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ABSTRACT

In 1989-90, Full Circle Program's Family Consulting Services (FCS) staff provided family reunification services to 50 children and their families in San Francisco and Marin counties. Staff members developed individualized treatment strategies for each family, acting as advocates for the needs of the child. These services included medical and neurological evaluation, diagnosis, and treatment; educational diagnosis and treatment through the Individual Education Program process; psychiatric or psychosocial counseling; and referral and follow-through with other appropriate agencies. Of the 50 clients served, 37 were successfully reunited with their families, 4 were emancipated, 4 remained in placement, and 5 were placed in foster homes. Key to FCS's ability to work successfully with several families were culturally appropriate case workers and aides. Some of the problems encountered by the FCS staff were the lack of coordination and oversight of social service agencies; being brought into a case at the last moment without the pre-unification time needed to build relationships with clients and their parents and to identify and ameliorate specific problems in the home; and, most significantly, lack of funding. A detailed case study of one of FCS's reunification successes and Carolyn L. Brown's article, "Family Reunification," which describes the project and discusses the advantages of employing an individualized strategy, are included. (AC)

Full Circle Program's Family Consulting Services

Abstract

Full Circle Program's Family Consulting Services, a project funded by the Administration on Children, Youth and Families of the U.S. Department of Health and Human Services, addressed family preservation and family reunification. The final report provides a descriptive summary of the project, in which an individualized treatment strategy was developed for each family served, resulting in a higher than usual rate of successful reunifications. The article, "Family Reunification," describes the project and contains a discussion of the advantages of employing an individualized strategy rather than an existing model.

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FINAL PERFORMANCE REPORT
November 1990

For the past 20 months, Full Circle Program's Family Consulting Services staff has been providing family reunification services to Bay Area children and families. Of our 50 clients, 33 were male, 17 female, 34 Caucasian, 10 Black, 2 Asian, and 4 Hispanic. We reached our full case load compliment of 50 clients, including 59 parents and 37 siblings. Of that case load, 37 client children are successfully reunified with their families (74%), 4 are emancipated (8%), 4 are still in placement (8%) and 5 are in foster homes (10%). With three of our emancipated clients it's still too early to tell whether or not they will successfully enter society as independent citizens.

We understand the importance of statistical information to grantors like the Federal Government and private foundations, but our staff believes that "data" frequently draws too much attention. For instance, if we included in our "successes" group the five kids "reunified" and doing well in foster homes, and the one youngster we **know** is successfully emancipated, we could **justifiably** claim a success rate of 86%! Pretty impressive, but distracting: our staff is happy with a 74-75% success rate as long as they can count on opportunities to sit around a table with other interested parties, including federal grantees for family reunification work, and discuss what worked and what didn't.

For instance, work with our 50 clients was approached very similarly: our case workers were armed with a model they believed in and the commitment they needed to stick with the child and family through all the ups and downs which were sure to follow. But, certainly, no two cases were alike. Each family was so unique, so completely different from the others in terms of problems and needs, so completely reflective of the **individuals** which made up the family, that no two families could be put in the same column on almost **any** statistical report. Of course, there were similarities: more than one family had problems with drug and/or alcohol abuse; a couple of the mothers were prostitutes; several of the kids were runaways; several problems involved step-parents.

The bottom line is that Full Circle FCS staff does whatever it takes to advocate for the child's needs: medical/neurological evaluation, diagnosis and treatment; educational diagnosis and advocacy, right through the IEP process; psychiatric or psycho-social counseling; referral and follow-through with other appropriate agencies. There are 50 fascinating stories to tell. Some illustrate the striking impact of simple services provided to clients, like transportation or child care. Some illustrate how our staff overcame tremendous personal frustration as clients went through periods of wanting to give up. Some of them illustrate how clients overcame serious and dramatic obstacles to

reunification. Each is complicated and lengthy, but we feel the following case history, which is not more or less dramatic than most, will help make clear how we work with kids and families:

The client is a 16-year old boy whose mother is Latina and whose father is Eastern-European. "Thomas" was incarcerated at age 13 as a result of his father turning him in to the juvenile authorities for stealing: Thomas took to his friend's house his father's video tape of an important boxing match. The father explained to the juvenile authorities: "He stole what wasn't his. He needs to learn a lesson." Thomas was put on probation for six months. When he missed one of his probation appointments, a bench warrant was put out for him, and the boy wound up in Juvenile Hall. When one of the workers at the Hall made fun of him, Thomas attacked him viciously, causing Juvenile Hall staff to do a four-point restraint and administer a shot of Thorazine. The boy went back to court and was assigned to a state training school for dangerous juvenile criminals.

