San Mateo's Family-Centered Approach to Community Ill Health

SAN MATEO COUNTY'S family-centered and community-centered approach to disordered behavior was the subject of the Annual Institute for Public Health Social Workers in California, held October 28, 1960, in Berkeley. The conference was sponsored by the bureau of public health social work, California State Department of Public Health.

With the premise that stress, frustration, and anxiety serve as the triggering mechanism for more disease than all the bacteria in Bergey's Manual, Dr. Harold D. Chope, director of the county department of public health and welfare, challenged public health workers to consider the implications of this idea. If modern public health practice goes beyond environmental sanitation, communicable disease control, and maternal and child health services, we must be concerned with the social-medical-economic health of the community, he said.

He explained how the San Mateo approach to three-faceted problems had evolved. When he, a physician trained in epidemiology, became director of social services for the county, he pondered such questions as why some people are sufficiently immune that they weather economic setbacks and disaster while others seem to become chronic dependents. What can be done to prevent or control the causes? What does society do to treat chronic dependency?

The process of seeking epidemiologic methods to apply to social welfare led to San Mateo's becoming the subject of a 3-year study, "The Prevention and Control of Disordered Behavior in San Mateo, California," by Bradley Buell's Community Research Associates, Inc. The study was supported by a grant from the Rosenberg Foundation of San Francisco.

The first step in this study was to define the clinical syndrome, since disordered behavior and maladjustment were vague terms, Chope said. Disordered behavior was defined as behavior that is legally prohibited or generally disvalued by society. Disordered behavior was divided into three categories: adult disorders which consist of major or minor crimes and misdemeanors and voluntary admissions or commitments to mental institutions; marital disorders which consist of divorce, official separation, desertion, and separation of children from their own homes; and child disorders which are officially reported delinquency, truancy, school dropouts for noneconomic reasons, and commitment to mental institutions.

All community agencies were requested to make a report on all cases served during January 1954 in order to get some general indexes as to the prevalence of dependency, chronic diseases, and disordered behavior in San Mateo County, Chope said. The concept of the multiproblem family did not hold true for disordered families; 56.3 percent of the cases were disordered families only and were neither dependent nor had members with chronic illnesses. But we did find that disordered behavior tended to run in families and occurred in clusters, and we began to pay more attention to the recidivist family than the multiproblem family. The theory that it is better to give intensive casework services of a high caliber than try to give all clients a little bit of service was borne out by the study.

When the study was completed, the citizens advisory committee was convinced that the 3-year research project had practical applications for the administration of health and social serv-

ices. They requested the county's Board of Supervisors to provide funds to continue the services proved effective by the study.

Coordinating Bureau for Family Services

The chief administrative tool used to apply the study's findings is the Coordinating Bureau for Family Services. The bureau's director, Madeleine O'Callaghan, described the agency's structure and functions. An independent unit of the county government, the bureau was established by an ordinance in 1958. It is composed of the heads of the county departments of health and welfare, probation, schools, and two lay citizens appointed by the Board of Supervisors. It is, in effect, a coordinating group of tax-supported agencies charged with responsibility for dealing with the community's problems of disordered behavior and financial dependency. The bureau reports annually to the Board of Supervisors on the number of successful and partially successful cases and the number of failures as well as making recommendations for future planning.

O'Callaghan described the three programs operated by the coordinating bureau. The first is the family roster, a statistical device for recording and organizing on a community basis the disordered behavior histories of certain families living in San Mateo County. The second is family classification and case management. This program is being carried out in the welfare and juvenile probation departments and provides basic, uniform information on the extent and degree of social and economic problems in the caseloads of each agency. These data enable administrators to assign caseloads selectively and have a direct bearing on staff deployment, budget, and planning.

The third program is the family-centered units. There are three such units in the county, a supervisor and five workers in the probation department, a supervisor and four workers in the welfare department, and a one-worker unit in the school department. Each unit uses the same methods and operates within the same framework of concepts, although the legal responsibilities of each differ.

Certain principles, O'Callaghan stated, characterize the operation of these units. Their workers have not only the freedom to try adaptions of policy but also the responsibility of finding new ways to use the basic skills of casework; a criterion of a caseworker's skill in these units is the ability to select the most effective approach, she said.

Caseworkers recognize that the typical, intensive weekly interview with one person is a technique to be used specifically, consciously, and in an organized plan for treatment. The caseworker also assumes responsibility for management of a case and for achieving a clear understanding of the extent and limits of participation of the several agencies usually serving a family in trouble. Fragmented services by diverse agencies usually mean no one agency is responsible for keeping the services integrated, O'Callaghan emphasized. The methods the social workers in these units use are not new; the new ingredient is that the methods are used in a structured, uniform, and organized pattern.

She listed the concepts that guide all the workers in the family-centered units. The family is the basis for diagnosis and treatment, not one member with a set of exotic symptoms, as often occurs. The problem must be identified on both the community level and the family-functioning level. The community, for instance, takes active responsibility for economic dependency, which is defined by official processes and eligibility standards, or for behavior that is legally prohibited or disvalued. Disorders on the family-functioning level are defined in casework terms.

Identification of the problem enables the worker to set specific and concrete goals, estimate the time needed to achieve them, and evaluate progress periodically. Aside from the administrative and budgetary implications of setting time limits, this step increases case turnover and fosters maximum use of the service potential of the casework units.

O'Callaghan, while acknowledging the trauma social workers suffer over terminating a case, pointed out that unless they devise methods that are sound and realistic therapy from the time-oriented viewpoint of the agency and the community, they will soon price themselves out of the market, for public agencies will no longer be able to afford their services.

The Costliest Families

How best to deploy expensive casework services was answered in the light of San Mateo's experience by Lilian Blackford, statistician of the county's department of public health and welfare. Each hour of service, counting the social worker's time and preparation, overhead, and clerical services costs something more than $5 and as much as $10. Because casework is an expensive, individual service, the family must get the most out of it, or a questionable expenditure has been made of tax funds.

A problem family can, in a sense, be defined as one that absorbs more than its normal share of tax money. Some families have problems which fit one specific agency's services, but many need help from several agencies, and often the social worker must reach into a maze of possible services from various agencies and draw up a plan to suit the particular difficulty.

Knowing how to select the appropriate kind of intervention is difficult, she said, but selecting the family to which services may most profitably be directed is even more of an art and a responsibility. And if social workers are to satisfy their employers, the community, the family selected should be able to use the services in a way that will restore them to the ranks of taxpayers.

Blackford pointed out that classifying problem families into appropriate problem areas is a more complex task than it might appear. Although financial dependency, physical illness, and maladjustment may appear to be clearly separated difficulties, they are actually closely related or overlap. Financial dependency may stem from the physical incapacity of the breadwinner, a physical incapacity of some member that overrides earning capacity, commitment of a parent to a mental institution, or insufficient provision for retirement. The area called maladjustment includes conflicts with the law.

The pattern that appears in this general overall look may indicate a multiproblem family or a multiagency family. But if the family is considered in a time sense, a different pattern emerges (see chart). Many families have a period in which dependency and behavior difficulties arise, but are able to contain the problem. Others develop a pattern of chronicity with problems going on and on. The difficulties may clear up of their own accord, or casework may produce results. Does this occur because of community resources, or because of factors within the family?

One situation seems to recur, Blackford said. The longer a family continues in the chronic pattern, the more intense the conditions seem to become. In addition to the multiproblem family there is the chronic multiproblem family. Such families may cost the community $5,000 a year for 30 years. These are the families which are hardest to change.

Data are scarce on how long persons remain with possibly long-term service, such as a hospital for those with chronic disease or an aid to needy children program. It appears that quite a number of cases are discontinued soon after intake, that the rate of discontinuance becomes slower, and that after a certain point, a case becomes chronic with the agency.

At what point would a casework effort be most profitable? she asked. In terms of the development of chronicity, it appears that the most treatable families are those in which the number, intensity, and duration of problems are not too great. But the most expensive families are those in which the number, seriousness, and duration of problems are the greatest.

Blackford cautioned against the specialized agency viewpoint. This often means the worker forgets that the individual who seeks help is a member of a family that is affected by what the agency does, or that the family may be known to many agencies, each acting without knowledge of the part the other agencies are playing and have played.

For example, she said, the worker in the aid to needy children program sees a sensible and considerate mother who manages a small budget well and keeps her children clean and healthy. Father isn't much in the picture except as extra paperwork. The worker from the district attorney's office sees a deserting father who is irresponsible and indifferent, and the mother impresses him as a shifty sort of person. He's had little contact with the children.

Often social workers are not oriented to medical problems. Blackford reported that, when social workers were asked to include the medical problems of the families in a random sample

of the continuing caseload in the aid to needy children program, many simply wrote "disabled." Even so, in the sample, more than a third of the families had serious medical diagnoses, and 42 percent had one or more separate entries such as psychosis, alcoholism, mongoloidism, retardation, committed to mental hospital, clubfoot, amputee, epilepsy, congenital hip, cerebral palsy, blindness, tuberculosis, old syphilis, diabetes, dermatitis, bursitis, stroke, kidney condition, ascites, heart attack, and lumbosacral sprain.

When the families in the sample were matched against the master files in the department, Blackford said, only 19 percent were known only to the aid to the needy children program; 74 percent were also known to medical welfare and possibly other services, 53 percent were known to public health nursing service and possibly others, and 17 percent to mental health services and possibly others.

Nor had these families been free of disordered behavior. During a 6-year period, according to the records of the county's family roster, 40 percent had one or more petitions against deserting fathers, 12 percent were given final divorces, 10 percent had children who at some time were cared for outside their own homes, 20 percent had a member convicted of a major or minor crime, 14 percent were known to juvenile probation for delinquency, and 9 percent for dependency and neglect.

The longer the family had been known to any service, the greater was the concentration of problems. Working with selected cases from a single agency may be valuable for that agency, but it is not going to produce much more of value in developing the new thinking needed on community social-medical-economic ill health.

Public health social workers, she said, are one of the few groups not tied by a multitude of rules and regulations because of responsibility for money or law enforcement. With their familiarity with epidemiologic and statistical thinking, they can look at families in a much broader context.

Blackford posed the dilemma of the distributor of casework services. The most treatable families are those where the number, seriousness, and duration of problems are not too great. On the other hand, the most expensive families are those with many chronic problems. If only a few of these families could be restored to self-sufficiency, there would be a considerable, demonstrable saving of the taxpayers' money. Or, a small amount of services used early might produce greater savings in preventing the development of multiproblem chronics.

There is little information to back up decisions to work on cases with a higher potential, she stated. Too frequently a case of low potential receives casework for a long period with little improvement because it is a morbidly fascinating challenge. We need to find the point of diminishing returns in casework, the point where it is more profitable to move on to another case, she said. Some hints from the evaluation of the work of the intensive family units lead us to believe the optimum time for intensive casework services is certainly less than a year.

Case Management Schedule

To help in deciding where to allocate services, a family classification and case management schedule was devised by the San Mateo Coordinating Bureau for Family Services (see box). O'Callaghan explained its purposes. The schedule was designed to be used in the departments of welfare, probation, and schools by trained and untrained workers.

The schedule contains all the basic data needed to develop a diagnosis and treatment plan for the family. The form, which has been revised and tested in operation, guides the worker through specific, sequential steps and sets a minimum reporting standard, insuring that certain basic items are given some measure of awareness, thought, and decision.

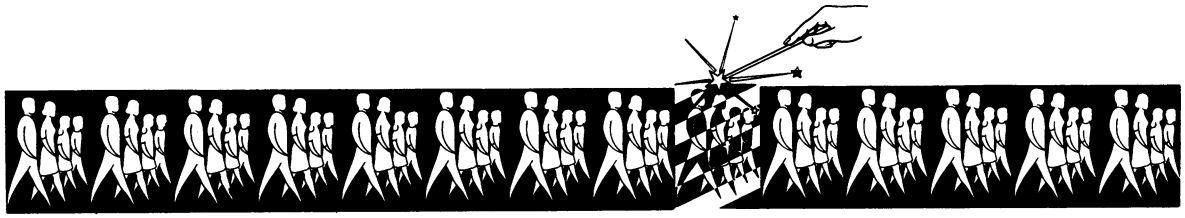
The Schedule

The seven-page diagnostic schedule which includes definitions and instructions may be obtained from the San Mateo County Purchasing Agent, Court House, Redwood City, Calif. Minimum order is 50 copies, which cost approximately $3 plus mailing charges.

