Principles from history, community psychology and developmental psychology applied to community based programs for deinstitutionalized youth (*)

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I am deeply honored by your invitation to give this keynote address. It is gratifying that you have found my previous work useful and I hope that I can adapt the ideas to the problem at hand. I wish that I had the language facility to address you in other than English, but it is a failing of American education that so many of us are limited to one language. In addressing the issues of the deinstitutionalization of youth, and the development of community based services, I will make use of some historical data and some of the principles of community psychology. My knowledge is limited to the American context, and I don't know how much of what I say will generalize to your social and political context. I hope I will state sufficiently general principles so

that you can extrapolate to the situation in Portugal. At any rate, that is my aim.

THE POLITICAL AND VALUE CONTEXT OF CHANGE

A basic premise is that there is no such thing as a social vacuum. All programs are implemented and function in an elaborate social context. All programs are social artifacts which are inevitably compromise products of their social surroundings. All services are necessarily embedded in the political system. Services are funded through the political system. Values in the political system affect the services that are supported, and how they are delivered. Although politicians may express sincere concerns about children, often they don't follow through with action or money; reform of services necessarily involves politics, government and money. You should be prepared to encounter the politics of services, including professional politics (competition among psychology, social work, psychiatry, and education).

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We can speculate about why services for children have been neglected. The neglect might reflect something fundamental about our values. The Ten Commandments of the Old Testament include a call to honor one's father and mother. There is no parallel commandment to nourish and cherish our children. At a basic level, children do not have the right to vote. Many children who are in need have parents who are in poverty or without political or social influence. If their parents are to be effective advocates for their children, they need a great deal of support. In the course of deinstitutionalizing, you should consider how to empower parents to be more effective in advocating for their children.

WHO IS IN NEED?

Although we say we are committed to the welfare of children, change takes place slowly. In the new edition of our community psychology textbook, we trace the recommendations of a number of U.S. government commissions on mental health. Official, national government commissions reviewed children's mental health needs in 1961, in 1965, in 1978, in 1990, and again in 2001. The problems described in the earlier reports continued unabated over those 40 years. In fact, the latest report could have been composed by cutting and pasting from previous reports.

What were these problems? First, the prevalence of disorder among children and adolescents is high, of the order of 20%. Second, resources do not effectively reach those in greatest need-children of poverty, especially with minority backgrounds, and those who had been abused and neglected and had been placed out of the home in foster care or in residential treatment. I suspect in Portugal, the rate of disorder is also highest among poor families with limited resources who rely on public agencies. These are the youth and families you will need to serve in community based programs. In the United States, children involved with the welfare, the juvenile justice and the inpatient mental health systems were the ones most poorly served. Moreover a clumsy, bureaucratic, patchwork of uncoordinated service agencies impeded the delivery of care. In 2001, the US Surgeon General estimated that about one in five children in need received services.

That is all a consequence of how services

develop in our complex social system which includes the federal government, the state government, local governments and private sector agencies recognized in law. Each agency has its own mission, its own priorities, its own admission requirements, its own fee structure, and its own limits on services. These requirements act as filters which allow some youth and families in and keep others out. The services are not appropriate for all, and many potential consumers of services do not see the service system as helpful as they see their needs. In planning for community based services, you should be prepared to deal with the fragmented service system and perception of what is helpful.

From the community psychology viewpoint, appropriate treatment in the community is limited if we relay exclusively on a medical model approach. The basic medical model affects both the definition of disorder and the definition of treatment. Once we define a problem as a medical disorder (after all the condition appears in the diagnostic and statistical manual of psychiatric disorders), we also define treatment as some form of therapy and the treatment has to be delivered by a "doctor", thus limiting the personnel who could be helpful. Medical model service providers don't often reach out to potential clients so many are missed. Many clients, especially those from poorer groups do not see talking as helping. Although medical model services are important and useful for many purposes, I will concentrate on alternatives.

The medical model assumes that once the illness is diagnosed and treated that all else will be well. Treatment of a child cannot influence parental substance abuse. It cannot affect inadequate housing, nor can it affect life in neighborhoods where children are frequently exposed to violence and where schools are inadequate. Treatment in a clinic for one hour a week cannot account for how children spend the rest of their time unsupervised on the street. Treatment in the medical model can't prepare young children to learn or encourage them to learn. In planning treatment in the community we need to take into account developmental considerations and the actual conditions of living.

TREATMENT IN THE COMMUNITY

When we go from institutional based treatment to community based services, there are some ine-

vitable considerations. In a total institution, living expenses, housing, food, clothing, education, recreation, medical services and transportation are all provided. If children are to be sustained in the community, those basic life supports will have to be provided, perhaps differently in urban communities than in rural communities. One size does not fit all.