At the "school," Thomas managed to get hold of a sharp object and with it, cut the inside of his elbow until he bled severely. He was found unconscious, face down on the bed in his cell. He was moved to a psychiatric hospital where he was diagnosed as clinically depressed with possibly both a conduct disorder and character disorder. Thomas was returned to the training school with instructions for the use of an anti-depressant medication. He hid his pills, and when confronted by staff, he went out of control and assaulted the staff members, resulting in his being put in a four-point restraint and being given a shot of Thorazine. Then he was placed in solitary confinement. He served 160 days in solitary confinement in a three-year period, at the end of which his continually-extended sentence was finally over.

Thomas was considered dangerous and not overly bright. He had spent his school time refusing to do assignments, particularly reading and writing. In response to his obstreperousness, the school officials assigned him to spend most of his time in clay shop.

Our staff was called by the Probation Department to help with this boy's reunification with his family. At this point he was 16 years old. A young woman staff member called the family and made an appointment to visit the home before the boy was released from the training school. When she arrived, the blinds were drawn and there was a pit bull dog chained outside the front door under a sign that said "BEWARE OF DOG." She called her supervisor to check about advancing in this set of circumstances, and the supervisor called the home to ask that the dog be removed. The family did this.

The mother and a younger brother, "James," were at home. In bringing the staff member up to date on the family situation, the mother explained that James was refusing to go to school and she

had just been laid off from her job as an aide in a convalescent home. The father had not returned from his truck driving job for three days and there was no money in the house for food for either breakfast or James' school lunch. The staff member took the mother to the grocery store for some of the basics -- bread, milk, peanut butter, strawberry jam, eggs, margarine, coffee, tea, tuna fish, carrots, potatoes, corn tortillas, refried beans and a turkey. They made lunch together for themselves and then drove James to school for the afternoon session. The staff person and the mother returned to the home, made a cup of coffee and talked about Thomas' return home.

The mother explained that she had watched helplessly as the alcoholic father (who had been beaten by his own father for stealing) had abused their two boys from the time when they were infants. He only did this when he was drunk, and he loved the boys dearly. Thomas received the worse abuse because he had the poorest judgement about what it was that would aggravate the father while he was drinking. The mother said that Thomas was very accident prone when he was small, often bumping into tables and doorways, and regularly crashing on his bicycle. He would sometimes become furiously angry and get into a rage that he couldn't seem to get under control. Then he would fall asleep for a while, when the rage had passed. She had been worried about what he might do in one of those rages. She said that he could handle arithmetic all right but reading and writing had always been a problem. He could never remember what his homework was or what she told him to bring home from the store if it was more than one item. She was afraid that her husband would yell at him, when drunk, and Thomas (who was now much larger in size) would attack him in a rage and they would really hurt each other.

The following day, the staff person began the process of building a support system for the family until they were able to stand on their own. She told the mother of a church group that had emergency funds for food, and offered to accompany the mother and James to James' school in order to find out what the school problems were and begin to figure out how to keep the boy in school. Based on the information she had received, the staff person believed it possible that Thomas had a neurological problem, so she recommended to the mother that a neurologist see both Thomas and his father to rule out a seizure pattern that might cause or exacerbate the rages and physical abuse. She also recommended a learning disabilities evaluator for checking on Thomas' reading, writing, auditory processing problems and problems in space-time distortions. Last, she recommended two good therapists: one would begin with family systems work and marriage counseling, make sure the family was taking care of its basic needs (like food!), and see that the younger son stayed in school. The other would help with individual work, including the father's substance abuse problem, and would advocate for Thomas as he returned to high school, with likely learning disabilities, after having been out of the normal, public school system for three years. The therapist would assure that Thomas was treated

like an important person with important needs. The staff member indicated that as soon as there was agreement to these suggestions, Thomas would be able to come home.

