

the way he used to be;  
and to know that he can  
learn something. . . anything  
if one can muster patience.

Douglas Powers

12/13/05

Norman -  
what are your  
thoughts on this?  
Ship passed this  
along to us -

Thanks  
Eddie

EDDIE SAVVIS

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## Questioning the Continuum of Care: Toward a Reconceptualization of Child Welfare Services

Earl N. Stuck, Jr.  
Richard W. Small  
Frank Ainsworth

**SUMMARY.** The notion of a "continuum of care" and the associated idea of residential care and treatment programs for children and youth as "last resort" interventions are endemic in the child welfare literature (Whittaker, 1979; Beker, 1981). The purpose of this paper is to question the utility of both of these notions. Indeed, it will be argued that the construct of a continuum of care as it plays out in practice is fundamentally problematic, inhibiting the use of appropriately intensive interventions even when they are in the best interests of children and families, and inhibiting rather than promoting family reunification in many complex cases. [Article copies available for a fee from *The Haworth Document Delivery Service*: 1-800-342-9678. E-mail address: [getinfo@haworthpressinc.com](mailto:getinfo@haworthpressinc.com) <Website: <http://www.haworthpressinc.com>>]

**KEYWORDS.** Reconceptualization of a continuum of care, integrated array of child and family services, residential care as a family support service

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### EMERGENCE OF THE CONTINUUM OF CARE AS A METAPHOR FOR SERVICE DELIVERY

During the past century, the field of children's services has become highly diversified, yet it did not start out that way. For most of this nation's history, there were few recognized options for children. Orphanages, apprenticeships, reform schools, alms houses, and informal inship care largely represented the main components of a loose system of child welfare. These generally reflected a viewpoint that society's responsibilities to children were limited to the fairly basic provision of care and the correction of antisocial behavior. Managed primarily by church communities, the system of care as well as its sources of funding were largely voluntary and parochial for most of the first two centuries of this nation's history (Bremer, 1971).

The last half century has witnessed the proliferation of a vast array of services to meet the many needs of children and their families. Each in turn represented an innovation, a new way of looking at children in response to their changing needs, as well as recognition of the advances in the technology of care. Alms houses and orphanages gave way to family foster care, adoption and enlightened schools for the reform of wayward youth.

As the life expectancy of the citizenry increased, and the waves of immigration declined throughout the Great Depression, so also did the number of true orphans. Society began to recognize that even when children had parents, they sometimes did not receive adequate care in safe surroundings. They often fared poorly, both socially and educationally. The effects of parental abuse and neglect were increasingly documented. There was an acknowledged need for new interventions to provide both for basic needs as well as remedial and therapeutic supports. Children who needed basic care were usually referred temporarily to relatives or family foster care. Orphanages struggled to adapt to the increasingly troubled children who could not be maintained in family settings. Some of these closed, while others diversified and developed sophisticated approaches to the treatment of a range of social, behavioral and emotional disturbances. Today's residential treatment centers in their many forms are the outgrowth of this evolutionary change.

In the latter half of this century, child welfare services became more complex and sophisticated, and more expensive. The major sources of support for these programs gradually shifted from the churches and

other private groups and individuals, to the public sector. Government saw its significant interest in both the protection of children, and in the promotion of quality services to help overcome the effects of past abuse and neglect. The recognition of society's responsibility to act "in the best interest of the child" resulted in the proliferation of a great variety of out-of-home care services during the 60's and 70's. At the same time, partly in recognition of the cost, and partly due to the prevailing cultural belief that children are best raised in their families, many other services focused on providing the support necessary to maintain children in their homes, and when removed, to reunify families or find other permanent families. Home-based family services, day treatment, child day care, and a variety of community-based family services developed with the goal of strengthening the capacity of families to care for their own children safely.