These new services will require funding. Institutional care is expensive, but until an institution is shut down completely, the institution will continue to absorb a large share of available funds. The number of children living in the institution may go down, but those still there will require care 24/7 and will require staff. The plant will have to be maintained. Moreover, if the children who are placed in the community first are the "easiest" cases, then the remaining ones will be more difficult and require more effort. The point is that even though the numbers of children in the institution go down, the reduced number will not make money available in direct proportion to the decline in the institution's census. New funds will be necessary, and new laws allowing the money to be used may also be necessary. It is much more than taking an escudo from one pocket and putting it into another.

I have said nothing about the feelings and attitudes of those living in the communities around the institutions. Many earn their livings by working in the institution or supplying it with goods and services. Closing an institution will affect their livelihoods and their communities in a way not very different from what happens to a community when an industrial plant closes down. If there are strong unions, their interests may have to be taken into account. Politicians representing the people in affected districts may wish to protect their constituencies. Politicians may want to look for alternative uses for the institution to preserve its economic value to the local community.

There are three alternative arrangements for care in the community: (1) Children can be returned to their own homes; (2) children may go into foster care, or (3) they may go into smaller residential units scattered throughout the community. In keeping with the spirit of problem creation through problem solution, I will mention problems that might be expected and should enter into your planning.

Return to own home

Children were removed from the parental home either because of death or illness of the parent, or the parent's incapacity to provide care for whatever reason. Perhaps the separation and passage of time will have solved the problem that led to the out of home placement in the first place. It is possible that some parents will be sufficiently "rehabilitated" so that they can accept the child back into the home and can provide competent and loving parenting. It may be that your social service workers have been helping parents all along and have prepared them to receive their children and to care for them. My best guess is that will be true in only a minority of cases.

We do know that perhaps a third of children, returned to their parents after having been removed from their homes because of parental inadequacy, will be returned to out-of-home care in a relatively short time because new problems emerged. It is not a safe assumption that a period of separation of parent from child will result in a "cure" of all the problems that led to the separation in the first place.

If a child is to be returned to the home, there is still schooling, money to support the child, and other support for parents. You may need to devise a program of help for the parent and the family in the period following the return of the child to the home. Perhaps the newly restored child will be welcomed and loved, but the odds are that family disruption may be expected as well. Complex family dynamics, sibling rivalry and conflict may be manifested upon the entry into the family of an additional person.

The child leaving an institution may be behind in school, and may have to cope with stigma as a result of having been in an institution. Children can be very cruel toward each other. The school may have to be prepared to help integrate the child into the social group, and to help the child cope with a curriculum and teaching methods which may be very different from that in the institution. Similarly, the child may need help in integrating into a social group, in finding friends, in engaging in sports teams or other recreational activities, and in avoiding bad company.

The movement toward deinstitutionalization came in the wake of a scandal in the large institutions. I don't know under what legal authority in Portugal children were removed from their homes, and what legal process is involved in returning them. Returning the child to the home does not

guarantee freedom from scandal. In the United States, on occasion, a child is returned with social services recommendations, and with judicial approval to the parental home and the child is later injured or even killed. Fortunately, such events occur rarely, but when they do occur, the media pay great attention. The media play a nasty blame game. Media attention occasionally results in some efforts at reform, but mostly it causes distress to the workers in the system without doing much to promote effective problem solving.

In the United States, at the present time, about 50 percent of out-of-home placements are with kin-relatives, mostly grandparents. These placements can work out effectively because they depend on family feeling and the basic expectation that family members feel responsible for each other. Grand parents also need support. As they grow older, they may not have the physical strength and energy to cope with an active youngster. They may be coping with their own limiting chronic conditions related to aging – heart disease and arthritis for example. Perhaps the grandparents are surrounded by loving, extended family members who will help take over the care of the child. However, in our society, people move from one place to another. Even if extended family members are living nearby, unless there is an existing norm of reciprocal care, the extended family network will have to be nurtured in order for it to be effective. I will show you a video in the next session depicting the New Zealand model of the Family Group Conference as a means to help make it possible to enlist the family's concern and resources. That may not happen spontaneously; in many families, it will require a sensitive inter-vention to create an active family network.

It is difficult to organize poor people into a social movement. However, it would be worth undertaking efforts to organize parents to advocate for their own children. Some parents will prove to be outstan-ding leaders, and participation may do much to overcome apathy and improve parental self esteem.

This first alternative of returning children to their parental homes is desirable if it can be accom-plished with adequate support. Periodic visitation by a social worker or a community health nurse may be helpful if the visit is not stigmatizing, truly helpful, and not merely intrusive. I will also discuss briefly a concept of a neighborhood community center to which all parents and children may come

for recreation, education, skill building, parenting lessons, and simple socializing to break down isolation.

