Family Support —

The First Option for Families in Great Stress

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SYNOPSIS:

The aim of this paper is to present Family Support as the optimal choice for the long-term well being of children of families in great stress. (This may be the primary professional resource or may be in combination with alternative care).

These families are described elsewhere as "multi deficit", "multi problem", "hard to reach", "hard core" and "excluded families", meaning excluded from the day to day services of our community. Not only do these families fear rejection and failure so do not attempt to use ordinary community services and resources such as community houses, libraries, maternal and child health nurses etc., but these services feel uneasy and poorly equipped to handle these families and their perceived needs.

A multi-service agency is required to effect change where there has been an inter-generational cycle of deprivation which gives rise to a "poverty of experience."

We will demonstrate the effectiveness of this approach through a case study where long-term fostercare seemed a likely outcome.

This paper presents a distillation of the knowledge about families and methods of working with them, that has grown and developed over the past 10 years at Careforce Outer East.

BACKGROUND

Since 1921 an Anglican agency, St. John's Homes for Boys & Girls, has been involved in the welfare of children, primarily through residential care. When the Commonwealth Government made funding available in 1977 for family support under the Alternatives to Residential Care Program, St. John's concept of "Careforce" was implemented gradually by the establishment of four separate agencies in Melbourne. This concept emphasised the value of home-based support for vulnerable families combining the skills of family aides with a variety of other services and staff. The program was established in the outer-east region in 1978.

MISSION OF CAREFORCE FAMILY SUPPORT SERVICES (OUTER EAST)

Careforce is a family support agency of professional and non-professional workers, working with families with children 0-13 years in Ringwood, Croydon and Nunawading.

These families are experiencing difficulties which are seriously affecting the well-being of the family unit and/or its members.

We work together with the family to strengthen their skills and ability to cope with day-to-day tasks so that the family can stay together.

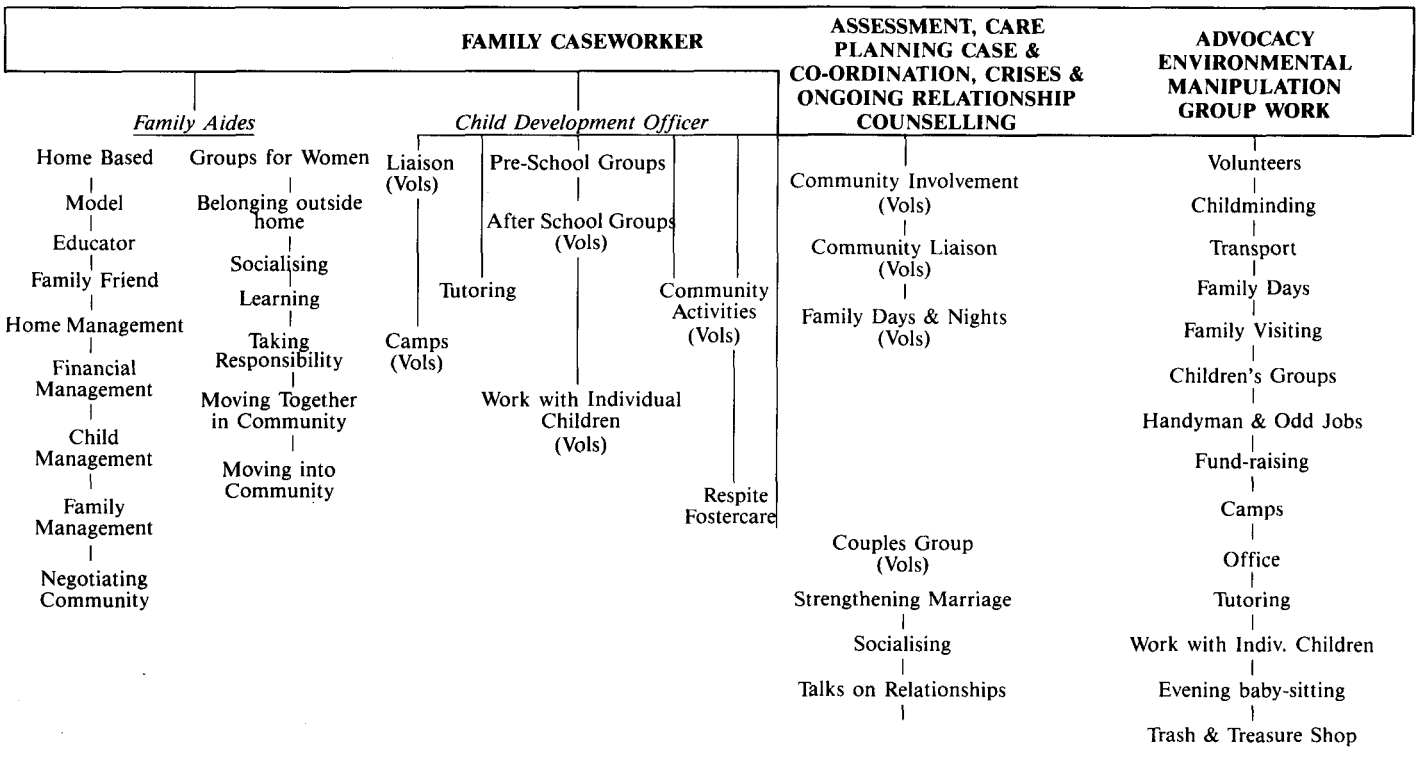
We also work to raise community awareness of injustices and inequalities of opportunity and act to make changes so that everyone's life options in our society are maximised.

The following are the objectives of the Family Support Service:

- To assist the families to develop skills in family relationships and management to enable them to live independently of formal support services.
- To ensure children are adequately nurtured.
- To assist families to develop their own support networks.
- To assist families to utilise community resources.

The practice wisdom that has accumulated over the past 10 years has resulted in an extensive list of beliefs firstly about families and children, and secondly about effective family support.

PROGRAMS FOR FAMILIES



The following is a resume of those beliefs.

A. BELIEFS ABOUT FAMILIES AND CHILDREN

1. Children are best brought up in their family of origin as long as the care is "good enough"[1] to adequately meet their needs for growth and development.
2. Almost all parents want the best for their children.
3. Families will work best on problems when they can have enjoyment and fun.
4. The bond between children and their natural parents should be protected and strengthened, as it is a cornerstone of self-identity.
5. With long-term disadvantage in parents, we may need to retain modest expectations about the extent of change/growth possible with them. We recognise that in many instances the real focus of growth is in the life options for the child(ren).
6. Human beings find it difficult to change established routines or ways of behaving or doing things. Many families develop entrenched ways of handling situations or crises. Families in great stress can find it even more difficult to change because they can often have little energy left to try (i.e. to risk) new ways.
7. People with low self-esteem are likely to have difficulties in effectively parenting their children. This may have origins in an emotionally deprived background compounded by current stresses, giving rise to feelings of being unloved. Others may have extremely limited practical, personal and social skills.

B. BELIEFS ABOUT EFFECTIVE FAMILY SUPPORT

1. Change is possible, but it is necessary to reach out and persevere for it to occur and be sustained.
2. To effect change where there has been a cycle of depression, a range of well-planned, coordinated services is required, addressing all constellations of family members as well as parents and children individually.
3. Each family's case plan for involvement and support from the agency should be unique, and regularly re-negotiated with the family.
4. There is a need for workers to regularly reflect with the family on progress and change. The recognition of achievements, no matter how small, will be a significant motivation for the family and the workers to continue.
5. The need for belonging is particularly critical as a base for growth for socially isolated families. Hence for some families a period of dependency on the agency may well be necessary as a secure base for them to be able to develop an appropriate level of independence in family functioning.
6. A basic principle which needs to guide decisions/actions is "will this empower or disempower the family?"
7. The agency must be able and prepared to offer practical and concrete supports to demonstrate effective assistance to the family, particularly in the engagement phase.
8. It is critical to involve the adult male member of the family.
9. Where the care and nurture of a child is not adequate and parents do not demonstrate a preparedness or capacity to change, the agency must be prepared to see the rights of the child as paramount and refer the matter to state authorities. The bottom line is the well-being of the child.
10. The intensity of this support work with families can raise personally unresolved issues for workers. The agency's supervision needs to recognise this and provide appropriate support.
11. Our resources will not be enough to assist some families to change.

KEY ELEMENTS OF METHOD

Assessment and intervention need to consider a range of internal and external dimensions affecting family functioning. We use the elements of family functioning as described by Geismar[2] which include relationships, individual behaviour and adjustment, care and training of children, social activities, economic practice, home and household practices, health conditions and practices, capacity to work with agency, and use of community resources.

From our experience, the theoretical knowledge and values of the professionally trained social workers and child development workers provide the conceptual basis for understanding, reviewing and developing our work with families. The realistic and practical approaches of family aides combine with those of the professionally trained workers ensuring a well rounded personable, caring approach which is experienced as relevant and tangible by families.

However, a critical dynamic for workers is the ability to maintain a tension between a personable and supportive approach, and a sensitively direct and honest expression of concerns to the family, when the need arises.

Another key element is that it is the responsibility of *workers* to demonstrate trustworthiness by being reliable and committed through having regularly timetabled appointments.

As well, we give a different understanding to the concepts of the "resistant" client and the "unmotivated client". By persevering despite an apparent lack of initial responsiveness, we demonstrate that we understand a "resistant client" is not one lacking motivation. "All people are resistant to change, the affluent as well as the poor; the copers as well as the non-copers, those with good self esteem and those with poor self esteem. It is really often a hardship, or something changing which we cannot control; that spurs any of us to dramatically look at our own patterns of dealing with things and relating to others. How much more apparent is this likely to be when nothing much has been good for you in life anyway. When referred to yet another agency, after so many unsuccessful engagements, the underlying feeling is 'Why should this service/person be any more caring and understanding, and therefore successful in helping than those in the past which have failed?' "[3]

Further, "Lack of motivation is often attributed to these families by persons in the helping field when appointments are not kept. More accurately feelings of inferiority and uncertainty as to how to deal with those perceived as in authority or as better educated, coupled with the practicality of managing pre-schoolers on inadequate transport which takes money away from paying bills and food, making such an appointment unattainable! Underlying the expectation that an appointment can be kept, is the message that the service cannot help them nor does it understand them. A sense of failue and rejection are again reinforced."[4]

There are two further elements we consider successful. One is that all members of a family need to be engaged as early as possible. This requires a commitment by workers to regular out-of-hours work.

The other is that the family team comprising the family and all workers involved with them need to work on a consensual goal-focused plan, coordinated by the family caseworker. Regular reviews of progress and setting of goals, involves all family team members.

PHASES OF WORKING WITH FAMILIES IN GREAT STRESS

There are five distinct yet overlapping phases of working with families in great stress. They are relevant for the majority of families with whom we work, but they are not essential to achieving desired changes. The flavour and mix of services will vary between families and over time.

Phase 1 *Reaching Out — Home Based*

The initial stage is one of "reaching out" to the family in their home, and may take some months of erratic contact, failed appointments, numerous crises, the workers resisting the family's attempts to put them off.

The family caseworker has prime responsibility for reaching out and engaging the family, at the same time beginning an assessment of the family's hopes, needs, strengths, stresses and supports. A family aide may also be part of the reaching out strategy, demonstrating through a closely working together on practical tasks, that things can change.

Phase 2 *Sense of Belonging Outside the Home — Centre-based*

We encourage families to see Careforce as somewhere they can feel safe, whether to visit, to phone or to participate in group programs. Participation in group programs is encouraged as early as possible. For some this may take as long as a year. For a few families it may only be the children who participate in groups. We enourage families to see Careforce as their 'club' — a concept not always thought quite professional! This sense of belonging at Careforce shifts the load of dependence away from one or two staff and promotes identification with other families. This is the beginning of making *networks* so necessary for sustaining families in day-to-day survival.

Phase 3 *The "Core" Tasks — Home & Community-based*

The family is now open to real change, having gained trust, hope for change through some successes, and a measure of social acceptance. Having gained some skills in practical tasks the more difficult area of relationships and child management can now be worked on together in an honest and direct way.

Phase 4 *Learning Together to use the Community and its Resources — Centre and Home-Based*
Having gained more confidence at home and also at Careforce, the next phase is learning to negotiate the wider community, remembering that when we know *how* to do something and have gained information and skills to be able to negotiate, then we feel more self-valuing. Hence members of groups organise to go together to recreation centres and parks, into the city using free entertainment facilities, have lectures from, or at outside bodies such as T.A.F.E., visiting the local Citizen's Advice Bureau or finance counsellor etc.

Phase 5 *Moving into the Community — the Termination Phase*
The goal of this phase is for the family to achieve independence of formal support services, having developed its own informal supportive network and skills in home, child and relationship management.

The case we have chosen to illustrate our method of working with families where there is a sense of family identity, illustrates the need for perseverance, the need to recognise small gains, for the family to remain in charge; and for there to be a variety of supports for the family and its members based on a psychodynamic understanding coupled with a systematic analysis. (Note:- the case is disguised to protect privacy).

In October 1984, a referral was made to Careforce Family Services by a Melbourne after-care hospital for a 34 year old mother with a husband and three small children. The very anxious and unhappy mother was about to leave after-care, with a new baby with whom she was experiencing difficulties in breast feeding.

The initial contact was made and an assessment began when the family caseworker visited Julie at the hospital. Julie expressed some reluctance to accept suggestions of help but eventually said she did want some help in establishing routines for housework and home management, help with child management and some personal support and companionship.

It was important to introduce some help immediately to give hope that things could change so a family aide was introduced twice a week.

It became clear at this stage that there were a number of issues that needed to be addressed. There were marital problems — including a lack of communication and support; there were home management problems — chaotic household with no sense of control and security; problems with child management — in particular a problem with the middle child who was thought to be at risk; low self-esteem of the parents — mother in particular who had a deprived, institutional background; and, most significantly, no effective support network around them. Neither parent had any effective support from extended family. Father's family were all interstate and mother had been separated from all of her family when she was placed in an institution.

Other supports were soon introduced — a creche and later family day care one day per week for Tom, a Careforce women's group and a concurrent playgroup for the two younger children. John joined the Careforce after-school program and attended Careforce camps. The family also attended Careforce family functions.