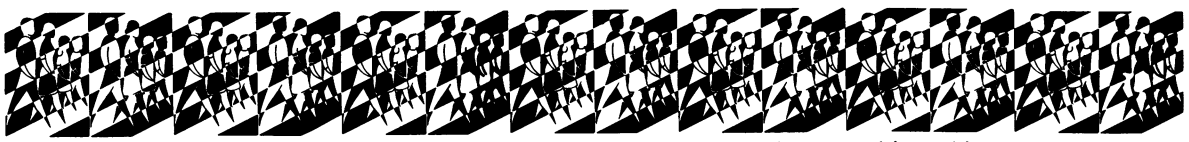
Which family to select for casework?

1940 — 1960

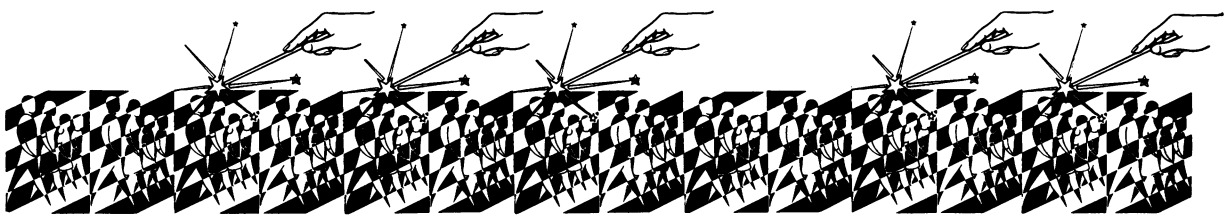
FAMILY A had an outbreak of problem behavior several years ago. In a brief period the family contained this behavior and continued uneventfully. No casework was done.



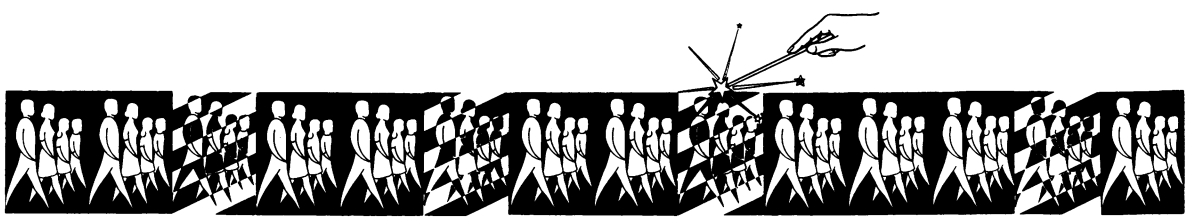
FAMILY B also had an outbreak of problem behavior and contained it within a short time. Good casework was applied.



FAMILY C has had a series of problem episodes, is constantly in trouble. No casework has been tried.

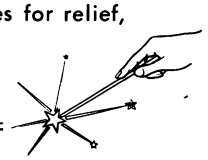


FAMILY D has also had a series of episodes. They have had casework; in fact they have been a proving ground for every new casework service. They still have problems.



FAMILY E has had intermittent episodes and long periods of remission.

FAMILY F has never required community assistance. No one ever applies for relief, gets in jail, or requires hospitalization for mental illness.

Casework = 

Items are recorded in five general areas of functioning: adult, marital, financial, child-rearing, and child. In each, the worker identifies the level of difficulties as no significant problems, moderate problems, severe problems, or no information. O'Callaghan noted that frequently even an experienced social worker overlooks important factors such as health, financial status, or school adjustment of children if her agency has specific responsibility for only one of these areas.

The schedule emphasizes how the family functions, not why it functions as it does. In each area the worker is asked to identify the assets and liabilities of the family as a guide to assessing rehabilitation potentials.