What the evolving system developed was a tremendous variety of care and service options. What the system did not have was coordination, nor a generally accepted way of determining when, where, and under what conditions these services should be provided. By the mid 1970s, at a time when nearly one half million children were in the child welfare system, having been determined to have been abused and/or neglected, there was a need to provide order to decisions that had great ramifications for the shape and substance of the service system, as well as the overall cost of such a system to the public. In 1980, with the passage of the Adoption Assistance and Child Welfare Act (P.L. 96272), a system was created that has been in place to this day. The new law determined that no child would be removed from a home unless he or she was shown to be at imminent risk of harm and that the authorities must make "reasonable efforts" to assure safety and maintain the child in the home wherever possible. If the child was removed, the subsequent placement needed to be in the "least restrictive" (originally intended to mean closest to home) setting available that could meet the child's and family's needs. Use of more restrictive and intensive interventions, such as residential treatment, could only be made when less intensive interventions were judged to be ineffective. At all times, "reasonable efforts" to prevent placement and to reunify families were required by law.

The 1980 legislation is the foundation of the "continuum of care" as a case management blueprint governing most decisions in child welfare today. The underlying beliefs of the continuum include:

- Children are to be raised in the home unless there can be proven risk to safety.
- The use of more restrictive interventions, especially out-of-home care, carry the inherent risk of harm to the child through broken family connections and institutionalization.
- Therefore, services should be considered for children and families in a linear, step-wise fashion, from least to most restrictive, as this approach is most likely to keep families together.
- Placement into group care should only be utilized as a last resort.

These underlying beliefs have attracted widespread support as they are consistent with and influenced by the ideologies of normalization, institutionalization, mainstreaming, minimal intervention and diversion that have powerfully influenced all of human services for the last twenty-five years (Fulcher and Ainsworth, 1994). The idea that the most intensive or intrusive services should always be used first has so found powerful support from fiscal decision makers allied to monetarist economic policies (Culpitt, 1992), as a key rationalization for reducing public funding for human services. Finally, ideology aside, the notion of a linear, prescriptive continuum has appeal for very practical reasons. Over the past two decades, the child welfare system has grown dramatically. Case decisions have increasingly been made by social service departments experiencing the stress of rising client caseloads due to court orders for care and the impact of mandated reporting (Hutchison, 1993), high turnover and large number of new workers cycling through the system, and the simultaneous pressure of budget cutting and increasing public skepticism of social programs. The continuum notion allows for patterned, politically viable case management decisions by even the most inexperienced workers.

### PROBLEMS WITH THE CONTINUUM AS A PRACTICE BLUEPRINT

Conceptually, while the continuum of care is based on the principle that the least restrictive of *appropriate* alternatives be utilized, only sporadic guidelines exist to assure that children consistently receive individualized appropriate care. The result has been a linear model for care that, in implementation, creates serious practical problems for both care providers and the children and families they serve. In a real

sense, the continuum has become a one-way street children and families must travel until they reach the point where the system can meet their needs at that time or until diversion of the child client into mental health or youth corrections takes the pressure off the system all together. The road leads always toward the more intensive services, but offers few opportunities to double back, pull off, or check the road map without having to start the helping process all over again. Specifically, the continuum as a guideline for practice trades the ease of patterned decisions for the accuracy of decisions based upon individual assessment of the child's and family's strengths and needs.

In a rather typical example of how the continuum defines intervention, a child is identified as being at risk of abuse. If the child welfare system has the resources, efforts are made to strengthen the home and to assist the parents to successfully raise the child. Too often, the problems are not recognized early enough to prevent harm, but only after real harm has occurred. Since the system's first response is usually with preventative services, the response may already be one click too late, a pattern which can come to be a feature of the system throughout.

Perhaps, however, if further abuse or neglect occurs, and also the child begins to display behavioral and emotional problems, at some relatively arbitrary point the decision is made to provide family preservation services. As distinguished from ongoing family support, these services are intensive, but mostly time limited. After a relatively brief try, these services are either assessed to have worked, in which case the family is usually effectively dropped from the case load with little further support, or continued abuse is identified, in which case the child is removed and placed in temporary foster care. From this point on, the family, which may now be labeled as "unworkable" or "resistant," moves increasingly further out of the picture. Because the child is not only the victim of abuse, but also may be acting out at escalating levels, the first foster home placement fails, beginning a trail of repeated attempts to "find the right match."

At some point, the frustrated worker has established a significant enough resume of failure for this client to present the case for residential group treatment. The child's biological family, which has ceased to be the primary focus of service many stops ago, may now be described in the record as "not identifiable." The child is disconnected, yet reunification remains the system's formal goal. The residential center

works with the child in a vacuum, receiving (or, to be fair, perhaps choosing to hear) the dual messages from the placing agency to keep the stay brief, but leave the family to us. If the child does well, and returns home, transitional and aftercare services are too often unavailable. The family, having been largely left out of the process, has little support and few new skills with which to cope. Too often the scenario leading to placement begins again. To compound the problem, the child usually is not returned to the place where she/he last received care, eliminating the chance to build on previous interventions helpful to the child and family.

### FUNDAMENTAL CONCEPTUAL FLAWS

We believe the helping process can and does play out as in the above example because of some very fundamental flaws in the concept of continuum.

#### *There Are Logical Inconsistencies in the "Least Restrictive" Standard*

The "least restrictive" standard in the 1980 Adoption Assistance and Child Welfare Act is at the conceptual heart of the continuum of care. Unfortunately, as implemented, in real-life systems, it can also be the biggest logical inconsistency. "Least restrictive," like its "least intrusive" counterpart in medicine is only important as a guide to *whether* and *when* to intervene, not to decide *how*. The surgeon should not pick up a scalpel until he is certain that less intrusive measures are unlikely to work. However, once this decision is made, he cuts as deeply as his assessment of the patient's *individual case* warrants. While "least restrictive" may be a fair indicator of when the child welfare system should intervene in a family, it cannot be the primary rule governing the nature of the intervention. Yet in child welfare practice, this is very often exactly the case. The result is an incremental approach to practice intervention wherein individual assessments are overridden by the systemic bias to begin with step-down helping options.

#### *Progress Along the Continuum Advances by Failure*

An approach that requires that the least intensive interventions should always be used first results in a system with case management

decisions driven by failure. As in the example above, family-based foster care is the intervention of choice for a child entering out-of-home care for the first time, as it is the least intensive, least costly option. Most of the time, only if family foster care fails, usually repeatedly, is more intensive intervention given consideration. This is in spite of evidence that the number of placements a child experiences has a negative impact on a child's development, and heavily influences the child's condition at the point of exit from care (Fanshel, Finch and Grundy, 1990). The presumption of the continuum in practice is that one uses an intervention not only until it does not work, but until one can prove that it cannot work. While this is arguable proof against the use of more restrictive (and expensive) services too early, it also increases the chance they will be used too late.

#### *"Progress by Failure" Biases the System Towards Crisis and Blame*

Movement from one stop along the continuum to another only after certified failure creates a negatively-biased system adept at recognizing risk, weakness and pathology far more effectively than strengths in individuals and families. The system tends to mobilize only around problems, with case decisions too often made in response to crisis. For those clients who remain in the system over time and make the long journey from least to most restrictive services, repeated failure can mean blame and alienation. Helpers and families increasingly relate not through partnership, but through corrective action plans demanding compliance. Connections between children and biological families are eroded or broken, only to find that when exit from the system is imminent, the resources and motivation needed to make the reunification plan work are missing. Likewise, the "trial by fire" process of reaching the proper level of care tends to destroy other resources along the way. In particular, experience has given us many examples of highly motivated, caring foster parents who eventually burned out because they were unable to cope with very troubled children, well after it should have been evident that more intensive interventions were warranted. The bottom line is progress by failure for child, family, and helpers alike, with each party tending to blame the other at every new crisis point.

#### *Realistic Family Reunification Is Compromised*

The hierarchy of least intensive helping services as "good for families" and most intensive helping services as "bad for families" widely

relieved imposed on the continuum by the 1980 legislation (though not in fact, spelled out in P.L. 96272 as written), in part based on the ideological position that truly functional families should raise their children with little or no outside support, also leads to an overly rigid definition of family reunification. Within this hierarchy, if incremental, time-limited services fail to prevent placement, complete separation of child and family usually results. At the other end of the continuum, work toward reunification of children in out-of-home care is seen as fully successful only if it is full-time reunification, the child returning home with minimal family support. In fact, the above premises are far too simplistic. Real-life practice suggests that family reunification should be defined more broadly as helping each child and family achieve and maintain, at any given time, the optimal level of reconnection from full reentry into the family system to other forms of contact such as visiting or shared care, that affirm the child's membership in the family (Warsh, Maluccio and Pine, 1994, p. 3). From this point of view, optimum family connections are compromised by a hierarchical continuum of intervention and practice methods within which reunification is a "pass-fail" event.

### *Boundaries Between Services Are Overly Rigid*

One of the most perplexing problems with the continuum concept is that it leads to case management as a series of digital decisions, i.e., either family preservation or out-of-home care; either reunification or termination of parental rights, etc. This means there is little possibility to mix and use various services in combination. The *sequential* delivery philosophy interferes with the possibility that *simultaneous* interventions may be appropriate. The fact that a child has been removed from home because a family-focused intervention appears not to have worked should not mean that intensive family work ceases, quite to the contrary in many cases.

A side effect of overly rigid boundaries is competition among services in the continuum, with the "good" (i.e., less restrictive) services defining their value in terms of preventing the "bad" (i.e., more intensive) services. Residential group care, for instance, is seen as the failure outcome of family preservation, strongly inhibiting the possibilities of integration. The capacity of a range of services to support a common goal is compromised by the competition both for resources

and the political high ground of being the "correct" service for children.

### **BEYOND THE CONTINUUM: TOWARD A CARE MANAGEMENT SERVICE SYSTEM**

Notwithstanding the above critique, it is important to acknowledge that for many families needing services of limited intensity and duration, the continuum of care and least restrictive notion helped to humanize child welfare services over the last 20 years. Foster care services have expanded and now serve a range of children who previously might have been placed in residential facilities. Treatment facilities for children and young people are no longer segregated, isolated institutions, distanced from the surrounding community, where children only have contact with staff and other residents.

Child care institutions, consisting of large congregate living units surrounded by an extensive although socially restrictive campus, have in the main given way to smaller, more culturally normative facilities. No longer isolated, many of these facilities have developed innovative, community based group care options. In addition, minor offenders are no longer placed for extended periods in training schools where the delinquent subculture tended to oppose reform attempts. Diversionary programs now try to keep legal intervention low key and to a sensible minimum.

But the ultimate question remains: is the incremental, implicitly hierarchical approach to service at the core of the continuum of care appropriate to the high risk children and families increasingly flooding the child welfare system? We think the answer is clearly no. Yet giving up the linear rigidity in the continuum notion as a blueprint for case management does not have to mean giving up family preservation or fiscal responsibility as cornerstone values. Indeed, our colleagues in health care have already learned that successful managed care with the high risk, even chronically ill populations is possible, but it is best understood as a process of "illness management," in which the emphasis is not on the success or failure of particular interventions but on the overall status of a person over the course of a whole lifetime. Within this model, the most aggressive interventions are not necessarily avoided or implemented as a last resort, but justified at various points in time as ultimately supportive of long-term stabilization based on the

individual needs of the patient and his family. While we emphatically do not intend to equate the needs of children and families in the child welfare system with illness or disease, we nevertheless believe that this way of thinking about services to the most vulnerable families may have great value for child welfare as an alternative to current formulations of the continuum of care. Taking a "care management" approach to the longest term, highest risk clients in the system allows an approach to service implementation which would:

- acknowledge that some children and families will require services at various levels of intensity over time, and that this may be a decidedly nonlinear process. From this perspective, the challenge becomes to provide appropriate (including appropriately limited) interventions at various points in time; to design each intervention as part of a continuous strategy of family stabilization so that past, present, and future interventions shape each other; and to manage helping resources for each family over time rather than seek quick-fix solutions;
- retain the emphasis on family empowerment and family connections at all levels of service, but recognize that optimum connections may not mean that every parent and child lives together full-time, or over the entire minority of the child without ongoing support;
- put a premium on continuous, coordinated assessment where the operative question is not where does the child and family fit into the system, but rather how do services in the system best fit the child and family needs at the time;
- put an equal premium on care and support to families *after* the course of intensive services, as a way of preventing costly future interventions as much as possible emphasize the choice of least restrictive (and costly) *appropriate* service for children and families, investing in intensive interventions at the outset and throughout the course of care if assessment dictates this is the best bet for dealing with trauma and/or for keeping families together over the long haul
- blend services so there are step-up and step-down options at all levels of intervention, and in particular so that the rigid boundaries between home-based and out-of-home services are eliminated;
- develop outcomes, including cost-benefit measures, not limited solely to discrete services but to long-range family stabilization and the real cost of services across time.

At the very least, taking this care management approach allows us to transform the continuum into a more integrated array of child and family services (see Figure 1). Especially noteworthy here is that, once and for all, the characterization of residential group care as a "last resort"/failure outcome is replaced with a view of residential options in support of families at all levels of the service system. As is clear from Figure 2, this greatly expands the potential range of creative uses of residential services. Of course, the challenge for those of us within the field of group care will be to retool significantly how, when, and where group care services get delivered.

We do not expect either the critique or the revision of the continuum in this paper to go unchallenged. However, we do expect this concep-