Foster care

In this section, I will emphasize the deficiencies of the foster care system, but I must point out that despite the deficiencies, a surprising number, perhaps 75% turn out to have no poorer social adaptations than children of the same socioeconomic class who remained with their parents. In other words, it is not all bad, and for many children, foster care is essential for their survival.

Historically, in small, rural communities in which many members of an extended family lived, the loss of a parent was less critical. A child would simply move to the home of an aunt, an older sibling, or a grandparent. There would have been no formal placement or adoption. Among the Maori in New Zealand, and to some extent among Native Americans, a child is not only a child of the birth family, but a child of the extended family, the subtribe and the tribe. It was not unusual for child to move to different family homes from time to time. Urbanization and geographic mobility with its separation and scattering of family members made this form of informal care less feasible. When a parent died, or was incapable of caring for a child, frequently children would be sent to large institutions such as poorhouses.

When we recognized that poor children needed specialized care, we developed separate institutions for children. However, for infants and toddlers, placement in large institutions or foundling homes was tantamount to a death sentence. In mid 19th century, anywhere from 50 percent to 90 percent of children died of disease. Concepts of attachment failure were developed partly as a result of obser-vations of how children were brought up in insti-tutions. If the child survived, contemporary observers characterized many, but not all, of the children as having damaged personalities because they were shaped by the inflexible and impersonal discipline of the institution.

Partly because of the death rate, dependent children in institutions were placed with foster parents sometimes because the women could serve as wet nurses for infants. Later some reformers came to understand that poor and dependent children shouldn't be removed from their homes, but that their mothers should be given resources to care

of the children in their own homes. These grants of money were first called mother's pensions, and later evolved into a public welfare program.

Foster care as part of the social service system originally developed to provide short term care for children if a parent fell ill and couldn't care for the child. The foster care system contemplated the quick return of the child to the parent when the crisis was resolved. One remarkable U.S. Supreme Court case tested the rights of foster parents to be involved in decisions about the child's placement. One of the justices wrote that foster parents had only minimal rights. They were contractual employees of the state. The justice, in his wisdom said that because the child was to be returned to the parent foster parents should not become emotionally attached to foster children. I think it was Dickens' Mr. Micawber who said, "The law sir, is an ass!" They do become attached and that emotional tie should be enlisted for therapeutic purposes.

In more recent days, the foster care system has had to cope with much longer placements. The average length of stay in foster care is about 33 months, but a third of the children stay three years or longer. Children are removed from their homes because of parental neglect or abuse, because the parents are addicted to drugs, or the parent is in prison. Given those backgrounds, many children will not be restored to their families. The longer children stay in foster care, the less likely it is they will be adopted or returned to their homes. The longer children stay in care, the more likely it is they will experience multiple placements with different foster families.

That is one of the limits of the foster care system. Children may be moved from home to home because some foster care families work best with younger children. Sometimes a child doesn't adapt in the particular home and unlike natural parents, foster parents can give the child back. Sometimes a child is unruly, or is aggressive, or has conflicts with the foster parent's natural children. Sometimes a sexually abused child become sexually aggressive, or seductive, leading to problems in the foster home. Sometimes, children are moved because the supervising worker needs to find a larger home for several siblings and that can be accomplished by moving one child into another home. Siblings are often separated when they can't be kept together. Some attribute attachment problems among foster children to multiple changes in placement.

We are also aware that in the United States, a large number of children in foster care do not receive adequate counseling, therapy, or sometimes even adequate medical care. There are many reasons for the lack of care. First among them is the multiple intersecting and overlapping agencies with their eligibility requirements and systems of reimbursement for services. The movement of children to different homes sometimes makes continuity of care difficult so that needed medical care is not received. We also know that child welfare commissioners, especially in larger communities, and caseworkers have high turnover rates. The workers often have too large case loads and cannot adequately supervise much less provide consultation or other help to foster parents. A new worker may have little idea of the history of a child's care or its needs. Foster parents need to be trained and encouraged to be advocates for their children, and the system has to accept their advocacy rather than consider those who raise problems as enemies of the system.

In the United States, we have made increased efforts to have children in foster care legally adopted. Often foster parents want to adopt, and when they do, they may be lost as a resource for the foster system. Foster parents also enter and leave the system. The social service agency must continually recruit and train new foster care parents as well as workers. If the demand for placement in foster homes is high, and the supply of foster parents is low, the social service agency may be less able to be selective and may have to accept foster families who are themselves problematic. The science of matching children's characteristics to foster parents' characteristics is not well developed.

Many youth remain in the system until they reach the age (age out) when the state no longer has responsibility for them. Put out on their own, without family support, and without adequate education or vocational skills, some end up homeless.

Some of these problems may be overcome by using principles of mutual assistance. A social services worker could organize small groups of foster parents into a support network for each other. The social worker's professional skills could be multiplied many times over. The foster families should be paid for attendance at regularly scheduled meetings. The foster parents could be encouraged to pool their resources and to serve as a moralnet to provide face to face social controls for each other. If regular

visits to each other's homes were encouraged, the system would have many eyes on each placement. An abusive or neglectful home could be identified quickly, or the members of the network could provide assistance to the struggling foster parent. They could provide respite care for each other so the foster parent could have a break and even a short vacation away from child care responsibilities. This same principle could apply to kinship care where family members essentially serve as foster parents for their relatives. A group such as this, and a network of groups could also be encouraged to serve as advocates for their children, and as critics of inadequate practices. The network could make up for the powerlessness of poor parents who have little influence in the political system.

Small group homes in the community

A third alternative is to develop small group homes serving a dozen or so children. These also require planning. First, an adequate physical facility is necessary. Sometimes the agency can buy houses in residential neighborhoods, but when they do, neighbors sometimes object because they believe the children are dangerous and that property values will decline. You may need some law to allow group homes to be developed in decent neighborhoods. In the United States a number of religious orders have decentralized and no longer live in the convent. Some of these have proven to be a good resource for group homes.

The second problem is staffing. It is necessary to recruit a 24/7 staff, to train them and to provide good leadership for them. Group home staff should be trained so they have an understanding of other community services and how to gain access to these. We don't have any clear ideas about who make the best staff and how to organize their work for the therapeutic benefit of the children and also to encourage personal growth among the staff. A good program will provide not only for the care of the children, but also for the satisfaction and growth of the personnel. The proper organization of the service in a group home so that the workers can do their jobs and the children can benefit should not be left to chance. A group home needs to be built on a therapeutic philosophy that all workers share. A therapeutic philosophy helps workers to understand how children are to be treated. The leader of the group home should be

committed to the philosophy, and should see that workers carry it out. The problem requires thought and a theoretical perspective. A good consultation program can be an excellent way of bringing professional expertise to bear and to help see that the therapeutic philosophy is carried out.

DEVELOPMENTAL CONSIDERATIONS

Attachment status

A program should take into account the attachment status of children. Some children may have been subject to such difficult conditions in early childhood that basic trust is lacking. It will be difficult to work with a child who lacks basic trust if the workers change every few months and are not available when and where the child needs assistance. When we change treatment personnel for our convenience, when the medical resident rotates on the 30th of June, we may not provide for continuity of care. If children are in a group home, it is helpful to create working conditions that minimize turnover among staff so that care is continuous.

Latency years

Children in the latency years need to learn to read, write and do arithmetic. Therapy alone cannot provide those skills and experiences. Children need to have people who can help them develop skills, and who appreciate the importance of accomplishment for development. If pre-pubertal children do not learn to persevere, to develop academic skills, beginning work skills, skills in working and playing with others, and skills in playing games, the child will be at a great disadvantage in adolescence. Teachers with a therapeutic orientation appreciate such concerns, but medical model practitioners often see these as "ancillary" rather than as central for helping youth. A community based program should take such developmental needs into account.

Adolescent sexual behavior

Youth begin to develop identities during adolescence. The problems of puberty and sexual development are of course important. In the United

States, we know that young women who have babies before they complete high school are less likely to complete school, more likely to go on public welfare and less likely to make as good an occupational adjustment as young women who manage to postpone child bearing. Young mothers are more likely to have daughters who also have children at an early age, and they are more likely to have children who become delinquents.

We need to teach adolescents to be responsible about sex. In the U.S., in recent years, we have seen a decline in both abortions for teenagers and in live births. Consider the formula: **Pregnancies = Live Births + Abortions + Miscarriages**. If live births and abortions decline, and assuming that miscarriages remain constant, it must mean that the sexual behavior of youth has changed. Youth may be using contraception more effectively and they may be postponing intercourse to avoid sexually transmitted diseases. We are not certain about all the factors, but the favorable trends encourage us that social norms can be changed. Social norms are not changed by delivering services in the medical model. Changing social norms requires reaching into youth culture. Community based services for adolescents will need to take into account their sexual development as well.

Adolescent identity

Adolescents are concerned with how they appear to others, especially peers. We cannot influence the effects of peer pressure by medical model helping forms. It is necessary to somehow affect attitudes in the peer group. All that may be accomplished with an individual may be undone when the adolescent is with peers who do not share the values. A community treatment model should somehow, and it is not easy, take into account peer culture and influences.