The schedule considers the family at two points in time, at the workup and at evaluation 6 months or a year later. At the time of workup, the social worker makes a forecast, such as no significant problems and none expected, there will be a marked improvement or some improvement, no change, or deterioration. By eliminating any interim recording on the schedule, the family can be seen in sharp perspective at the time of evaluation. Objectivity is enhanced, and the decision as to whether service goals have been achieved is easier.

The reasons for the format of the case management schedule were outlined by Blackford. The format is such that it can be used by a variety of professions for a number of purposes, in a survey or research project, or applied whenever benchmarks are needed.

The format was adapted to the way people work. Elaborate codes were avoided since mistakes are more frequently made by those who use coding only infrequently. The codes that are used are printed on the schedule. Multiple choice questions are employed whenever possible. Professional jargon was avoided, with Webster's used as a guide to definitions, since one of the purposes of the schedule was to aid communication between professions. Instructions and definitions, including definitions and examples of the various levels of problems, are printed on the backs of pages for easy reference.

The schedule represents a structured approach to observing and assessing a family's problems within a framework of definitions, she pointed out. Listing the definitions insures uniformity of observations and is a major step toward data that are worth analyzing. The schedule is already precoded and adapted for transfer to a statistical system. It is a measuring device that can add stability and uniformity to data in an area where measurements are difficult, she concluded.

The supervisor of the family-centered unit in the welfare department, Olga MacFarlane, and the supervisor of the family-centered unit in the juvenile division of the county probation department, Howard Wespieser, described how the schedule was used in their units.

In the welfare department, the schedule for a family is supplemented by a chronologic list of significant events and a psychosocial summary. Caseloads are limited to 20 families per worker and are selected according to criteria developed by the Coordinating Bureau for Family Services.

Usually the families are multiagency-multiproblem families. Typically, they include several school-age children. The mothers have received assistance for more than 2 years, although some have for 5 years, and for some, financial dependency has become a way of life.

In the families where parents have long-established negative patterns, casework is geared to saving the children and improving their adjustment, MacFarlane stated. In the younger families, casework is aimed at reconstructive services with mothers, to help them build ego strengths and a sense of responsibility, with the social worker as a helpful parent substitute. The caseworker takes responsibility for liaison with schools and health services, perhaps with direct treatment services provided by other community programs.

Probation Department

Wespieser felt that the schedule not only aids the juvenile probation department in fulfilling its responsibilities to the court, the child, the family, and the community, but is effective in helping the hard-to-reach family. The schedule gives the information needed for reports and recommendations to the court and is a clear, accurate document which, he emphasized, replaces much of the time-consuming recordkeeping that plagues the average probation officer.

He profiled the families the probation department worker encounters. These families have few friends, make little use of community facilities, avoid community activities, question the motives of those around them, and tend to think only in the present, perhaps because they are not proud of the past and have little hope for the future. Therefore, long-term goals have little meaning for them.

Often a long line of social workers, policemen, probation officers, and school personnel have failed to help them and have become helpless, confused, and disturbed by the raw emotional outbursts of members of these families. Frequently the families have been called "untreatable" and placed in the back ward of the caseload. Remotivation of agency workers and others to try again may be a treatment problem itself, he observed.

Wespieser cautioned that authority delegated by the court is no substitute for assertive casework. Since these families are action-prone,

Case History of the Williams Family

The family is composed of the father, mother, and two sons, Jack, aged 12, and George, aged 8. This case has been in the unit 10 months. Generally, the father and mother have been seen together, although individual interviews were held with each member. Jack, the ward of the court, was seen monthly.

The community where the family lives has been deteriorating for several years as the population changed. A few years ago, Mr. Williams was active in attempting to stem the tide of new families. The Williams family is in constant conflict with newcomers. The neighbors made little effort to reduce tension and on numerous occasions were responsible for some of the conflicts.

Mr. Williams is certain that outside forces are organizing against him. In this conspiracy are the real estate men, city council, school people, police, and the social worker. He has a good employment record, and family income is managed reasonably well.

Although Mrs. Williams wanted to leave the area because she was aware of the destructive impact on the family, she passively accepted her husband's position. More recently, with the support of the social worker, Mrs. Williams has been able to stand firm about moving, and her husband started renovating the house for renting or sale.