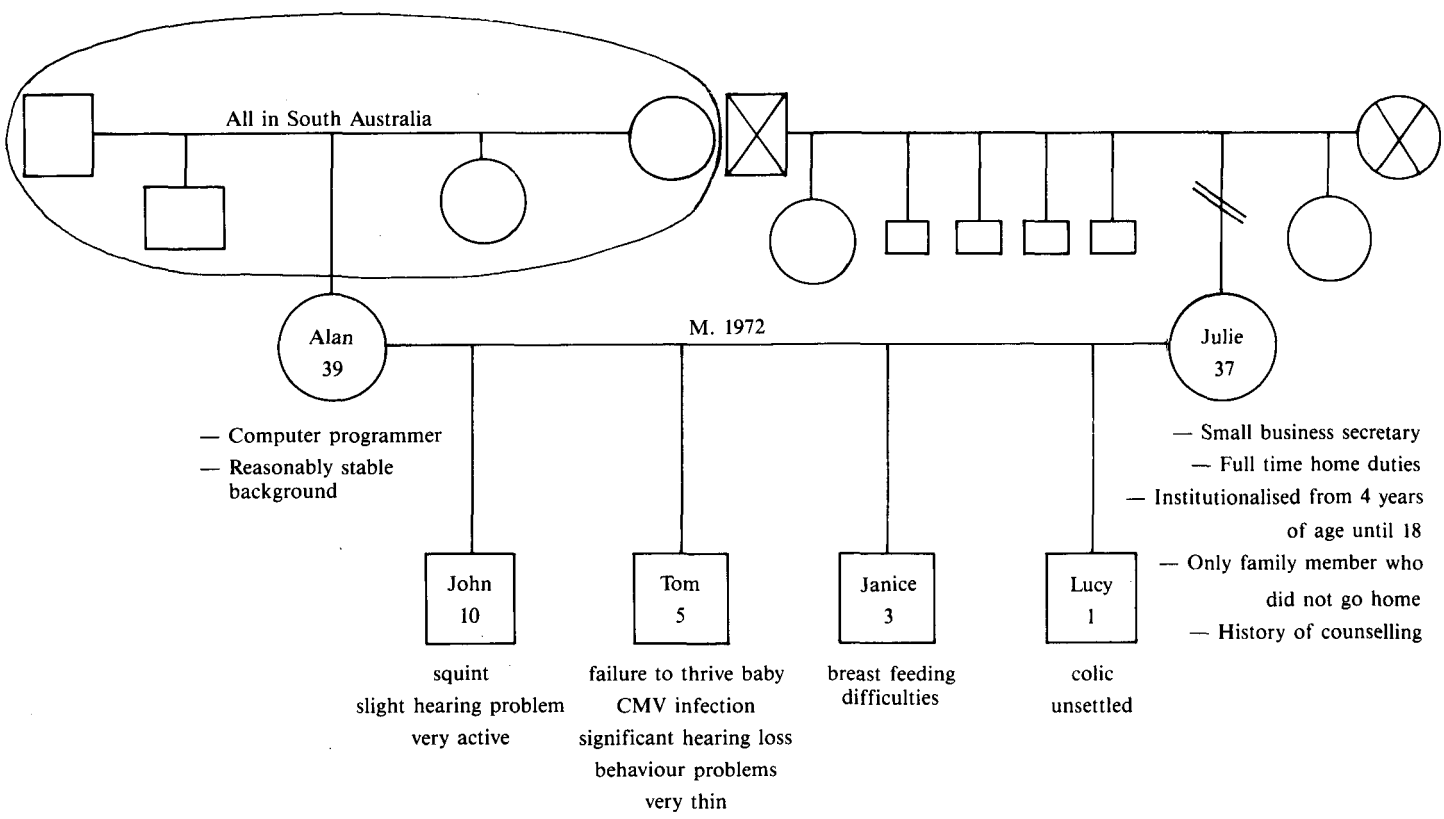
The family caseworker began regular counselling sessions, weekly at first, and later fortnightly, involving both mother and father, and the children to a limited extent. During this period the assessment was clarified, the family was "engaged", strengths and problems were delineated, and goals — and strategies for working on them — were agreed upon. The casework role required counselling sessions in the home (sometimes at night), oversight of the introduction of other supports, and liaison with other significant people — such as the referring hospital, the local maternal and child health nurse, the local doctor, paediatrician, gynaecologist, creche and family day care.

After six months the family aide in particular noted that Julie seemed to have insatiable needs and made constant demands. She was depressed and feeling hopeless. There had been an early improvement soon after family aiding began, but she seemed to have slipped right back. She was barely coping and collapsed emotionally when she began to re-live her experience as a four year old child being separated from her mother and placed in an institution.

She was frightened that her bottled up anger and torment would be directed at the children in an uncontrollable way — or at herself; she was having suicidal thoughts.

This was similar to feelings experienced early in her mariage during which she was physically violent towards her husband and then towards herself — biting herself, pulling her hair out and banging her head against the wall.

GENOGRAM AS AT OCTOBER 1987 — 3 YEARS AFTER INITIAL REFERRAL



As a result of the continued rejection by her mother and the series of abuses and torments she had herself suffered in institutions she felt it took her a very long time to trust anyone. She had started to trust Careforce and had become afraid that this trust would not last.