Surprisingly, because our staff person wasn't sure the mother would have the courage to act without the father's concurrence, the mother committed to following through on the advice of our staff person; thankfully, when the father returned two days later, he was sober. He expressed his willingness to "give it a try." Upon Thomas' release, and with staff's help, the boy received a thorough neurological workup, and was tested by a learning specialist. The results showed what staff had expected: Thomas had a mild seizure disorder, was severely dyslexic, and had an auditory processing problem. The neurologist prescribed an anti-seizure medication and vitamin supplementation based on Thomas' blood chemistry evaluation. The learning specialist advocated on Thomas' behalf with the school district, which agreed to create an Individualized Education Plan (IEP). Then he arranged special help for Thomas to deal with his auditory processing problem.

Three months from the time our staff person was first introduced to this family, these changes have been made: Thomas has returned to his home, and he and James are both attending school regularly. With their parents, they are seen by a therapist once a week. (Both therapists will stay with the family for at least six months, to a year.) Thomas' father is a six-week member of a 12-step program and has an appointment to be seen by the same neurologist who treated his son. With strong encouragement from the staff person and help from the church, the family is eating regularly and has drastically reduced their sugar intake. Thomas is a much calmer person, is seeing a therapist by himself once a week, and is beginning to show signs of being able to talk about problems. There have been no incidents of rage at home or at school. The mother is still looking for a job, but can do so now without worrying about where her sons are.

The amount of time our staff person spent with this family varied from week to week. During the first week, there was daily contact in person or on the phone. Contact was almost as frequent for the next two weeks. Since that time, staff has contact with the family an average of four times a week, and expects to continue to see them for up to a year, though far less frequently as time goes on.

Conversations tend to be very informal and sometimes very long: staff takes pains to make sure that the family understands what she is talking about. When the neurological issue arose for instance, she spent over an hour talking with the mother, trying to demystify the issue, and making sure the mother understood that neurological problems didn't mean Thomas' is not intelligent or that he is crazy. It is important to note that our staff

members confer with each other regularly, sharing information, seeking consultation.

The conversations also allowed the family to realize they were participating in making decisions -- they never expressed concern over being "made" to do anything. Rather, they helped **design** the management of their case. This level of participation is of critical importance in our efforts to help a family "heal."

We are fortunate to have many happy endings to relate: another of our client children will be returned to her mother in December. We wrote of this case in our last quarterly report -- a woman who has three children, the youngest of whom was born cocaine-addicted in July. Since that time, the woman, who was earning her living as a prostitute, has secured employment as a nurse's aide in a convalescent hospital. She has begun classes which will allow her to upgrade her position at the hospital, has consistently attended 12-step meetings to control her drug and alcohol abuse, visits regularly with all three of her children and as mentioned above, will have her youngest back with her in December. She also followed through with her plans to have a tubal ligation. We are very proud of this woman and optimistic about her future. Her other two children are doing well in foster care and are looking forward to being "home" again.

Key to our ability to work successfully with these children and their mother, and three other client families, was our Spanish-speaking case aide. We are convinced that culturally-appropriate case workers and aides are absolutely necessary to a successful reunification team.

Although we rightfully pride ourselves on taking the "hard" cases, we didn't take **every** case. We don't take people who are drug addicted and are not trying to get help. We don't recommend reunification until and unless adults and teenagers are ready to look at their substance abuse problems and commit to doing something about them.

Sometimes, we don't take cases because we don't think the kids should be removed from placement. For instance, we didn't take the case of a 13 year old boy who was anxious to be reunified with his family. At home, he had been selling crack cocaine, making several hundred dollars each week, and saving his money for a car which he was not old enough to drive. In pre-release conversations with this youngster, it was obvious that he had every intention of resuming his old life, and as soon as possible. It was impossible to reason him out of his decision. Our staff recommended against reunification and refused to take the case.

Another case involved a physically mature 15 year old girl whose mother was a hard-working prostitute. They lived in the "projects" in Oakland. The girl had been propositioned several times by local pimps. At home, she was almost completely

unsupervised, and her mother, who was a very nice woman in a not-nice business, realized that in their neighborhood, the likelihood of her daughter staying "safe" was not high. Again, we recommended against reunification and did not take the case.

Because of our experience with our residential care clients, we expected to have a large number of our reunification clients tested for neurological problems. As it turned out, we tested only three. All were diagnosed as having neurological dysfunction, and although those diagnoses proved very useful in putting behaviors and academic problems in perspective, with the exception of Thomas (see case study, above), the neurological problems did not get solved: medications are expensive, and the process of fine-tuning dosage requires a certain amount of discipline on the family's part. The heads of two of the three families did not follow through. This points up to us the importance of accomplishing this type of testing, when indicated, while a child is still in care. It has been our observation that children in trouble generally -- educationally, psychologically, behaviorally, etc. -- are frequently damaged neurologically, significantly more often, we suspect, than are their peers. We also believe, based on our case work, that some of this damage is directly related to the abuse of drugs and/or alcohol on the part of the mother during pregnancy. Understandably, our agency is not set up to scientifically address this subject, but we strongly urge the Children's Bureau, perhaps in conjunction with the National Institute of Mental Health, to support a double-blind study to determine whether or not our suspicions are correct. Early identification of neurological problems can head off a myriad of other difficulties in a child's life, and can unlock a far more capable and successful person, free of many physical problems such as facial tics, no longer confused and frightened by unrelated emotional outbursts, and able to concentrate for far longer periods of time on school work and hobbies. It should be noted that Full Circle Programs advocates the use of medication only as a last resort. But when pharmacological intervention is indicated, it would be irresponsible not to use appropriate medications.

As most people in the social service business acknowledge, California is the promised land for many people needing or wanting "services." This is true even with the infamous cutbacks in the mental health system which resulted in hundreds of mentally ill people flocking to the streets. (Also true is the fact that the State does not fund family preservation or reunification state-wide, even in the face of PL 96-272, which mandates reasonable effort to keep children in their homes.) Services to women are particularly abundant in parts of Northern California. We are proud of the services, but frustrated and concerned by the lack of oversight and coordination of those services: families can seriously take advantage of the "system" or be picked apart by different agencies demanding different kinds of actions in order to remain "eligible." We see agencies so paternalistic that a co-dependent relationship between the

agency and client develops to the point where the clients are discouraged from independence! Certainly, the goal of all social service agencies, public and private, must be to encourage competency and independence. Reunification frequently depends upon the capability of adult and teen aged family members to secure and keep jobs.

Another problem we have faced is that we are brought on to a case frequently when a child's return home from care is imminent. Although it was our goal to work with clients and families as many as three months prior to actual reunification, emergencies and last-minute decisions sometimes take place at social service agencies, particularly Child Protective Services, making it impossible for us to have the pre-reunification time we desire and find optimum. Pre-release time enables us to build relationships with both the child and parent(s), and to determine specific problem areas which might be ameliorated before the child's return home.

Perhaps the most significant problem which exists in this area is the lack of funding generally for reunification. There are far more clients who need reunification services than are being funded.

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Full Circle has a history and reputation for being open to new ideas, for trying new techniques and approaches to dealing with severely disturbed and at-risk young people. We were fully ready to scrap our family reunification model if it didn't work. But we found that it did. Indeed, we are very, very proud of our model. The most important aspects of it are: respect the dignity of the individuals and family, believe that they can and want to change, and engage them in the process of designing their family management plan; find out what's wrong -- test where indicated for medical, neurological, allergic, and educational problems, and follow through with diagnostic indications; reframing -- help the family re-evaluate the problem and think about them in another way, without blame and guilt; be there when the family needs you -- enough and long enough to make a difference. Perhaps the word which best describes our model is "responsive." We never force treatment on our clients: indeed, we are convinced that if they don't help create the treatment it might as well not happen at all. We don't set time limits: we know that family problems come and go, get more and less intense, and that we need to be there for families when we are needed.

With regard to our commitment to publish a Family Consulting Handbook: The Hale Fund has provided funds to Commonweal, an organization with which Full Circle has a long history and shares staff, to produce the handbook. Full Circle and Commonweal staff have already collaborated on the content of the handbook, and a professional writer, who has edited several health care publications, will begin work on the piece in January 1991.

Publication is scheduled for June, 1991, and Full Circle and Commonweal will collaborate also on the dissemination of this handbook through the Commonweal Training Institute, and through Full Circle's participation in the Prevention/Early Intervention Committee of the California Association of Services for Children, and through the national network of family preservation projects.

Lastly, we would like to report our progress with San Francisco and Marin Counties relative to "hard" funding of family reunification services. Although we are still optimistic about San Francisco County funding these services under the Robert Wood Johnson Foundation initiative, we must report that to this date, no agreements have been made. Anne O'Reilley, head of the San Francisco Social Service Department, is still committed to this program, and to Full Circle, and is continuing to work with us, RWJ, and other interested parties. Marin County's head of Social Services, Frima Stewart, has recently applied for funding under AB 1696, a measure which extended a three-county pilot project to 11 additional counties for three years. If Marin becomes one of the 11 counties, they will fund both family preservation and reunification. Meanwhile, we are working with the Marin Community Foundation on a proposal which would allow us to serve 50 families in 1991.

Attached is an article written by Dr. Carolyn Brown, Director of Family Consulting Services at Full Circle Programs, Inc., as an additional narrative portion of our final report to HDS. In October, the article was submitted for publication to "Children Today," and will be considered by that magazine within the next four months.

FAMILY REUNIFICATION

By Carolyn L. Brown, Ph.D., Project Director
Full Circle Family Consulting Services

Item: A low-income woman whose child has been reunified gets five days jail time for missing her appointment with her probation officer. Her sentence will be suspended if she agrees to do 72 hours of cleaning at a local government building. These hours must be done Monday thru Friday between 8:00 a.m. and 5:00 p.m. She barely has enough money for rent and food if she works full time. She could lose her job if she takes time off.

Item: A 15 year old boy leaves two years of residential treatment which was initiated due to the abuse that he and his sister suffered at the hands of his natural father. His mother has remarried and the first two months of reunification are not working: the new stepfather wants to assume a strong father's role with him.

Item: A 14 year old girl historically has had problems in school, very low self-esteem, and was placed in residential treatment for out of control behaviors, petty theft, and self-endangerment. A learning disability assessment shows a constellation of learning problems, including short term memory, a word retrieval problem, and very poor spelling ability.

All three of these cases require solutions that differ vastly. But each solution qualifies for family reunification that is wholly responsive to the presenting problems.

In the case of the woman, 72 hours work with no pay solves nothing. It's punitive. The court was asked to consider a plan devised <u>with</u> the woman which would include a paying job, on-going work within a substance abuse rehabilitation program, and individual and group counseling--much more sensible if reunification was truly the key objective.

Staff helped the stepfather understand that even though he meant well, his ten-foot tall, father-knows-best identity did not create safe ground for his stepson. What the child needed was safety and friendship.

A strong lobby was initiated to obtain an Individual Educational Plan (I.E.P.) for the young girl with learning difficulties. It was decided that she should be placed in a non-public school on a day program basis--not residential treatment--where she would receive the specialized help she needed. (Too often children are shuffled off to residential care when there is an educational problem. This puts them into contact with more disturbed youngsters, frequently causing them to adopt behaviors and attitudes even more harmful than their original problem.)

Family preservation and reunification strategies are emerging as preferred approaches to dealing with certain families of at risk children. This home-based work offers opportunities to work closely with the entire family and is highly appropriate when the safety of the child or children can be assured. Problems can be addressed within the context of the home and the needs and desires of family members. And it makes sense. Since a child is largely a product of his or her environment, it is logical that working with the child within the family environment offers the best chance for lasting and positive changes. This work will also directly benefit the adult family members, creating improvements to the productivity and self-esteem of the entire family. Needless to say, this benefits the community as a whole.

Full Circle Programs, Inc. is a 20-year old organization which provids a variety of services to at risk children and their families throughout the San Francisco Bay area. These services include a High School Support Program for youngsters on the verge of dropping out of school for a variety of academic and emotional reasons; Residential Treatment for severely emotionally disturbed and learning disabled boys 10-16; and Family Consulting Services, which provides family preservation and reunification services. Family Consulting began six years ago when Full Circle became aware of the increasing numbers of children in placement, a figure which rose almost exponentially in 5 years to well over 500,000 by 1989. Family Consulting chose to address this problem in two ways: the first was by helping families find ways of solving problems to the extent that the child(ren) could safely remain in the home.

The second was to provide similar services to children and families when a child was returning home from foster or residential care. The agency recognized that the danger of recidivism would be considerably lower if there was some intelligent support of the reunification process.

Full Circle has been providing preservation and reunification services under contracts with Social Service and Child Protective Services Departments, through grants from the federal Department of Health and Human Services' Children's Bureau, California Office of Criminal Justice Planning, and several private foundations. Currently, the agency is in negotiation with two counties for fee-for-service contracts.

Many models have sprung up over the country, and most rely on a period of intense intervention for a prescribed period of time. But after 18 months of providing family reunification services in the San Francisco Bay Area to a wide variety of client children and their families (with a high rate of success), Full Circle has found that using "models" may get in the way of providing appropriate services. We are convinced that we need to treat each case individually in order to be able to see and respond to presenting problems. Although "common" themes exist, no one formula can be effective in dealing with all families, since each family situation is so vastly different.

Case assessment and planning looks like this: rather than limiting the program to a preset model of treatment, we try to determine what the family and individuals want and need, through observation, clinical diagnoses, and a great deal of family input. Then we go to work to help facilitate necessary changes. The only aspect of treatment which we could label a "model" is referred to as "reframing". This is the step that says, "think about this problem in another way," rather than "you were wrong." Families frequently feel that their identified problem child is bad, not intelligent, or mentally ill. The parents feel that they themselves are failures, bad, and at fault. We try to help them understand that in most cases they are beset by an illness, a condition, or a pattern which can be responsibly managed and positively transformed through their own understanding and management. We seek to inform and empower parents and children to take command of their own situation. And we try to help them find the tools and support they need to accomplish their goals. Successful reframing defuses guilt and blame and allows families to treat problems as opportunities. This ongoing process can produce tremendous change. Once parents can neutralize their guilt and blame, their children can begin to get rid of their own. As negative issues lessen, self-esteem has a chance to grow and success can come in a wide variety of areas like school, community, and family.

In the project it has become clear that we need to approach each family as a completely unique system, and be willing to be totally responsive to the family's requirements. Even the amount and kind of time we spend with a family may be very different in each case. Some families respond well to an intensive, on-going intervention over a three to six-month period. Others need a little help at first, then want to have case workers available on an as-needed basis for a year or more. Project staff schedule an average of five hours of personal contact per week for each family, realizing that it might be much more, or much less.

Situations and needs are so varied! We had two little girls, aged 4 and 6, as clients. They were placed when the mother had been jailed and the father was unemployed and in a substance abuse treatment program. Work with this family consisted primarily of providing transportation for the father and his two daughters until he could find a job and save enough money to purchase a car. Once that was accomplished, in only six weeks, he handled his life very capably and the girls are safe and doing well. Again, project staff spent "therapeutic" time with this family only in the very beginning of our involvement, and at case closing. Instead of formalized meetings, conversations en route to drop off or pick up the kids, or to the father's place of employment offered opportunities to put changes into context, express frustration, or celebrate successes.

On the other hand, even the most intense and concentrated work with one of our families has not seemed to solve their problems. They continue to function just on the verge of crisis after more than a year with the agency.

We are highly interested in testing for a variety of potential problems which may hinder the reunification process. Specifically, if we find that our clients or their parents present symptoms and have not been tested for learning disabilities, neurological problems, or other medical difficulties, we encourage the family to let us arrange for appropriate diagnostic appointments. Many of our client children were placed outside the home because of their violent behavior or that of their parents. We are finding that some of these behaviors can be directly linked to neurological problems, and that those problems sometimes can be solved with anti-seizure medications. As an example, Billy had been in residential treatment for a year. Nothing seemed to stop the emotional outbursts which always ended with his having to be restrained from hurting himself or others. He had been tested for allergies, his diet was excellent, he was being seen by dedicated, highly capable therapists, but nothing was changing. Finally, he was taken to a neurologist-psychiatrist in San Francisco who tested and found evidence of neurological problems. Within two weeks of taking his anti-convulsant medication, Billy's biggest problem was dealing with being "normal." Changes in behavior can be dramatic and immediate. They can also be subtle. Medications have to be prescribed carefully and accurately to meet client specific needs, and to avoid side-effects. Certainly, this approach is appropriate only in a minority of cases, but this experience convinced us of the need to test and rule out physiological problems which manifest themselves in emotional and behavioral problems.

Our emphasis on ruling out medical problems represents a significant difference in our model, and extends to the child client's family as well. For instance, when a child is returning to a family where there is an adult with a history of serious violence, we would recommend medical evaluations for that adult before the reunification took place. We would want to rule out pre-diabetic or diabetic conditions, or a seizure disorder that could cause behavior that would not allow for a safe space for the child. When medical problems are evident, we recommend treatment before the child physically returns to the home.

In this work, success is measured in increments. When we arrange an educational assessment and assure good follow through and appropriate school placement, we know our client child can be more successful. Getting an alcohol or drug abusing parent into an appropriate rehabilitation program, and helping them to stay with it, is of critical importance. As mentioned before, simply providing transportation to people until they can transport themselves may be the difference in maintaining the unity of that

family. With careful planning, the pieces can form a whole which will provide the security and safety of each individual in the family and the family as a unit.

Still, we know that not every reunification will be completely successful. Some will last indefinitely, some only for weeks or months. When reunifications do fail, we understand that it takes a long time for a family system to break down to the extent that the children are removed from the home, and that it's silly to think that these breakdowns can be repaired easily or immediately.

When a child has to return to residential treatment after a failed reunification (or for other reasons), it is challenging to find the right care facility. We have often found return to care much less traumatic when there is familiarity with the child care facility. Assuming the program is a good one, it is far better to build on past successes than to start from scratch, especially when the child has been out of care for a very short period of time (up to one month). However, our experience has also shown that some youngsters need a fresh start, and that they feel more comfortable when they can re-enter care without any "baggage" collected from a previous stay. And sometimes, when a child has entered a care facility as a pre-adolescent and is now an adolescent, he or she will frequently get more out of a program which is more specifically geared toward the child's age group. Again, the important thing is to be flexible enough to let the needs of the child create whatever action is taken.

In California, funding for family preservation and reunification has come largely from private and governmental grants, and from fundraising activities. Still, our state now has several pilot projects with counties who fund the programs out of money set aside for childcare reimbursement. We are thus hopeful that preservation and reunification work will eventually be funded state-wide. Our agency is currently in negotiation with two Bay Area counties toward fee-for-service contracts for family reunification.

Full Circle Programs' experience in family preservation and reunification began over five years ago. Since then, the agency has served more than three hundred families and twelve hundred individuals with a 75% success rate in retaining children in their homes. Our staff consists of a psychologist, a social worker, case workers, case aides and interns, all of whom work closely with our team of consultants, including a psychiatrist, pediatrician, allergist, and neurologist to assess and treat each client child and family individually. Besides helping the children and their families, this work has saved hundreds of thousands of tax dollars--reunification service for a family costs an average of $3,000...less than one month of residential care in California!

Family reunification is difficult and delicate work. It is difficult because of frequently ambivalent feelings of the child(ren) and parents who may both desire and fear reunion. After

all, this has been the most powerful experience of failure for both. It is difficult for staff because of the long and erratic hours of work in intensely "charged" situations.

Reunification is delicate because a balance must be struck between eliminating guilt for past failures and helping families change to provide for the safety of each individual family member. Cultural issues must be understood and integrated into the plan. The demands of the courts and public welfare agencies and the social and economic realities in the 90s must be reconciled.

Most importantly, we must assure that our own paradigms and models emphasize listening to what the family is really saying with their words and their actions. We must honor their individuality and encourage them to answer the critical questions facing them: Is this a safe place to be? If not, what can we do about it?