In addition to peer pressure, adolescents are faced with the problems of integrating skills, interests, and roles they have had in the past with an occupational future. *What will I do when I grow up* is a concern that all older adolescents face. After all, for most adults, the center of identity is one's occupational role. Our therapeutic modes do not speak to such concerns. They do not provide adequate opportunity to experience and to explore new roles and develop skills and responsibility. Our therapeutic modes do not expose our youth to role

models who might help them in accomplishing this task of development. Some research suggests that delinquent youth "grow out of it" if they have some adult they admire and with whom they can identify. A community based program for adolescents should confront these issues of preparation for growing up.

Developmental considerations are important even for those youth who have psychiatric impairments. Impairments wax and wane, but growing up does not. Growing up is ever present and inevitable. It may be true that you are only young once, and that you can be immature forever. Youths' lives will be influenced by social expectations for age appropriate roles. Youth have to be prepared to adopt adult roles. We cannot write these developmental demands off simply because the youth has a psychiatric diagnosis.

One of the most important aims of any service is to prevent children who have limited future time perspectives from doing things now that will irretrievably spoil their lives in the future. Many adolescents fail to appreciate the significance of preparing for the future. But that doesn't mean the adults who work with them should forget the rapidly approaching future. A developmental perspective in planning community based services for youth allows us to envision more options in the nature of services, in the institutions through which they are delivered and the personnel who deliver the services. Seymour Sarason noted that the universe of alternatives is always large, and should be explored in planning for new services. Thinking "out of the box" is helpful in finding and making the best uses of resources. Go past the conventional in planning, but do that thoughtfully.

EXAMPLES OF PROGRAMS

We have some historical examples that may provide models for your task of providing community based services in place of institutional services.

The Settlement House

One of the most successful services in the United States for immigrants and their children in the early 1900s was the settlement house. Immigrant communities at the beginning of the 20th century were plagued with social problems. The settlement

house deliberately set out to provide the best of modern culture to the immigrants and their children as a remedy for social problems. However the services were not limited to those who had problems. They were offered to all, thus avoiding stigma. The settlements provided a variety of activities including music, drama, poetry, art, a place to do homework, competitive athletics, discussion groups, lessons, and clubs that became training grounds for democratic participation. The clubs had as many as 70 members. Each had a staff person to guide them, but the members elected officers, and planned their own activities. They were multipurpose clubs. The clubs kept their members for many years. Club members became a reference group for the others helping to develop norms about proper behavior, and mutual encouragement to accomplish academically and in the arts and sports.

A settlement house-like facility which offers a broad range of services and facilities including opportunities for parents to meet together, to develop their skills, to have fun, and to receive support in their tasks of child rearing should be considered as an option. A number of such community centered programs have been put into place and show some advantages especially for prevention.

A juvenile court that served youth

The juvenile court was created to prevent children from being put in prison with adult criminals and to prevent crime. The court created in Chicago, Illinois is generally credited with being the first such court. However, a juvenile court was created in Denver, Colorado in 1899 by Judge Ben Lindsey. Judge Lindsey, a unique charismatic personality, related to youth. In addition to using the court as a means of social control – youth were punished and sent to reform schools – Judge Lindsey used social processes to make the court an institution that served youth as well as punished them. Judge Lindsey had regular Saturday morning sessions in which all youth under his jurisdiction appeared. If out of school, the youth had to present a report from his employer. If in school, the youth had to present a note confirming he was attending school and was not getting into difficulty. Judge Lindsey reviewed the reports publicly. He praised those who were showing progress. When a youth was in violation of the conditions of probation, all knew it so the judge's actions were not seen as

arbitrary. Judge Lindsey's approach might be characterized, in the words of our former President Ronald Reagan, as "trust, but verify". He invented a feedback system. Judge Lindsey did send some youth to a correctional institution, by far the largest number of youth were maintained in the community on probation. When he sent a youth to the reform school, gave the youth his papers, the cost of a trolley car ride and send the youth off to present himself at the institution's gates at the outer edge of the city. He saw his practice as a way of building trust. Over the years, hundreds of youth were sent to the institution and only 5 ran away.

Judge Lindsey didn't just send children off to institutions. Judge Lindsey regularly visited the main institution to which he had committed children and youth. He provided "eyes" on the institution to prevent abuses. He opened his chamber to hear complaints from youth about adults, and he helped young pregnant girls while maintaining their privacy and confidences. He created a public bath in the court so youth could be clean at least once a week. His court also found jobs for youth, including summer employment, ran dances and other social affairs. Because Judge Lindsey related so well to youth, a contemporary journalist characterized him as the leader of every kid's gang in Denver. Some forms of delinquency may actually have declined in Denver. Lindsey was an elected judge. The youth became part of his political machine distributing leaflets for him and urging their parents to vote for the Judge. Newsboys would sell their papers by telling everyone who passed what the Judge had done that made the news.

Judge Lindsey was a unique personality, but the concept that an institution should serve as well as control youth is worth considering. By serving youth, the court had a presence in many aspects of a youth's life and Judge Lindsey created conditions for reciprocity. Youth helped him and he helped them. Can community services be designed with those principles in mind?

"Eyes" on the institution

The principle that services should be monitored is important even when community services are created. In the state of Maine, a law suit triggered by children's advocates demonstrated that conditions in the institution were unconscionable. The large, state supported institution for the care of those

with mental retardation came under a court's jurisdiction. The court ordered the state system to reform itself. The court ordered blueprint for reform included as goals the reduction in the size of the institution and the creation of group homes in the community. The court also appointed a monitor with great authority to review compliance with the blue print for reform.

The story of how change was brought about is intriguing in itself. However, I want to emphasize that after successful deinstitutionalization, a mechanism was put into place to see that the reforms in the institution and in the community based group homes were maintained. A Board of Consumers was created with powers to enter and to observe in all the services. In addition, coordinators responsible to the Board of Consumers recruited volunteers to serve as "best friends" for those who lived in community facilities, and especially for those youth who had no family. The best friend had access to the youth's individual written treatment plan. The law required that each youth have such a plan. The "best friends" were instructed to visit regularly and to check to see whether the treatment plans were being carried out. They reported to a coordinator who had the power to require that treatment plans be carried out. In addition, the Board of Consumers was directed to hold open public hearings annually, covered by the press, with notice given to advocacy groups so they could testify. The state commissioner was instructed by law to respond publicly in writing to the issues raised at the hearing. In other words, the process included a feedback mechanism that triggered corrective efforts. I think this concept or some variant of it should be built into any community based service and to provide oversight of institutions as well.

We will never do without some institutions. In the field of mental retardation, as most residents were discharged to community facilities, the institution itself was left to cope with the most difficult and most disabled individuals. It is easy to neglect and abuse those in greatest need, and unless there is some way of keeping "eyes" on the institution, we can expect new problems to emerge from time to time.

B=f(P,E) – Behavior is a function of Person and Environment

Youth sent to treatment institutions do improve. However, the literature supports two additional conclusions. First, that those who improve the most were those who were least impaired at the outset. In other words, those who were better off to begin with benefited from treatment conditions. Second, improvement in the institution did not predict later outcomes in the community after discharge from the institution.

Two inferences follow. First, many who could have succeeded in the community with some assistance were placed in institutions unnecessarily.[1] That term "unnecessarily" has to be qualified. Troubled and troublesome youth are difficult to live with. Parents and other caretakers needed relief from their anxiety about their adolescents. However, commitment to an institution was not necessarily the best relief. When the youth were released, they had histories of psychiatric hospitalization which can be stigmatizing in other contexts.

Second, the medical model of "cure" neglects the implications of the Lewinian formula $B=f(P,E)$. The person interacts with the environment. When the environment changes, behavior also changes. Youth in the community live in many different environments. They are at home, in school, and in the community interacting with peers. The formula $B=f(P,E)$ implies that therapeutic program may have to have some presence in each of those areas. Stanton Coit, one of the early settlement workers expressed the problem in these words:

> If we consider the vast amount of personal attention and time needed to understand and deal effectively with the case of any

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[1] In fact, in the United States, the population of private psychiatric hospitals for youth actually increased during the time the census of institutions for adults was declining sharply. In part, the growth of private psychiatric hospitals occurred because there were insufficient effective community based services. Many parents had access to outpatient treatment, but outpatient treatment in the medical model was not fully effective for disturbed and disturbing youth. In part, the growth of private psychiatric hospitals was powered by the fact that medical insurance would pay for the expensive care, at least for a while. Private hospitals could make a profit serving these youth. In part, the rise in institutional care was due to a ruling of our Supreme Court. The Court said that youth had few due process rights when their parents wanted them institutionalized. They left the protection of children's interests to professionals who profited if the children were accepted into the institution.

one man or family that has fallen into vice, crime or pauperism, we shall see the impossibility of coping with these evils alone, *unless the helpers be both many and constantly at hand*. (emphasis added).

MST

Multisystemic therapy (MST) created by Scott Henggeler takes the principle of **B=f(P,E)** seriously. The well tested treatment model is both family and community based. The treatment has been demonstrated to be effective with antisocial youth. A therapist is assigned to a family and may see the family several times a week, or in periods of crisis as often as necessary. The therapist is available 24 hours a day ("constantly at hand") if necessary and meets the family in its home. The therapist also goes to the youth's school, and meets with the peer group and even members of the extended family. Therapists have a low caseload, but the cost of the service is more than recovered by the savings in the high cost of institutional care when out-of-home care is avoided.

The therapist's purpose is to teach the family to deal with problems in the present and hopefully in the future as well. A therapist may well try to involve the neighborhood social network including friends, neighbors and extended family members to become activated as a resource for the family.

The process begins with identifying problems within the family. The family takes an active part in the diagnostic process. Family members help to define the problem, not in psychiatric terms, but in practical terms of managing a difficult and troubling set of problems. The parents are involved as key helpers, not as patients. The therapist may work with the parent to enhance their discipline skills, to reduce marital discord, and to enhance or empower the parent to be central in the youth's rehabilitation. For example, if truancy is a problem, parents are encouraged to contact the school on a daily basis to verify the youth's attendance. Therapists also work with youth. Specific goals are set with the youth. The approach is strength based rather than focused on identifying pathology. If the peer group is a problem, the therapist will encourage contact with more pro-social peers and will work to help the youth develop social and other skills. In other words, the aim is to improve the family

and the circumstances sufficiently so that improvement lasts. Henggeler's writing says little about the professional background or the personal qualifications of the therapists. Most of MST work is done through social agencies. The program relies on careful training in MST methods and close supervision by those trained in MST methods. I assume the workers are largely social workers or counselors.

Family Group Conference

A variant of MST is the Family Group Conference first developed in New Zealand. The Family Group Conference is used in association with either child protection or juvenile delinquency cases. A professional coordinator brings together the family including members of the extended family, the youth, and the victim if a crime is involved. Neighborhood people with an interest in the youth, and representatives of professional agencies who have had contact with the family are invited to participate. The family meets privately during one part of the conference to make a plan for resolving the issues presented by the youth. Because many people are involved, the possibilities for solutions are greater than simply a referral to counseling. Using their resources, members of the Family Group conference might find a new place for the youth to live, require that the youth report to a grandparent after school, and require the youth to take a part-time job with someone who also agrees also to supervise the youth. Some of the pay may be used to repay the victim for losses. The plan can involve many people in the community, the many helpers who are constantly at hand. The many helpers also have "eyes" and can provide feedback about whether treatment plans are working out.

If the group can't arrive at a satisfactory plan or the plan fails, the youth may be referred back to the youth court and a judge for disposition. The youth may be strongly motivated to have an active voice in the plan, as against being placed in the hands of a judge who may be far less sympathetic.

Consistent with United Nations Convention on the Rights of Children

Several of these programs make an effort to involve the youth in the treatment planning and

in carrying out the program. This involvement of youth is consistent with provisions of the United Nations Convention on the Rights of Children that call for as full participation of youth in those matters that affect their lives as is feasible. Portugal is a signatory to that convention.

PERSONNEL WHO PROVIDE SERVICES AND THEIR TRAINING.

Professional training

The methods of social treatment, reminiscent of MST, were used regularly in the early child guidance clinics, especially prior to the 1930s. The emphasis in social treatment was on practical adjustments in the life of the youth who was identified as a case. The workers made home visits, met the youth in the youth's neighborhood, obtained resources for the youth (e.g. funds to obtain a scout uniform), worked with the youth's teacher, encouraged the parents to support study at home, accompanied the youth to medical clinics, and provided general encouragement and friendship. It is interesting that such research as was available showed these methods were effective in bringing about improvement in about 70% of the cases. The rate of success actually dropped when the child guidance clinics later started using psychoanalytically based talking treatment provided in the clinic's treatment rooms (Levine & Levine, 1992).

These methods ceased to be used when American social workers developed ambitions to be recognized as a profession. Education in a professional method is one of the hallmarks of a profession. The social workers were often trained by physicians with psychoanalytic background who taught them "talking treatment". The treatment was to take place in the office, and not in the client's community. Our book *Helping Children* (1992), traces some of the consequences of this striving for professional status on the development of services for children. It resulted in barriers to treatment for many low income families and an emphasis on treating upper income families whose children suffered from "nervousness".

Selection of personnel

The selection process of workers for professional training may not encourage those who have the best personal qualifications for work with youth in need. I have no data to support this next point, but I think that helpers with an athletic background are more at ease with aggressive youth than those who are more academically inclined. I think such individuals are less intimidated by youth who tend to be physical and threatening in manner. The helping person's ability to maintain calm in the face of aggression may be effective in keeping the youth's aggressive behavior within bounds. Selection for professional training may screen in those who are more bookish and screen out too many of those who are more comfortable with aggression. It may be important to try to match personnel with children.

