    _____

    _____

8. Current and/or previous legal involvement:_____

    _____

    _____

    _____

9. Existing (and/or past) family stressors _____

    _____

    _____

    _____

10. Family strengths and/or motivators:_____

    _____

    _____

11. Parenting strengths:_____

    _____

    _____

12. In any order, please list your frustrations and/or areas you feel the family (or
    family members) has difficulty with and/or the family could benefit from:_____

    _____

    _____

    _____

13. Previous interventions utilized and results:_____

    _____

    _____

    _____

14. Prioritize four to ten goals (or list deficit areas) that you would like the family (or family members) to work toward realistically obtaining in the next four to six months:_____

_____

_____

_____

15. What might get in the way of the family reaching their goals:

_____

_____

_____

16. Other comments:_____

_____

_____

_____

_____

SELF-SUFFICIENCY PROJECT: IN-HOME PARENTING COMPONENT

DATE:_____COMPLETED BY:_____

FAMILY MEMBERS PRESENT: _____

_____

IN-HOME CONSULTATION

1.   Goals currently targeted:

2.   Results of intervention:

  a.   Followed through:

  b.   Progress/strengths:

3.   Parent/Child interaction:

4.   Resources offered and/or utilized:

5. Condition of house:

6. Any significant changes from last visit:

7. Miscellaneous other:

8. Areas/Strategies to work toward next week: