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**Reducing the pain, healing the wound or breaking the cycle:
Organizational approaches to alcoholism prevention**

Bush, Irene Rubenstein, D.S.W.

City University of New York, 1993

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**300 N. Zeeb Rd.
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REDUCING THE PAIN,
HEALING THE WOUND OR BREAKING THE CYCLE:
ORGANIZATIONAL APPROACHES TO ALCOHOLISM PREVENTION

by

Irene Rubenstein Bush

A dissertation submitted to the Graduate
Faculty in Social Welfare in partial fulfillment
of the requirements for the degree of Doctor of
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11-17-92
Date

Irving Steiner
Chair of Examining Committee

11/17/92
Date

David Plummer
Executive Officer

Irving Steiner
Mildred D. Mailick
Arthur J. ...
Supervisory Committee

Abstract

REDUCING THE PAIN, HEALING THE WOUND OR BREAKING THE CYCLE: ORGANIZATIONAL APPROACHES TO ALCOHOLISM PREVENTION

by

Irene Rubenstein Bush

Advisor: Professor Irwin Epstein

Prevention has failed to adequately capture the imagination of social workers as an area worthy of theory building, education and practice. This study seeks to identify organizational factors that are key to defining alcoholism prevention in social work and to implementing alcoholism prevention programs. It employs a comparative case study methodology and ideal type analysis to determine how prevention was conceptualized and implemented in three prototypical social agencies. In addition to agency observation and use of available documents, focused interviews were conducted with eighteen administrators, professionals and other agency staff. Transcripts of the interviews were analyzed and extensive verbatim quotes were used to generate and report the findings.

The overall analytic framework for this study is systems theory in organizations (contingency modeling) in conjunction with prevention theory from public health and social work. Key organizational dimensions were revealed through the interview process. The variations in these

dimensions and in the definitions of prevention were the foundation for creation of a descriptive taxonomy of "ideal type" agencies at three different levels of conceptualization and implementation of prevention technologies and strategies. These are an Ameliorative Prevention Approach, a Reactive Prevention Approach and a Proactive Prevention Approach.

These different approaches to prevention are closely related to differential commitments to social change. Perspectives on work with the disadvantaged, social workers commitment to such work, and possibilities for social change were also explored. Finally, implications of the study for social work education and practice, policy and research were discussed.

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The eighteen administrators, social workers, one marriage and family therapist and public relations people who entrusted me with their perceptions of prevention and their hopes for their clients, provided the substance of the study. Their individuality, commitment and frustration with the difficult problems clients present and hard choices agencies must make about service provision are inspiration to define prevention and build its technology. I hope they feel that the findings do justice to their commitment to people and to the reality and complexity of their jobs.

Irwin Epstein is a wonderful teacher in the classroom and in carrying out research. His contributions to the conceptualization and process of this study are beyond measure. He is the rare mentor who can anticipate needs, problems and solutions and, with humor, offer encouragement and help. I am extremely grateful to have had the opportunity to work with him.

Mildred Mailick and Andrea Savage were key supporters of this effort. Mildred's interest in prevention led to my ability to do some of the research that was the foundation of this study.

My work with the Children of Alcoholics Foundation,

which was established ten years ago to bring education, research and policy advocacy to bear on breaking the cycle of the intergenerational disease of alcoholism, made this research possible. It is difficult to adequately thank Migs Woodside, President of the COAF, for her support and for her hard work, professionalism and dedication to children who grow up in families where there is alcoholism. The many projects undertaken by the COAF to offer help and hope to young and adult children of alcoholics were inspiration for this study.

My husband, John Bush, was a steadfast supporter and a helpful critic throughout the time this work went on. And, I thank my children, Daniel and Drew, for indulging my need to monopolize my computer and for foregoing the pleasures of SimAnt and all the other programs they would have installed on my hard drive had I permitted it.

To all of these people and to the dear friends who really listened when I responded to "How's it going?," thank you.

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CHAPTER I

INTRODUCTION

Discovering Normal: A Parenting Program for Adult Children of Alcoholics and Their Partners was designed for national use to prevent alcoholism and other psychosocial problems in grandchildren of alcoholics. That Discovering Normal (DN) addresses this at risk population by targeting their parents parallels movement in social work theory development to better distinguish prevention services from those of treatment and amelioration/rehabilitation. This study of the conceptualization and implementation of DN is intended to illuminate social work's struggle to arrive at a definition of prevention that is distinct from the public health/medical "disease" model. In addition, it is intended to foster an appreciation of the unique contribution social workers can make to development of prevention services.

DN was developed for the Children of Alcoholics Foundation over a two year period. Pilot evaluations were performed in Spring and Summer of 1990 that demonstrated its effectiveness in improving parenting attitudes, knowledge and skills of participants and the ability of facilitators to comply with the program design. Results

indicated satisfaction with the content and processes of the program on the part of participants, facilitators, and agencies participating in the three pilots. The contribution DN makes to preventing alcoholism and related problems in the children of participants was not a subject of the pilot evaluations except indirectly through measures of change in family functioning (cohesion and conflict) which may be an indicator of later chemical abuse. The relationship between DN and actual prevention of alcoholism, however, is beyond the scope of the dissertation project and will be addressed, hopefully, through ongoing evaluation of the program by those who use it including longitudinal followup of participants and their families.

DN is syntonetic with a social skills developmental rather than remedial or clinical social work model (Abrams & Niaura, 1987; Freud, 1987; O'Leary, O'Leary & Donovan, 1976; Tropp, 1971). Its implementation calls upon commonly held professional values, knowledge, and skills. However, it differs from many social work program efforts in that the help offered is prospective rather than retrospective. Preliminarily validated as a worthwhile and popular intervention in its formative evaluation, DN provides an opportunity to develop knowledge about a preventive approach to working with a specific at risk population.

Background

The agencies that piloted DN were distinctly different case examples which served as units of analysis for this exploratory study. The sites were:

- o A child guidance agency with a community education program on the edge of a suburban area of a large city bordering on the Midwest,
- o A family agency that provides a variety of services including alcoholism treatment to families and children in an urbanized suburb on the hub of a large Midwestern city,
- o An alcoholism treatment agency in an urban, inner-city area on the outskirts of an Eastern metropolis.

Nine mental health professionals, primarily social workers, were chosen by the administrators of their agencies to attend a one-day training session in New York City on April 20, 1990. The formative evaluation was implemented under similar controlled conditions with these training facilitators over the Spring and Fall of 1990. Visits to the same three agencies for this study were made during the Spring and Summer of 1991.

While process data from the formative evaluation confirmed expected differences in the individual style of facilitators and in their rapport with a participant groups, it yielded positive information about the ease and replicability of program implementation. The results of the pilot evaluation suggests that DN is a valuable intervention for adult children of alcoholics (ACOA) that can be implemented with minimal training and relative ease

by a variety of social workers with masters degrees. No major differences in levels of participation were found despite the differences in agency types (Emshoff, 1991).

As the project director for the development of DN, the author had an already established, positive relationships with administrators and workers at each agency. She had arranged the pilot evaluations, trained the facilitators and observed sessions of the pilots in each setting.

DN was an ideal vehicle for this study for three reasons.

- o While there was systematic variation of the location and agency auspice, no significant differences in outcomes related to setting, participant characteristics, or facilitators were found.
- o The design of DN, targeting two generations of families for direct and indirect intervention, permitted a range of conceptions about the intervention that include prevention, treatment and amelioration.
- o Administrators and staff, primarily social workers with graduate degrees, were quite willing to make themselves available for interviews.

Other programs designed to intervene before problems occur and to reduce the need for treatment services also might have been used for this study. However, the fortunate happenstances of DN's design and evaluation, and the researchers's knowledge and commitment to it, made DN an ideal choice. The careful attention to pilot requirements and the variations in how DN was viewed and implemented made the agencies and their personnel ideal subjects for study.

Jansson (1982) examined variables (agency politics,

economics, mission, organization, and staff) that promote or discourage prevention activities. He states that "preventive services in particular may require a supportive ecology because of intrinsic difficulties in conceptualizing and providing them (p. 21)." This comparative case study explores these "intrinsic difficulties" by examining how organizational factors--characteristics of agencies and their personnel--mediate the way in which an alcoholism prevention program is conceptualized and implemented. The study reports multiple perceptions and definitions of prevention that derive from the particular features of the three agencies that participated in the pilot evaluations of DN.

The project is unique in that it seeks to develop knowledge about prevention within an organizational context with a goal of enriching social work training and practice in this important area.

Problem Statement

Social service agencies tend to respond to clients who already experience problems-in-living. Despite increasing national sense of individual and family breakdown, agencies have remained relatively static in their provision of services, concentrating efforts on those who already experience problems. Nonetheless, lip service often is given to the need for prevention programs to halt the

growing numbers in need of treatment services. Although much has been written about prevention as a science whose "time has come," little has been accomplished that demonstrates prevention's potential. (Bloom, M., 1981; Buckner, Trickett & Corse, 1985; Klein & Goldston, 1976; Price, Cowen, Lorion & Ramos-McKay, 1989) Barriers to organizational and technological change involve both resistance to prevention as an endeavor that is distinct from treatment and difficulties inherent in implementing any new social program. (Beck, 1960; Bloom, B.L., 1968; Buell, 1959; Gilbert, 1982; Matus & Nuehring, 1979)

Social work is committed to psychosocial and ecological models that empower and maximize strengths of individuals, groups, and communities (Germain & Gitterman, 1980; Hollis, 1964; Perlman, 1957) and that prevent problems by providing service before problems become manifest. However, the movement from a focus on the person in environment (as embodied in the height of the Settlement House era) to a focus on the intrapsychic marked a shift in practice from broad social concerns or prevention to the psychodynamic or treatment. Stated differently, social work moved from a health to an illness model. (Austin, Baizerman & Guzzetta, 1974; Reichert, 1962) Although some social workers may intend to practice prevention, we have not adequately distinguished prevention from treatment. (Rapoport, 1961) We have not claimed prevention as a major area of social work intervention, nor do we give it much attention in

professional education. The continuum of social policy to protect members of our society from entering the overwhelmed social welfare system to programming for at risk populations fails to capture the imagination of social workers as an area worthy of theory building, education, and practice.

Barriers to Provision of Prevention Services

Ongoing problems in definition left over from our adoption of a disease model from the fields of mental health and public health leave social workers with a lack of clarity about prevention services. (Giovannoni, 1982) Question also must be raised about whether current definitions of prevention are compatible not only within the current policy climate which favors personal services rather than environmental approaches, but also with social work practice, itself. We need to illuminate the links between prevention and treatment: the ways in which these two modes of intervention and the strategies employed for each are similar and different. We need to better understand the organizational factors that enhance implementation of prevention programs. We need to evaluate the implications of prevention for social change and to strengthen our commitment to developing effective prevention capability in our workers and prevention services in our agencies.

Three decades ago, Lydia Rapoport (1961) conveyed that

social workers have borrowed from the public health model in a distorted and confusing way which, in effect, label all of our activities preventive. Florence Haselkorn (1967) evidences this propensity in her statement that, "In social works' ounce of cure lies a pound of prevention" and her view of the preventive and therapeutic functions as an "interlocking continuum" wherein social workers treat when they prevent and prevent when they treat. (p.63) As early as 1959, an NASW Commission on Practice, SubCommittee on Trends, Issues and Priorities affirmed the need to conceptualize prevention in order to strengthen its impact, but was unable to refrain from defining prevention without embracing all of social work's rationales, objectives and methodologies; namely, treatment. (Rapoport, 1961, pp.5-6)

The implications of Rapoport's critique are that we must distinguish between prevention and from treatment and amelioration without devaluing or lessening our commitment to either. Indeed, "imaginative application of all social work methods (to prevention) in anticipating problems and needs" is of great importance to the field. (p. 12)

Definitions to date fail, however, to sharpen our understanding sufficiently to give impetus to more focused activity in social work education or in practice. Even the continued use of the term "primary prevention" rather than "prevention" is evidence of our continuing inability to separate ourselves from the public health model and develop our own. An examination of some recent attempts to define

prevention underscore this dilemma.

Elsewhere, Martin Bloom (in Staulcup, 1980, p. 4) reviews several dozen definitions of primary prevention from the 1960's from an interdisciplinary literature. The "working definition," not a "final statement" that he comes up with is multidimensional. He states that primary prevention regarding social concerns involves activities:

1. stemming from or directed toward those portions of the biological-social-physical environments which are demonstrably and systematically related to the target population, both their strengths and competencies, as well as their weaknesses;
2. on a time dimension before some predicted untoward event (or some desired goal) has occurred, as well as sufficiently long afterwards to sustain effective functioning;
3. directed toward reducing the incidence of the problem in a specific population of persons (at risk or with potential);
4. such that the activities could obviate the negative and promote the positive events, with due consideration of unanticipated outcomes;
5. using passive as well as active strategies as they seem appropriate, feasible, and ethical; and
6. with concomitant evaluation of the progress and outcome of such preventive efforts. (p. 13)

While it is a comprehensive, albeit complicated, definition, it parallels, in most respects, the public health model of primary prevention.

More succinctly, but related to Bloom's definition, Joyce Borkin and Sheldon Siegel state:

The term "prevention" is synonymous with primary prevention and describes only those efforts aimed at reducing the incidence of specified social-functioning or mental health problems, whether for an individual, group, or larger population at risk. "Treatment" refers to the efforts aimed at reducing the prevalence of a given problem or condition, whether by eliminating it, shortening its duration, or reducing its severity. "Rehabilitation" is defined as an activity aimed at

reducing the impairment resulting from a given problem or disorder. (in Bowker, 1983, p.25)

Prevention as it has been defined in social work thus far, then, parallels the public health model: it aims to keep something unwanted from occurring; that is, avoid onset of a negative condition or situation or, at the least, lower the rate of new cases. Prevention may involve early discovery, control and elimination of multiple causes and conditions which can bring about measurable breakdown of functional self-sufficiency through attention to particular at risk populations or situations, or through social policy directed to the population at large.

Borkin and Siegel find it helpful to conceptualize prevention along a continuum from reactive to proactive. An example of proactive prevention is an outreach program to prevent or decrease teenage pregnancy. An example of reactive prevention is an outreach program to pregnant teens to prevent low birthweight babies. A parenting program like DN may be viewed as reactive prevention for ACOA who are parents and proactive prevention for their children. Borkin and Siegel state, "Whereas reactive primary prevention is concerned with helping the individual to cope successfully with an event or condition, proactive primary prevention focuses on the elimination or avoidance of the stressful event (p. 29)." In order to maintain distinction between prevention and treatment, reactive prevention needs to be understood as avoiding onset of

problems in the next generation; that is, as being proactive in that new problems are prevented by providing intervention to those already experiencing problems.

While this conceptualization of reactive and proactive prevention is an attempt to define the range of efforts that may be labeled prevention, it is easy to lose the distinction between prevention and treatment and, thus, the clarity for program design, evaluation and development of a social work educational effort.

It may be necessary to change definitional focus from the more narrow provision of service to better encompass assessment of resources that lessen risk and commitment to social change. Rapoport (1961) comments on this issue as follows:

the goals of social change appear somehow made out to be antithetical rather than identical. Perhaps there is an implicit assumption that one can prevent only if one can hold static the variable of social change, which in itself continually produce the germs of new disorders and problems. The statement fails to recognize that preventive activities themselves are generally vehicles for social change. . . . The social work interest in prevention should arise out of the profession's commitment to social change (p.7-8).

Indeed, a social change, health promotion model for prevention that focuses on resources and social work roles to meet developmental needs may better distinguish prevention from treatment than the term "primary prevention." We may find that it better suits social work to struggle to define a desired state and discuss

prevention in terms of institutions and strategies that will bring about that desired state and avoid its opposite. Writing about developmental provision and prevention, Alfred Kahn (1962) states, "prevention as a concept remains tied to the control and eradication of pathology. . . .(p. 144)." He argues for larger scale social programs to meet group needs for developmental provision.

Prevention, however, can encompass the concept of provision in that it anticipates and targets resources for specific populations and the problems that they can be predicted to encounter. Prevention, then, may need to be defined as a way for social workers to assess need and access or create material, educational and other resources (Vigilante & Mailick, 1988) before problems are experienced.

In addition to the need to better define prevention in social work, there are other barriers to establishing prevention services (Nance, 1982; Nuehring, 1978) among which are:

- o the tendency of organizations and the professionals employed by them to continue doing what they are accustomed to and comfortable with doing;
- o the difficulties in defining prevention sufficiently to evaluate the outcome of prevention efforts;
- o the lack of resources and the scarcity of new sources of funding for prevention;
- o the lack of attention to prevention in social work education.

Too often, we maintain the status quo, doing what we have always done for many reasons including limited resources, comfort level with a technology, managerial blindness to innovation possibilities and rigidities of organizational structure which effect the programs that are implemented.

Barriers Related to All Social Programs

Social programs, particularly successful new projects, can both reflect and influence our national public policy agenda. However, problems of implementation cloud reciprocal stimuli for innovation. All programs suffer setbacks in the process of implementation. Few programs unequivocally meet the hopes that were held for them.

Walter Williams (in Williams & Elmore, 1976, p.3) provides two definitions of implementation:

- o "to provide or equip with the means of carrying into effect"
- o "to carry into effect"

He states that "implementation in an organization can involve both a continuing effort over time to raise the capability of that organization or associated organizations to carry out programs or projects, and a onetime effort to put an organizational decision into place." (p. 3)

Problems of implementation--moving from the decision to do something to actually doing it--is "the crucial barrier to

improving the quality of social programs." (in Williams & Elmore, 1976, p. xi) More than monetary or political problems, implementation is the "major substantive hurdle to better programs." (p.4) Williams points to weaknesses in organizations and personnel as the primary obstacles to better programs, not the experimental designs used to evaluate programs. (p.5) Rather, program evaluations are seen as constrained and influenced by the organizations in which they are performed. It may truly be said that "implementation seems to slip between the cracks in social program organizations and has received scant attention by researchers and policy analysts." (in Williams & Elmore, p.14) For this reason, gains will come from "investigating the process of implementation," decisionmaking, its many actors, who has what responsibilities and how responsibilities are carried out by key actors. (p. xii)

In a study identifying ecological or contextural factors of organizations that promote prevention, Jansson (1982) states that,

In the absence of supportive planning, an environment oriented toward change, and other necessary factors, prevention may founder

More routine coupling of theories of direct service with materials from community organization and organizational theory is needed, then, as well as research that probes linkages between specific ecological factors and agency services. If attention is not paid to ecological realities, serious discrepancies may continue to exist between prescriptions for services and those that exist in reality. (p. 21)

Assessment of organizational dynamics is an essential

piece of the evaluation of any program effort, especially when there is a need to overcome significant barriers to moving from a favored technology (treatment) to one that is less accepted (prevention). Without such attention, organizational factors will remain a barrier to embracing promising prevention technologies.

Purpose Of The Study

The purpose of the study is to identify organizational factors that may be key to defining alcoholism prevention in social work and implementing alcoholism prevention programs. Targeted for a specific population and a particular social problem, DN embodies evolving social work definitions of reactive and proactive prevention strategies. It is not known how human service agencies characterize DN and programs like it. Are they considered to be preventive? Are they considered to be treatment? Do they contribute to social change? Can they reduce the flow of new cases? Are they vehicles for developing a definition of prevention in social work?

Through the prism of three distinct types of social agencies--family, child, and alcohol treatment--this study examines how the actors involved define and implement a program designed to contribute to breaking the cycle of intergenerational alcoholism. The study involves examination of agency mission, goals and values, formal and informal structures, and technology within the context of

the environmental supports and constraints that impact such a program.

In addition to describing how prevention is defined and implemented, the study presents an opportunity to learn whether such a program might be part of an incremental change that will encourage the further development of better defined prevention services. Through studying the impact of implementing DN, it is possible to better understand the process of agency change.

By examining the organizational factors in each of three social service agencies that piloted DN and whether or not DN was institutionalized as a permanent program element, it was hypothesized that understandings would emerge concerning factors that were most salient to defining prevention, to implementation and to agency change. Also, it was expected that it might be possible to elicit definitions of prevention applicable to programs other than DN by devoting attention to the dynamic tension between social workers' thoughts and efforts for individual problem solving and for promoting social change. While this study addressed primarily the implementation of a targeted prevention effort, it sought to identify the possible ramifications of it on the function of the social service agency and the implications for social work education, practice, and policy.

Theoretical Framework

A gestalt or global vision is fundamental to change, even if the change sought occurs through incremental steps. Lacking vision, existing programs more often are fine tuned in an attempt to perfect a technology that may no longer be equal to the problems we face as a nation or to the political processes through which resources are allocated. In Images of Organizations, Gareth Morgan (1986) proposes two views of organizational change: a traditional view of change in response to environmental change or an interactional response--a "circular, internal pattern" in which its own "self-production mirrors the environment(p.236)." The first view is linear, causative; the second, pragmatic and visionary. For a traditional social agency to implement prevention activities that stop the flow of new cases requires a non-linear, pragmatic, visionary organizational style.

When choosing and implementing a project such as DN, it can be hypothesized that the effective organization blends the visionary with the possible. If organization personnel see only clients in need of treatment, more of the same work will be done. If the problem is reframed to "turning off the faucet to stop the flow" of new cases, (Bower, 1963, 1972) possibilities for prevention begin to exist. Important clues that give direction to such an approach are derived from analysis of persistent social problems, the ways national concerns about them are expressed, and in how

governmental and other sources prioritize programs and funding. Children of alcoholics have become such a focal point in the area of substance abuse both at grass roots and high levels of government. The "COA Movement" has become a legitimate way both to define this social problem in such a way that intervention is seen as desirable and in the best interests of children rather than as inappropriate intrusion into the sacrosanct province of the family. As a result of the movement's popularity, many agencies are mounting programs directed to COA of all ages.

"Effects" Proposition

A proposition underlying this study is that agencies that are able to articulate a preventive role and implement prevention programs are necessarily involved in a process of organizational change that better enables them to shape and take advantage of aspects of national and local agendas to stop the flow of particular social problems. Such agencies will either reduce treatment services; replacing them with prevention services or develop new resources to support an increasing amount of prevention activities. These agencies will identify and adapt existing prevention programs or develop their own to fit their evolving mission, goals and changing structure. In the context of Glisson's (1981) contingency model of organizations, the key to this process is the managerial subsystem as it interprets mission, goals and values and how they permeate

the organizational culture and structures.

"No Effects" Proposition

Conversely, using the same systems model, an agency that grafts a prevention program onto its current organization without the ability to articulate a preventive role and a commitment to implementing prevention programs, will continue to provide primarily treatment services. Concomitantly, there will be little organizational change as mission, goal, and structure remain relatively static.

The proposition that changes in an organization must take place when a new program initiative is implemented is supported by Milbrey McLaughlin in her study of innovation in education. She states that "successful implementation is characterized by a process of mutual adaptation. . . ." Implementation in her view is a dynamic organizational process that is shaped over time by interactions between project goals and methods and institutional setting (in Williams & Elmore, 1976, p. 11). McLaughlin also states that "most innovative efforts have focused primarily on technological change, not organizational change." She argues that "without changes in the structure of the institutional setting, or the culture of the school, new practices are simply 'more of the same' and are unlikely to lead to much significant change in what happens to students." (in Williams & Elmore, p. 168)

For her, organizational change, then, is not based on a

model of classroom organization, but rather on a common set of convictions about the nature of learning and the purpose of teaching and her model of help is to give tools rather than to be the tool. The parallel in implementing prevention technology is a conviction that a prevention ideology for reducing the number of new cases must prevail rather than grafting prevention strategies onto existing program. It may be supposed that there will be a range of organizational change related to the clarity of the organization's definition of prevention and its mission in the process of implementing a prevention effort.

In studying the three agencies that piloted DN, the following outcomes are possible:

- o Neither DN nor other prevention programs were implemented after the pilot implementation.
- o DN was grafted on to existing services with little or no organizational change.
- o DN stimulated clearer articulation of mission, definitions of prevention and growth of prevention activities using DN and/or other programs.

Among the premises that may then be examined are:

1. Agencies with a broader perspective on social need and a commitment to stopping the flow of clients in need of services will enlarge their mission and goals and seek out prevention programs that target specific populations or the population-at-large with resultant changes in the structure of the agency.

Staff and other resources will be assigned.

New funding will be sought and/or fee structures will be revised.

Other similar (prevention) programs will be

institutionalized.

Staff may participate in deciding the targets, types of program, or other aspects of preventive intervention.

2. With a beginning conceptualization of prevention as something that is different from treatment, workers will use their unique skills for prevention

Workers will recruit participants who would otherwise not seek out agency service

Workers will use non-traditional means to recruit clients.

Workers will adapt DN to local needs and conditions.

The propositions against which the cases will be compared assume a tight/loose contingency model (Sherraden, 1985) which depends on effective leadership to foster staff commitment and creativity (intrapreneurial programming) (Lauffer, 1986) to bring about a reallocation of internal and external resources for prevention.

Management, then, is responsible for or must delegate responsibility for analysis of client need, problem definition, and leverage for change to mount a continuing effort to raise the capability of his or her organization to carry out prevention programs.

Importance Of The Study

The study seeks to generate information about the definition and implementation of alcoholism prevention programs. The question at the core of this study is how does social work contribute to bringing about positive

social change. The study has implications for two dimensions of social work practice and education. At one level, the study may develop knowledge about implementing a particular prevention program that can be a model for implementing other like programs. At another level, the study may develop knowledge about prevention in social work such that practitioners can be better educated to advocate for and perform preventive interventions in social agencies.

With regard to learning about implementing new programs, DN provides an opportunity to examine the "operations sphere," well below "policy at the highest level," in the form of a small scale program at the agency level. This is the level where "policy really gets made." (Williams, in Williams & Elmore, 1976, p. 6) As a model project, DN has the potential to increase prevention programming. Populations other than ACOA might be addressed through similar programs using similar technology.

On more profound level, the study offers an opportunity to build theory about social change in the area of alcoholism prevention by better defining it and looking at its implementation in social work settings. At the same time, it may contribute to better understanding of the current and unique contributions of social workers to prevention activity and to the preparation of future social workers and the work they seek to do in human service

agencies.

Scope Of The Study

The pilot implementations and subsequent offerings of DN were studied at each of the original pilot sites. Data resulting from the pilots and collected from each agency were examined to enhance understanding of the nature of each of the three organizations.

This study involved at least two levels of interviews: those with the administrator who chose to participate in the pilots and who has since determined whether DN is a continuing program of his or her agency; and those with facilitators who present DN to agency clients. Where feasible, other staff members at each agency who are not directly involved with DN were interviewed to gain additional perspective on the organizational factors that impact defining and implementing this program.

The study includes ten administrators and professionals from the three pilot sites who were directly involved in implementing DN. It also includes eight others who were not directly involved, but who had knowledge about DN or other similar programs. All added to understanding the organizational factors that determined their definitions of prevention and how they implemented prevention programs.

Key Definitions

The following are definitions of terms that will be

used in this study:

Children of Alcoholics (COA) refers to children of any age who were raised in homes where one or both of the parents were alcoholics. These may be biological, step, foster or adopted children.

Adult Children of Alcoholics (ACOA) refers to the subgroup of children of alcoholics who are generally above the age of 18.

Alcoholic is defined as someone who has been diagnosed as an alcoholic, treated for alcoholism, attended self-help groups (AA) for his or her drinking problem, or whose drinking caused problems for others in the family who consider this person an alcoholic. Alcoholism, then, is defined in terms of the consequences of the drinking behavior to self and others. The illness may be either active, indicating a current use of alcohol (non-recovering); or it may be inactive (recovering), indicating the alcoholic is not currently consuming alcohol.

Alcoholism is defined as a chronic illness, that is potentially fatal, and that is of a biopsychosocial origin. It is characterized by a loss of control over alcohol consumption, tolerance to alcohol, physical

and/or psychological dependency, and/or serious problems in the areas of employment, school, finances, health, legal matters, and/or relationships with friends and family. A person need not have all of these symptoms to be considered and alcoholic.

Parenting education is defined as a leader-led group activity in which conceptual knowledge and affective responses are shared in relation to developmental information about the possible ranges in behaviors and needs of children and of styles and behaviors with which parents respond. Parenting skills are defined as training in communication (listening, empathic responding, "I" messages), discipline, problem solving, and planning family activities.

(Definitions of COA, ACOA, alcoholic and alcoholism are adapted from Lawson, 1988, pp. 19-20)

CHAPTER II

REVIEW OF THE LITERATURE

How social service agencies define and implement alcoholism prevention programs can only be understood within a context of the history of prevention theory and activity in social work practice and education, the current social policy climate, a particular problem to be prevented, and the technology to be used. Consequently, this review of the literature is organized as follows:

- o Prevention in Social Work Practice and Education
- o Prevention and Social Policy
- o Intergenerational Transmission of Alcoholism
- o Parenting Education as Prevention Technology
- o Organizations as Mediators of Prevention Implementation

The literature review establishes the legitimacy of the children of alcoholics and adult children of alcoholics as an at risk population and DN's place in the stream of parenting programs used for substance abuse prevention. It also augments those notions presented earlier about organizational change against which definitions of prevention derived from the cases may be compared. The purpose of this review then is to set a context that enables inductive emergence of multiple conceptions of prevention and an understanding of organizational factors that affect prevention implementation efforts.

Prevention in Social Work Practice and Education

While not a new concept in social work, prevention has been gaining momentum as an intervention strategy. (Bloom, 1981; Collins & Pancoast, 1976; Geismar, 1969; Germain, 1982; Germain & Patterson, 1988; Miller, O'Neal & Scott, 1982; Parad, 1965; Price, E.P., 1962; Roskin, 1979, 1980; Staulcup, 1980, 1983; Wittman, 1977) Funding and program priorities during the New Deal and the Great Society had a profound impact on social work and the expansion of social work education. The paucity of resources available to meet social needs and growing recognition that current efforts to ameliorate social problems are costly and inadequate has led to growing interest in prevention as a cost effective means to reducing the extent of future social and human problems. The prevention branches of the various institutes that comprise the National Institutes for Mental Health and the Office of Special Education contribute to this movement.

Newer governmental funding and initiatives in prevention are apparent in the establishment of the Office of Substance Abuse Prevention (OSAP), child abuse and neglect legislation and its related funding, and other areas such as juvenile justice. Trends, especially those that carry funding, have a profound effect on practice and on professional educational institutions. Governmental initiatives in prevention are leading to increasing interest in the establishment of specific coursework in

particular prevention areas such as child abuse and substance abuse as well as in developing integrated programs for prevention education in social work educational institutions.

In late 1988, 20 social work deans and faculty members gathered under OSAP's auspices for a critical review of the need for substance abuse prevention material in the curricula. At present, there are no requirements by the Council on Social Work Education (CSWE) for courses in this area. Decisions about prevention content are made individually by each school. Of 62 schools surveyed, 25 reported inclusion of materials on substance abuse prevention. ("Deans eye," November, 1989). Roskin (1980) and Staulcup (1983) report that only a few schools of social work include courses that present preventive social work as an autonomous subject. Some schools include preventive content in core courses on policy, human behavior and social environment. The George Warren Brown School of Social Work represents a model for integrated prevention content in the total social work curriculum and for offering a specialization and field practicum in this area. Other prevention curriculum and field work efforts reveal extreme variety ranging from mini-projects to extensive curriculum building. (Libassi, in Bowker, 1983; Kinney & Kurzman, 1989; Staulcup, 1980; Tandler, & Metzger, in Nobel, 1981)

As social work educators further explore this important

area, care must be taken to develop and provide the opportunity for knowledge building and training in preventive services in such a way that respects our value base and parallels our research and theory building in provision of treatment. Rather than being seduced into either superficial initiatives (as with "Just Say No" in the area of chemical abuse) or quickly conceived, broadly focused shift in provision of services (as with the "War on Poverty"), we must effectively assess the needs of our client base and their ability to use the services that might be developed. Too, because targeting prevention efforts to specific populations carries with it the danger of labeling and stigmatizing groups, care must also be exercised in how we seek out and serve clients.

Historical Context

Attention to prevention is evident in the evolution of social work from the early activities of societies for prevention of cruelty to children and the dual focus both on the problem conditions of children and their families and on the larger social and political context that affected them. Early interest and efforts in social reform and social change such as this were diverted into increased attention to developing methodologies for individual treatment of psychosocial problems. Early movement away from social concerns served, for example, by the settlement house movement to the intrapsychic may well have

exacerbated social work attention to treatment rather than prevention. Herbert Staulcup (1983) and others believe that the strength of the Freudian psychoanalytic movement slowed down the development of community prevention programming which otherwise might be considerably further developed today.

In the 60's and 70's, there was an upsurge in hope and activity around prevention in mental health. Prevention has been called the "fourth mental health revolution," a "normal science" (Bloom, M., 1981) and an "idea whose time has come." (Klein & Goldston, 1976) If not a revolution, the 1963 passage of the Community Mental Health Act marked a significant attempt to shift from case-by-case services to comprehensive planning for communities. Despite increasing interest in this direction, efforts are fragmented and there are few means for systematic sharing of learnings. Numerous prevention organizations and associations--such as the National Association of Prevention Professionals, the National Committee for Prevention of Child Abuse, the Family Resource Coalition--actively lobby the government, develop citizen and professional membership groups, provide information to the public and pilot prevention programs. While social workers are active in these movements and the Council on Social Work Education has sponsored conferences and published on prevention, the evolving models and methods for delivering services to individuals and groups before

problems occur have not methodically been addressed in the professional literature or found their way into most social work education.

Despite a history of interest in and commitment to prevention, there is also frustration with the slowness of actualizing its promise. This is clearly evident in a series of three articles by Eli Bower, a past president of the American Orthopsychiatric Association. In 1961, he eloquently presented a "conceptualization of primary prevention and programs of research and demonstration" (p. 832) to counter what he believed was a desultory, defeatist attitude toward such activity. He concludes and sums up his notions of prevention using the metaphor of an old Cornish test of insanity as follows:

Prevention has to do with the quality of the interactions and the degree of effectiveness of the primary institutions of a society in providing each person with increments of ego strength and personality robustness for coping with the "slings and arrows" of life. The nature of these interactions and experiences would be considered preventive to the extent to which such experiences enhance the degrees of psychological freedom of an individual to select behavioral alternatives and to act upon them. This preventive model and point of view was succinctly illustrated by an old Cornish test of insanity. . .The test situation comprised a sink, a tap of running water, a bucket and a ladle. The bucket was placed under the tap of running water and the subject asked to bail the water out of the bucket with the ladle. If the subject continued to bail without paying some attention to reducing or preventing the flow of water into the pail, he was judged to be mentally incompetent. Similarly, any society that attempts to provide more and larger buckets to contain the problems of that society, without simultaneously attempting to reduce the flow, might be equally suspect. Treatment, rehabilitation and incarceration are our necessary buckets to contain

the flow. Prevention, however, deals with the tap, the sources of flow and the leverages needed to turn the faucet down or off. (p.847)

Bower (1972) refined his ideas about the wide range of enhancing, health promoting aspects of primary institutions for prevention as "key integrative social systems (K.I.S.S.) for children and their families "to help all children to make a good beginnings in their life." Sadly, he also states that "prevention is not compelling; mental illness and criminal behavior are. Our action then is always too late and generally ineffective." (p. 565) In 1987, he wrote a brief article "Prevention: A Word Whose Time Has Come," which expresses his feeling that prevention is being "talked to death (p.4)." Further, he states,

Indeed if we continue to define prevention as what we do for those already singled out as needing mental health services, we are not in the prevention ballpark.

Bower suggests giving up the public health paradigm of primary, secondary, and tertiary prevention and, returning to his metaphor, learning how to turn the spigot down and eventually off. "Prevention," he says, "is finding out how to reduce the flow--and doing something with our knowledge (p.5)."

Present Context

As far as we have come, we have much further to go to actualize prevention activity. Social workers find themselves or have the opportunity to place themselves in "key integrative social systems"--those that address the

health, family, play and schooling needs of children and to develop strategies for prevention. Staulcup (1983) makes the important point that, while social workers are taking a leading role in prevention programming, they have not yet adopted a theoretical framework that distinguishes prevention as a special part of social work. We are doing it, but we have not named or claimed it. Most social workers do not perceive prevention as a distinct area of social work and do not attach special significance to it. Before we can do so, we need to define prevention in a social work context. Indeed, while we can learn from the public health model, we must develop our own.

Prevention and Social Policy

Prevention, according to Rosemary Taylor (1982), has become a battle cry to deal with a variety of issues, but its content and its underlying strategy are contested. It grows out of the intersection of different sets of problems and different sets of solution that do not always neatly correspond Consensus is lacking. . . on the specific program that should constitute a strategy of prevention. (p. 40)

She analyzes two etiological theories that lead in two different directions; namely a "theory that blames self-destructive habits" on the individual and a "theory that points to social change." (p.40) These theories lead to different arenas for action and echo a major dichotomy of social work:

- o Prevention directed toward the individual--persuading people through education or sanctions to change self-destructive habits;

- o Prevention directed at the social--reducing environmental threats such as air pollution, carcinogenic chemicals, industrial accidents, or, within the social work realm, poverty.

According to Taylor, "results from behavior modification will be trifling. . . .compared with the potential from state and federal action against environmental" hazards. In the area of substance abuse, the former leads to strategies of socialization (demand-side strategies--deterrence, treatment, and prevention--that eliminate the desire for drugs); the latter, to strategies of control (supply-side strategies that reduce the availability of drugs through crop eradication, interdiction, and domestic enforcement. Programs that are designed to affect the demand for drugs attempt to change the values, beliefs, skills, and ultimately, the behaviors of potential users. In contrast, supply-side strategies attempt to block access. (Fraser, & Kohlert, 1988, p. 104-105)

Prevention, as one of the three demand-side strategies has within it two major alternative strategic approaches:

- o The generic--for avoidance of any drug use including experimentation for which the accepted prevention goal is promotion of a community norm of abstinence.

- o The targeted--for prevention of regular use or which the accepted goal is identifying and providing carefully crafted program interventions to high-risk youth and vulnerable communities. (Fraser, & Kohlert, 1988)

DN falls in the category of targeted prevention to

reduce demand by persuading individuals through education to change self-destructive habits. Yet, its implementation (as well as that of other targeted prevention projects) may hold promise of broader change in service delivery systems and, more importantly, contribute to national vision for attacking social problems.

Intergenerational Transmission of Alcoholism

There is increasing public concern about chemical abuse. While strategies related to reducing supply of illegal drugs are in ascendancy, there is significant movement toward decreasing demand for all drugs. Governmental and other support for health promotion and disease prevention has directed increased attention to intergenerational aspects of many health and social problems such as child abuse and neglect, poverty and chemical abuse, particularly alcoholism. Indeed, "breaking the cycle" is a theme commonly used in connection with a growing number of social problems.

Children of Alcoholics

Within this context, children and grandchildren of alcoholics have been identified as a population at greater risk to their own alcoholism than others. One in eight Americans grow up in alcoholic families. Those who do have a four times greater risk of developing alcoholism than those who do not. Their children are believed to have a

three times greater risk than others to developing alcoholism. (Macdonald & Blume, 1986) While COA have been targeted for prevention and treatment efforts, few interventions have been developed that address their needs in relation to their children. A growing body of literature points to specific ACOA personality characteristics and deficits in parenting knowledge and skills that affect family functioning as possible factors predisposing chemical abuse in their children. (Biraben, 1987; Blume, 1985; Giglio & Kaufman, 1990; Lawson, 1988; O'Gorman & Oliver-Diaz, 1987; Wegsheider, 1981; Woodside, 1982) As a result, federal agencies especially the Office of Substance Abuse Prevention are funding initiatives to promote and to evaluate parenting programs to prevent chemical abuse.

Risk Factor Research

Research conducted in the mid-1980's suggests that effective prevention strategies might be based on the identification of the risk factors that predispose youth to substance abuse and, then, either reducing or eliminating the factors or protecting against them. (Bell, 1988; Goodstadt, 1989; Hawkins, Lishner, Jenson, Catalano, 1987; Jones & Battjes, 1985; Kumpfer, 1987; Pitman, Wright & Lloyd, 1989) This is quite different from earlier strategies involving programs designed to provide information about illicit drugs which apparently influenced

youth to experiment rather than abstain. Among the risk factors identified, those that particularly support parenting programs as a prevention strategy are:

- o a family history of alcoholism related to both environmental and genetic components.
- o poor and inconsistent family management practices such as a lack of clear expectations for behavior, failure to monitor children, excessively severe and inconsistent disciplinary practices.

Positive family relationships appear to discourage initiation of alcohol and other drug use. Other risk factors that were identified are economic/social deprivation; low neighborhood attachment and community disorganization, transitions and mobility, community laws and norms favorable toward alcohol and other drug use, their availability, antisocial behavior and hyperactivity, parental use and positive attitudes toward drugs, academic failure, low degree of commitment to school, alienation or rebelliousness, association with peers who use drugs, favorable attitude toward drugs, and early first use. (Hawkins, et al., 1987; Pentz, 1985) These relate less directly to strengthening parenting practices and suggest the need for additional prevention strategies.

Risk Reduction through Parent Education

DN was developed with the premise that provision of specific parenting skills tailored to the ACOA population

could play a part in breaking the cycle of alcoholism to which they and their children have greater predisposition than others. Programs for ACOA are a relatively recent occurrence. (Macdonald & Blume, 1986) ACOA have received some attention as part of this general movement, but the attention has not generally extended to their own children. DN is one of several efforts to develop and evaluate programs that provide for the needs of the children of ACOA.