Recently, Jack lost a fight with a neighborhood boy. The father ordered him to return, fight, and win. Mr. Williams accompanied the boy, and when his son started losing, he stopped the fight. Mrs. Johns, the other boy's mother, accused Mr. Williams of hitting her son. Two witnesses were willing to testify that he did assault the boy. A relative of the two witnesses had been arrested by Mr. Williams some time before. A police officer came to arrest Jack, but ended up arresting Mr. Williams for assault and battery and interfering in the officer's discharge of his duties.

In the next 4 days, the social worker took the mother to court, interviewed the father, saw the judge, talked to the victim's mother, stopped Jack when he was starting another fight, and had telephone contacts with Mr. Williams' attorney and the assistant district attorney.

After much encouragement from the social worker, the mother saw Mrs. Johns twice, and the victim's mother was willing to drop the charges against Mr. Williams if he was not told about it.

The worker telephoned Mr. Williams and talked for an hour and a half. The interview started with the father reiterating his past comments of discrimination. He added the assistant district attorney and the social worker to those working against him, and said that he was going to get a few of them before they got him. He resented the worker's efforts at being a peacemaker. The worker carefully elicited what had been unfair treatment and frankly discussed this with the father. He questioned the father's distortions or projections.

As the interview continued, the father shifted his focus. Instead of attributing his difficulties to outside forces, he spoke of his feelings of distrust and then discussed his goal of moving to a more desirable neighborhood. This was the first real breakthrough of the father's defenses, although he had been moving closer to this kind of sharing of his own feelings for 2 months. The social worker spent 12 to 15 hours during a 12-day period on this case.

the initial approach of the worker is usually a well-thought out and realistic act, such as helping someone find a job, helping to improve living conditions, providing financial assistance, persuading a utility company to continue service, or intervening in behalf of a client with school officials, police, or neighbors. The worker's honesty, the promises kept, the regularity of contacts, and the staying power of the social worker through recurrent difficult situations appear to be the only way to demonstrate a real willingness to help.

He cited, as an example of responsible casework, how a crisis was handled in one of the families served by his agency (see case history). This was assertive, family-centered and community-centered, prompt and realistic action, based on the concepts in the case management schedule. It is likely, he commented, that traditional correctional agency service would have emphasized the boy, rather than the key person, his father, and the community implications of the conflict would have received superficial attention.

U.S. Birth Rates in 1960

In 1960, 4,257,850 live births were registered in the United States. The national figure announced by the National Vital Statistics Division, Public Health Service, includes Hawaii for the first time.

There were 4,000 fewer births registered in the 50 States in 1960 than in 1959. Over the last 4 years, total births have alternately increased and decreased, but the number of births per 1,000 population has decreased slightly each year, from 25.0 in 1957 to 23.7 in 1960. Although nearly 700,000 more babies were born in 1960 than in 1950, the live birth rates for the 2 years differ only slightly.

Since 1950, birth rates have dropped more than 5 percent in 13 States in the south, an area with traditionally high birth rates. This decrease appreciably affects the national rates; increased rates elsewhere do not quite offset the decrease in the south.

Alaska had the highest birth rate of any State in 1960, with 33.4 live births per 1,000 population. It ranked fourth in 1950. Hawaii and Mississippi, each with a rate of 27.2, ranked sixth in 1960. In 1950, Mississippi was third with 29.8, and Hawaii was sixth with 28.1.

The lowest birth rate in 1960 was recorded for West Virginia, with 21.2 births per 1,000 population. In 1950, West Virginia was 22d with a rate of 25.2, while Connecticut and New Jersey ranked last with 20.2.

According to the Public Health Service, some of the important causes of these State-by-State changes in birth rates are: probable postponing of births in certain areas with high unemployment; migration of young adults of child-bearing ages; effects of previous high birth rates on the age composition of the population; and effects of long-existing differences in the age composition of State populations.

Provisional birth data for 1961 indicate that there may have been some 25,000 more births in 1961 than in 1960, but the rate may have declined slightly to about 23.4.