Taking into account the well being of the worker

Professional training in medical model therapy with its value on heroic cure, may contribute to worker burnout when working with severely limited youth whose progress may be very slow. Some who have a religious commitment to service may be far more patient, and more able to take pleasure in small accomplishments. The people who are effective in one setting working with one type of youth may not be effective in another setting.

It is necessary to think through the question of the conditions under which people working with difficult youth can do their jobs. One needs to make provision for the well being of the workers as well as the well being of the youth. The question of the social organization of the work setting that will help maintain worker enthusiasm and morale and enable the youth and the workers to function at their best is not settled by a table of organization. It is an issue that needs to be thought through. I recommend Seymour Sarason's book The Creation of Settings and Ira Goldenberg's book Build Me a Mountain for the further development of these ideas.

Paraprofessional helpers

There is a literature on paraprofessionals, on nonprofessional helpers drawn from the community to be served. Paraprofessionals need supervision and direction, but on the whole they can be very effective. It is easier for youth to identify with those who share many aspects of their culture

and language than with someone from a different social class with a different skin color, accent and family experiences.

The Residential Youth Center in New Haven, Connecticut serving difficult youth, was staffed largely by paraprofessionals. The professionals associated with the program served as supervisors and consultants. The center of the program was the work crew, supervised by a paraprofessional. Youth received a stipend for working half a day five days a week on a work site painting fences, or repairing park equipment, or cleaning park areas under the supervision of a work crew foreman. The youth gained work experience and regular work habits. They also identified with the work crew foreman who could talk with them naturally about many subjects when the issues arose, not in a set hour during the day. The youth and work crew foremen had common family experiences, shared the same heroes, knew the sports figures and the current popular music and music stars. The work crew foremen helped them do things such as open a bank account, or they accompanied the youth when they had to deal with a bureaucratic agency.

The work crew foreman were encouraged to work to teach skills the workmen had such as repairing small machines, repairing automobiles, doing woodwork, taking care of plants and cooking. Encouraging the work crew foremen to expand their roles and to bring in their avocations increased the work crew foreman's commitment to and enjoyment in the job.

The work crew foreman also accompanied the youth to their half day academic programs. They sat in the classrooms and helped maintain order in school. Many of the youth developed close relationships with their work crew foremen. This program worked effectively. One limitation however was the lack of an adequate program to move youth along to paid employment in more skilled occupations. Nonetheless, the program was consistent with developmental needs of older adolescents – the development of work skills, and the identification with a role model.

SUMMARY

In summary, any program will take place in an elaborate social context which includes govern-mental, bureaucratic and other social factors. There are many models that can be effective. (1) All of these models will take into consideration the formula **B=f(P,E)** and have a presence in many aspects of a youth's life. (2) The developmental needs of youth should be at the forefront, even for youth who have limitations. (3) A developmental orientation will emphasize working with a youth's strengths. We should be looking ahead and try to find strengths to emphasize rather than weaknesses to undo. (4) Youth will also relate better to those who can work with them to develop skills, and who do things with them. Youth can identify with those who have skills and characteristics they admire. Talking with youth to influence them takes place more effectively as a byproduct of other activity rather than as a central activity. (5) We should not necessarily rely on academically trained workers as the primary therapists. People with a variety of skills and personal experiences that make it easier for youth to identify with the helping person should be employed under proper supervision, and encouraged to take responsibility. Professionals should be available to the workers to help them think through problems and to uphold standards of care. Professionals are best used as participant conceptualizers who can help the paraprofessionals maintain appropriate goals. (6) We need to pay attention to the conditions of work for the helper as well as conditions for the youth who are the target of helping efforts. We should be concerned about the good life for the worker as well as for the youth who are in their charge. (7) Agencies should have "eyes" on them as a form of feedback to help find and avert inferior or scandalous care.

These are some general principles deriving from some successful models that you can consider in your own work. It is your task to decide whether or how these principles are suitable for your cultural, social and political context or how to adapt them.

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ABSTRACT

This article analyses the issues of the deinstitutionalization of youth, and the development of community based services, using some historical data and some of the principles of community psychology. The basic premise is that there is no such thing as a social vacuum. All programs are implemented and function in an elaborate social context.

RESUMO

Este artigo analisa as questões referentes à desinstitunalização dos jovens e ao desenvolvimento de serviços na comunidade, fazendo uso de alguns dados históricos e de alguns dos princípios da psicologia comunitária. A premissa de base é de que não existe o vácuo social. Todos os programas são implementados e funcionam num elaborado contexto social.

Palavras-chave: Psicologia comunitária, desinstitunalização dos jovens, serviços na comunidade.