Preventing Out-of-Home Placement for High-Risk Children

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Preventing the removal of high-risk children from their families is investigated through two community-based programs. One program followed a day treatment model; the other used a home-based approach. These programs treated populations that shared common features but also had important differences. In both programs, a high percentage of children were maintained in the home and were still at home one year after discharge. It is suggested that such community-based intervention programs enhance the likelihood that high-risk children can remain with their families.

INTRODUCTION

The removal of children from their families and their placement into alternative care often involves the making of difficult decisions. The data and literature on the negative effect of separation on children are considerable and persuasive [1]. The risks, both emotional and physical, to children growing up in abusive or neglectful families can, however, be substantial—even life-threatening [2]. There are also significant risks to children who are inadequately treated for psychiatric disorders [3].

This paper reviews two community-based programs whose goals are to maintain children at severe risk in their homes and in treatment. Although these programs serve different populations in different ways, they share common roots. They embody the principle that "so long as a child is a member of a functioning family, his paramount interest lies in the preservation of his family" [4]. From this principle grows the conviction that, in most instances, children are better served when they are maintained in their homes and their families are helped to function more effectively. It is widely accepted that out-of-home placements should take place only after alternative remedies have failed [5,6,7].

The Greater Bridgeport Children’s Services Center Day Treatment Program (GBCSC) provides a full range of clinical and educational services to children who otherwise might be placed into inpatient psychiatric units or residential treatment.

Abbreviations: DCYS: Department of Children and Youth Services, FSS: Family Support Service, GBCSC: Greater Bridgeport Children’s Services Center

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centers. The Family Support Service (FSS) provides in-home clinical and material services to children who otherwise would be placed in foster care due to abuse or neglect. Both programs attempt to provide the interventions and services necessary to enable "at-risk" children to remain with their families. "At-risk" is currently defined by the State of Connecticut Department of Children and Youth Services (DCYS) as a child's high vulnerability to injury or neglect due to insufficient care and protection. Risk assessment criteria used by DCYS to determine "at-risk" status include evaluation of primary caretaker, alleged perpetrator, family strengths, environmental supports, and current stressors. Given the increased social concerns regarding inpatient care [8,9], there is an immediate need for the development of alternative outpatient programs such as those presented here. This study attempts to demonstrate that intensive family-oriented treatment programs can enhance the likelihood that at-risk children can remain with their families.

METHOD

Setting

FSS is an intensive, time-limited (eight to 12 weeks), in-home program for children in New Haven, Connecticut, at risk of placement outside the home due to neglect or abuse. It is a collaboration of Yale University, a neighborhood health center, and the State Department of Children and Youth Services (DCYS). FSS is intended to offer the support needed to help the family function sufficiently to prevent child placement, to assess the family's strengths, to evaluate the parents' capacity to continue to provide a safe and nurturing environment, and to enhance planning for the child's future.

The program is staffed by trained lay Family Support Workers and master's-level social work clinicians from the Yale Child Study Center. A Family Support Worker (hereafter referred to as "FSS worker"), a clinician, and a DCYS child protection worker form the case team.

Children are referred by DCYS because of the high degree of risk for removal from their homes. The clinicians assess both children and families for their service needs. The FSS workers seek to establish non-judgmental, empathic relationships with parents and to arrange for practical services for families. Clinicians and FSS workers visit with their clients three times weekly at a minimum, and more frequently when necessary. The team exchanges information and clinical impressions, which are used continuously to evaluate case progress and fine-tune intervention strategies.

In order to give coherence to decision making and subsequent treatment planning by the child protection agency, the clinician applies clinical knowledge to the task of understanding family conflicts and identifying the areas of parental functioning upon which the therapeutic efforts of the team can best be focused. Most often it is the FSS worker who provides ego support for the parents. Less frequently, the clinician is directly involved with the parent in psychotherapy. The pairing of the FSS worker with the clinician allows the clinician to focus the worker's efforts in a specific and goal-directed way, which is based on a psychodynamic understanding of the family's problems. In a parallel fashion, the FSS worker provides observations and questions that focus the clinician's approach.

Before attempting to improve family interactions, attention is directed toward meeting the basic needs of the family, such as food, clothing, and shelter. Only after this process begins to be accomplished are other issues addressed. In addition to
evaluating the immediate needs of the family, the clinician assesses its needs post-discharge. Together, the FSS worker, the DCYS child protection worker, and the clinician identify the community resources which are appropriate and available to address the family's longer-term needs.

The GBCSC was established in 1978 by the Department of Children and Youth Services in Connecticut as an innovative and intensive family treatment model program. In collaboration with several university graduate training programs, it serves as a model program for family treatment in a day treatment context. The GBCSC offers the immediate support necessary to prevent out-of-home placement of children who have been referred for serious problems, such as severe unmanageability, suicidal ideation, and other emotional problems (Table 1). Subsequently, the goal is to return children to a less restrictive level of services, such as local special education programs, along with outpatient individual and family therapies.

GBCSC is staffed by psychologists, psychiatrists, social workers, psychiatric nurses, special education teachers, and child-care workers. There are four interdisciplinary teams, which consist of representatives from the above disciplines. A typical team consists of a clinician, a teacher, and a child-care worker. Children are assigned to teams according to their developmental needs and social skills. General admission criteria require that children are between the ages of five and 13 years and that amelioration of their referral problems has been attempted through less restrictive treatment on an outpatient basis. In addition, children must demonstrate at least average intellectual potential, as evidenced by standardized psychological evaluations. Most essential, parents must be willing to engage in family therapy, which is a significant component of their child's treatment. The treatment focus of this program is on the whole family, who are seen together in therapy at least once weekly in collaboration with their child's individual and group psychotherapies.

All treatment is provided in the context of a planned therapeutic milieu, in which children gain insight into their own patterns of behavior and feelings in order to learn how to function more appropriately in their families and in their communities. Daily team meetings and periodic case conferences focus on the discharge goals and post-discharge resources necessary for successful long-term adjustment. The average length of treatment in this program is 18 months, at which time the primary clinician transfers the child and family to the appropriate and available community resources, which continue to provide for the family's psychological and social needs. When more intensive and restrictive levels of out-of-home treatment are required to assure the safety of the child and family, every effort is made to continue to work with the family during this period and to promote the child's return to the family as soon as feasible.

Subjects

The FSS sample consisted of 250 children in the first 105 families served. These children were targeted by the state protection agency as at risk for removal from their homes because of neglect and abuse. Cases of 32 children from 32 consecutive families discharged from the GBCSC Day Treatment Program over the previous year constituted the second sample. The children and families served by these programs showed both similarities and differences. In both programs, ethnic minorities were overrepresented (Table 2); however, the ages of the children served were significantly different ($t = 9.14$, $p < .001$). In the FSS program, 83 percent of the children were less than seven years old, with a mean age of 3.6 years. In the GBCSC program, 90.5 percent
TABLE 1
Data for Children Referred to the Greater Bridgeport Children’s Services Center

\( n = 32 \)

| Referral Source                          | \( n \) | % |
|-----------------------------------------|--------|---|
| Family or Guardian                      | 8      | 25 |
| State Department of Child Services      | 7      | 22 |
| Outpatient Clinic                       | 6      | 19 |
| Local School                            | 6      | 19 |
| Other (court, therapist, and so on)     | 5      | 15 |

| Primary Reason for Referral             | \( n \) | % |
|-----------------------------------------|--------|---|
| Unmanageability                         | 8      | 25 |
| Suicidal ideation                       | 7      | 22 |
| Emotional distress                      | 7      | 22 |
| Sexually abused                         | 7      | 22 |
| Fire setting                             | 3      | 9  |

were seven or older, with a mean age of 9.3 years. All children in both programs were identified as at risk for out-of-home placement as an essential criterion for referral. Children in the GBCSC program, but not in the FSS program, carried one or more psychiatric diagnoses using DSM-III-R criteria [American Psychiatric Association, 1987].

Procedure

At regular follow-up intervals, these cases were monitored by staff clinicians as to their placement status and continued involvement with state protective services. The follow-up was done by the child’s therapist. Follow-up data were collected at the time

TABLE 2
Demographic Data for Family Support Service (FSS) and Greater Bridgeport Children’s Services Center (GBCSC)

|                         | FSS \( n \) | GBCSC \( n \) |
|-------------------------|------------|--------------|
| Children                | 250        | 32           |
| Families                | 105        | 32           |
| Ages of children        |            |              |
| 0–3                     | 172 (69%)  | 0            |
| 4–6                     | 35 (14%)   | 3 (9.5%)     |
| 7–12                    | 33 (13%)   | 27 (84.5%)   |
| 13+                     | 10 (4%)    | 2 (6%)       |
| \( \bar{x} \) age in years | 3.55      | 9.33         |
| SD                      | 3.39       | 1.73         |
| Ethnicity               |            |              |
| White                   | 110 (44%)  | 12 (37.5%)   |
| Black                   | 112 (45%)  | 12 (37.5%)   |
| Hispanic                | 18 (7%)    | 7 (21%)      |
| Biracial                | 10 (4%)    | 0            |
| Asian                   | 0          | 1 (4%)       |
of discharge and again at one year post-discharge. The GBCSC therapists telephoned each family and inquired about current functioning, need for additional services, and placement status. DCYS supplied records for all FSS cases with respect to out-of-home placements. In addition, all children were monitored for psychiatric diagnosis, psychotropic medication treatment, and inpatient psychiatric hospitalization throughout the intervention and follow-up phases by GBCSC and FSS clinicians.

RESULTS

At the time of discharge, 91 out of 105 (87 percent) families in the FSS program had been able to avert out-of-home placement of their children (Table 3). These children, who represent 77 percent of the original sample, remained in their homes with no subsequent placements and no subsequent referrals for abuse or neglect. In addition, the state child protection agency terminated its involvement with 70 of these 91 families. Grouping these 105 families by the length of time post-discharge from FSS suggests that the effect of the intervention continues beyond termination. Sixty-six of 74 (89 percent) families discharged from FSS for six months or more still had their children at home, and 99 of 105 (94 percent) of the families discharged for a year or more continued to maintain their children in their own homes.

The severity of the GBCSC group's problems is reflected by the fact that all of the children carried at least one psychiatric diagnosis and ten of these 32 children were taking psychotropic medications. In addition, five children had received inpatient psychiatric treatment within the year before they were admitted into the day treatment program, and another five had been recommended for inpatient services during the year prior to admission.

Follow-up data were obtained at the time of discharge and again one year post-discharge (Table 3). At the time of discharge, after an average of 18 months of services, 24 children (75 percent) were living at home and entering into either local special education (n = 29, 91 percent) or regular education (n = 3, 9 percent) programs. Seven children (22 percent) were discharged to inpatient psychiatric programs, and one remained in foster care. At one year follow-up, the only placement changes after discharge were two youngsters who went from home into inpatient psychiatric care, and one child who transferred from an inpatient psychiatric program to foster care. Thus, 22 of the original 32 children (69 percent) were still at home one year post-discharge.

### TABLE 3
Number of Families with Their Children in the Home at Follow-Up

|                | FSS        | GBCSC      |
|----------------|------------|------------|
|                | n = 105    | n = 32     |
| At discharge   | 91 (87%)   | 24 (75%)   |
| One-year follow-up | 99 (94%) | 22 (69%)   |

FSS, Family Support Service
GBCSC, Greater Bridgeport Children's Services Center
DISCUSSION

This paper describes two mental health programs embedded in the child welfare system of the State of Connecticut. Both programs are child-oriented and family-focused. Although the primary treatment modalities differ substantially from each other, and the samples also demonstrated important differences, these programs share a common goal of maintaining the constancy of caregiving relationships and preventing out-of-home placements. The populations served overrepresent ethnic minorities, who are at high risk for family disruption. The results of this study suggest that it is feasible, through intensive community-based intervention, to maintain high-risk children in their homes. Furthermore, the high rate of success in averting the placement of the children served by both programs to more restrictive treatment environments appears to be correlated with the provision of intensive and comprehensive support for the families of these children. The greater success at one-year follow-up for FSS may be related to the more severe psychopathology of the GBCSC group, all of whom carried psychiatric diagnoses.

In the current environment of cost constraints, efforts to avert out-of-home placements have come to be valued not only for their effectiveness in meeting the psychological and developmental needs of children but also for their effectiveness in cost reduction. Recent evidence suggests that out-of-home placements may be much more costly than supportive services employed to maintain children in their own homes [10]; however, longer-term follow-up is needed to determine if the apparent gains of the children and families will endure.

The best interests of children were defined by Anna Freud [11] as the need for affection, the need for stimulation, and the need for unbroken continuity in caretaking. The best interests of the parents have been well defined as the need for evidence of adequacy as parents; the need for adequate social, economic, and political security and sovereignty; and the need to receive effective assistance from their community when faced by crisis, whether psychological, economic, social, or physical [4]. This paper suggests that attempts to meet the parent's needs will enable the parent to satisfy the needs of the child.

In the interventions described above, diverse populations of children with respect to age and psychiatric status were able to remain within families after being specifically identified as at risk for out-of-home placement. This success suggests that child-focused, family-oriented interventions are feasible in a variety of settings, for the delivery of child mental health and child welfare services.

Recently, the use of preventing removal from the home as an outcome measure for programs such as those described above has been questioned [12,13]. There is little doubt outcome measures which consider the child's emotional and social development would offer stronger testimony to the success of a program. The authors believe, however, that the prevention of placement has value and can promote healthy child development among children who might otherwise be placed out of the home. Further research needs to go beyond demonstrating the feasibility of community-based interventions. For example, the outcomes of these children could be compared to those of children referred to these programs but not admitted. Another study could compare the cost of these programs with residential treatment and inpatient care for a similar group of children. Increased understanding of the longevity of the effect of the intervention as well as more specific data relative to which families are best able to
utilize these services will help further refine our efforts to provide children with what they need, when and where they need it most.

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