FIGURE 1. Child and Family Services

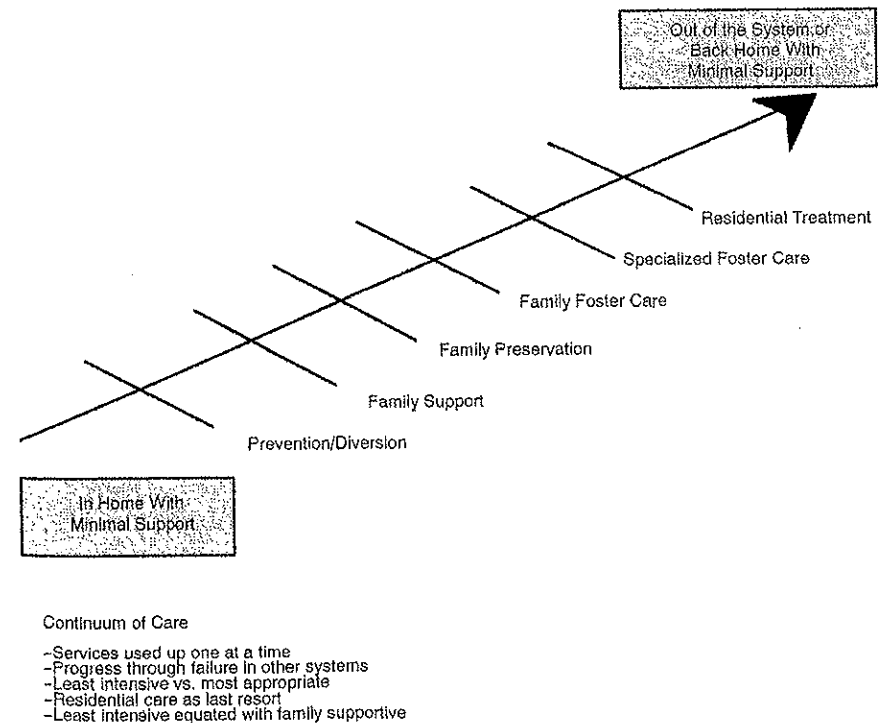
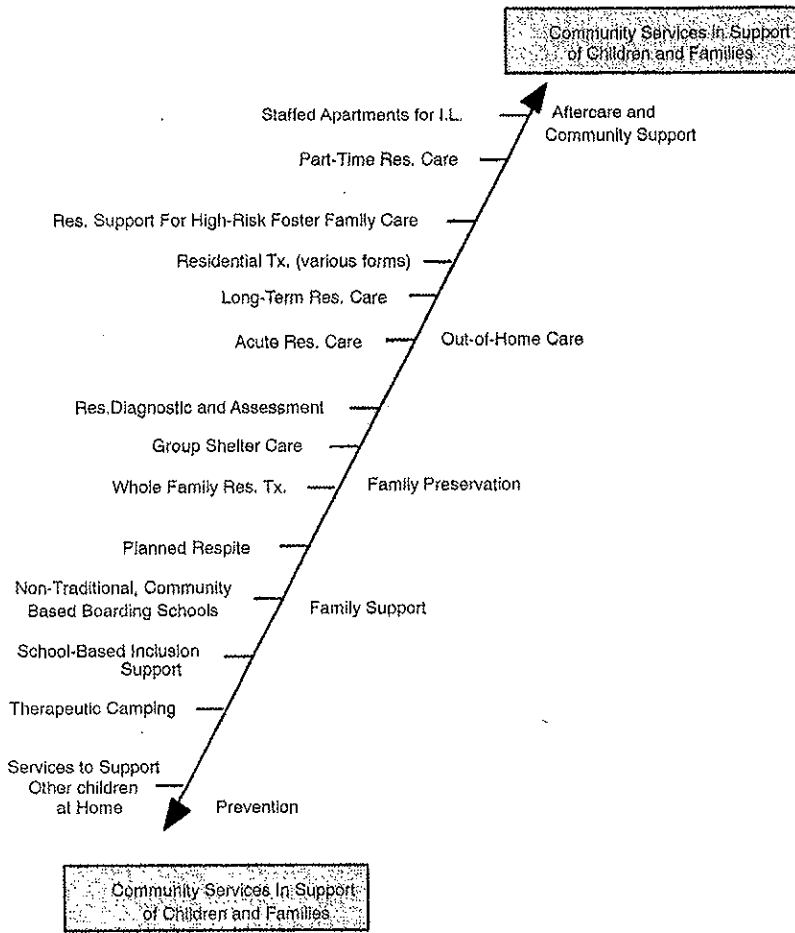


FIGURE 2. Community Services in Support of Children and Families



Case Management Service Array

- Residential care as support for families and other services, not last resort/failure outcome.
- Services integrated rather than sequential. Some children move both in and out of high intensity services over time.
- Broad definition of family reunification
- Clients enter the system at various points based on individual assessment

tion of care management within a flexible array of services supporting a wide-range of reunification options, or something like it, will shape the political and economic future of child welfare services for years to come. We invite response from our colleagues.

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BIOGRAPHICAL NOTES

Earl Stuck, Jr., is a well-known teacher and lecturer on subjects such as administration, group care, juvenile justice and youth issues, and working with families of children and youth in out-of-home care. Mr. Stuck serves as Associate Director for the Child Welfare League of America's National Center for Consultation and Professional Development.

Richard Small, Ph.D., has served as the Executive Director of the Walker Home and School since 1985. Mr. Small is an author, educator, and consultant to child welfare programs around the world. He also served as Executive Director of the Massachusetts Governor's advisory Committee on Child and the Family. He served as a consultant and primary writer for the Carolinas Project.

Frank Ainsworth holds an academic position at Edith Cowan University in Perth, Western Australia. He has also held similar positions