The concern that had been present regarding her relationship with Tom from the outset, together with Tom's continued failure to thrive, reached a peak. When Tom was born Julie cried for a week because he was not a girl. She haemorrhaged severely and then developed severe post partum depression so that she could not even recall his first nine months. As a small child he had a history of recurrent minor illnesses, poor weight gain, irritability and behaviour and relationship problems. He was at times detached and withdrawn and at other times unpredictably aggressive or violent. Serious consideration was given to longer-term foster care for Tom as the parents at this time were overwhelmed by their many problems. However, it was decided to increase supports to the family, in the hope that this would avoid the feelings of failure that necessarily accompany such a placement. These supports included immediate "time out" for Julie at a rest home for mothers, extra help from the Council Home Help, and a weekend holiday hosting once a month for two boys was commenced. This gave the boys other positive relationships and an opportunity to join in family life in another stable family; it also gave the parents a break. Psychiatric help was offered but Julie chose to continue with counselling with the caseworker.

Other services used over three years included the Couples Club, individual work by the child care worker with both boys, referral to a child psychologist and volunteer assistance with baby-sitting, home-based work, transport etc.

Over the three years since initial contact began, there have been many stresses and the family has used all the support available. For the first two years, Julie in particular crashed with every crisis. There was also concern at times about emotional and physical abuse of the boys — Tom in particular; they occasionally had bruises and marks. Janice had a near cot-death experience; the arrival of the fourth baby to complete an image of the ideal family; and Julie's tubal litigation were all traumatic.

However, Alan and Julie at most times expressed a genuine desire to cope better and to be more capable parents, able to manage their children and their lives more effectively. The marriage was strengthened through casework and the Couples Club, achieving a more stable and cohesive family. Alan and Julie have individually gained in self respect, Julie doing regular voluntary work and Alan being considered for management positions. They have gradually developed the strength to cope with crises and Tom is a more accepted and loved member of the family. The family has developed an effective support network separate from Careforce.

CONCLUSION

This case is just one example of the growth and development we have seen in families and their members with whom we have shared so intimately their life struggles and achievements. The beliefs and methods arise out of practice guided by fundamental concepts of child and personality development and an understanding of family dynamics and functioning.

Where there are families with some motivation and capacity for growth — no matter how small — family support should be tried as a first option before children are placed in alternate care other than respite or emergency placements, unless of course there is seriously inadequate protection for a child.

FOOTNOTES

1. D. Winnicot, *The Family and Individual Development.* Tavistock 1965.
2. Geismar L., *Family & Community Functioning.* Scarecrow Press p51 ff, 1981.
3. M. Matters, *Mission to Fractured People.* Unpublished article presented to National Anglican Welfare Conference.
4. Ibid.
5. There are parellels wiith the work of social workers in the early 1900s who lived and worked with families in their communities.

FURTHER READING

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2. Fraiberg S., Adelson E. & Shapiro V., *Ghosts in the Nursery.* A psychonanalytic approach to the *Problems of the Impaired Infant-Mother Relationships* J. Am. Acad. Child Psych., 387-421 (1976).
3. Lidz T., *The Person — His Development Throughout the Life Cycle.* Basic Books N.Y. & London 8th print 1968.
4. Tiddy S., *Creative Co-Operation Involving Biological Parents in Long Term Foster Care.* Jrn. Child Welfare Volum L & V No. 1 Jan/Feb 1986.
5. Gydal Monica, *Hard to Reach Families — a Dilemma of Treatment in the Work with Children who are in Grave Danger.* Nic Waals Institute, Spangbergu, Oslo Norway. Unpublished paper presented at Internal Conference on Child Abuse, Sydney 1986.
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8. Anderson, P. and Weekes, E., *Family Aide Work with 'At Risk' Families. A Retrospective Study.* Unpublished paper of Family Action Organisation, Melbourne 1986.