The assumption underlying development of DN is that adults whose own parents were alcoholic display particularly rigid patterns of relationship and lack models of effective parenting than others from less dysfunctional families of origin. (O'Gorman, & Oliver-Diaz, 1987; Kumpfer, 1987) A parenting education program may have potential to offset these deficits, offer supports to individuals and families that improve their structure and functioning and, thus, have far reaching effects as a prevention technique for the next generations. Daro, 1988; Halpern, 1990; Kowal, Kottmeier, Ayoub, Komives, Robinson & Allen, 1989; Miller & Whittaker, 1988; Stanton, 1986; Waite & Ludwig, 1985)

Parenting Education as a Prevention Technology

Studies that examine parenting education and training as a prevention technique occur within the context of a stream of studies on the effectiveness of parenting

education and training in general. The literature on prevention research and on parenting education raises many questions about effectiveness and benefits of program efforts. A review of the literature on general parenting training pinpoints many of the difficulties of research in this area. Among these is the difficulty of comparing a large quantity of parenting programs which are derived from at least three major theoretical bases: the Rogerian, the Adlerian and the behaviorist. An evaluation of 48 investigations of these three types of programs indicated poor baseline measures of parental goals, knowledge, and attitudes about childrearing; little attention to the impact of parental characteristics and their interaction with the goals of each category of program; factors related to facilitator effectiveness; lack of appropriate research designs, control groups and multiple assessment measures. (Dembo, Sweitzer, & Lauritzen, 1985). As a result, little can be said about whether a particular program or a particular category of parenting program is more effective than another. This review points up the need to operationalize knowledge and skills to be taught and adequately measure the level of knowledge and skill in experimental and control groups prior to and after intervention.

To date, six studies have been identified and reviewed that employ parenting education as prevention to reduce the likelihood of negative outcomes in children. (Bush, 1988)

These six studies fall within the two strategic approaches delineated above: the generic, those that test the premise that parenting education can be used as a prevention technique with the general population and the targeted, those that address a specific at risk population such as parents in poverty or adult children of alcoholics. Of the studies reviewed, three applied parent education to samples drawn from the general population (Klein & Swisher, 1983; LeCroy, Koeplin-LeCroy, & Long, 1982; Shain, Suurvali & Kilty, 1980); three studies (Alvy, 1987; Knapp, 1987; Kumpfer, 1986) targeted particular at risk populations and, of these, the latter two specifically targeted parents who were alcoholics in recovery and/or had familial histories of alcoholism. Unlike the pilot study of DN which takes its sample from a population not necessarily known to treatment agencies, both Kumpfer and Knapp recruited their samples from chemical abuse treatment centers.

The methodological questions raised through review of general parenting education are repeated in the studies of parent education as a prevention technique: namely, lack of random assignment of subjects to different treatment conditions; heavy reliance on self-report data at the expense of behavioral measures; use of inappropriate statistical procedures; lack of adequate control (no treatment or placebo) groups; disregard for problems surrounding experimenter bias and demand characteristics; and lack of long-term follow up (Shain, et al., 1980),

uncontrolled intervening variables (such as personality and training differences in those who administer the programs and, thus, doubts about comparability and replicability of results and maintenance and durability of training), and thoroughness of data about gains in areas where skills and knowledge are imparted specifically and family functioning in general. It is often unclear whether the procedures employed fully capture a program's effects.

Problems that further confound causal interpretation are those of attendance and dropouts and difficulties in follow-up. Three of the programs studied (Klein & Swisher, 1983; LeCroy, et al., 1982; Shain, et al., 1980) evidenced concern about inter-rater reliability given the amount and variety of measures used. Only Alvy (1987) commented extensively on facilitator training and abilities. Findings from all of the studies reviewed raise issues yet to be answered about the kind of parenting program (Adlerian, Rogerian, behavioral) and about the need to combine parenting interventions with joint or parallel interventions with their children to be most effective in decreasing chemical abuse in children.

There is, however, sufficient promise in this formative research to encourage ongoing efforts both in provision of parenting programs to ACOA and concurrent programs to parents and their children. Kumpfer's (1986) comparison of substance abusing and other families illuminated five clusters of characteristic differences between abusing and

non-abusing families that have important implications for the design and use of parenting programs and other social support techniques. She found that substance abusing families are [i] more insular and socially isolated; [ii] more enmeshed with one another yet disengaged and rigid; [iii] afflicted with greater chaos and have fewer rules; [iv] more disturbed; [v] more depressed and have greater stress. Empirical studies that accumulate this kind of data or attempt to link these characteristics or deficits with specific intervention techniques in parenting programs and other social supports programs may provide ways to measure the effect of intervention on the next generation.

The questions raised by a review of the literature on parenting programs used for prevention of social problems influenced the design of the pilot evaluation of DN. A purposive sample of participants was sought; however, problems of attendance and completion of pre/post tests reduced the sample size somewhat.

Several improvements over previous evaluations were implemented. The various components of the parenting course were operationally defined and more systematically studied. Behavioral and self-report measures were used in conjunction with observation of the experimental condition. Facilitators had similar educational backgrounds. They were trained in DN as a group and their performance was monitored. Setting was systematically varied to understand whether the program was equally

effective in a variety of settings for different samples of the ACOA population. The question about whether predictive statements can be made about the results of intervention was attended to by choice of two sets of instruments used in a prior study to measure change in family functioning. (Kumpfer, 1986)

The report on the pilot study states:

Using both qualitative and quantitative methods, it can be concluded that the program was implemented effectively and with fidelity to the curriculum . . . both the subjective experiences of the facilitators and the participants, as well as the quantitative data provided by the questionnaires suggest that the program accomplished its objectives with respect to specific changes in knowledge, attitudes and behaviors.

It often takes considerable program revision and development before innovative programs can produce such results. That Discovering Normal was able to demonstrate effectiveness at this early stage is impressive. The suggestions raised in this report would seem to be useful in strengthening a positive program. These findings would seem to suggest the efficacy of replication and the consistency of findings across participants and sites indicates that such replication can be done with enthusiasm. (Emshoff, 1991)

Better answers to questions about effectiveness, replicability, and long-term effects of intervention will certainly impact agencies' willingness and ability to devote their limited resources to prevention projects and programs like those described above.

Impact of Organizational Factors on Implementation

Gareth Morgan (1986) gives new meaning to the

contingency model as a basis for understanding organizations. Rather than a system with linear, one-directional relationships between the parts, it can be seen as a system with interconnections in both directions between the subsystems within an organization. Even more important, the environment is not just another contingency that impacts the organization. It is both an effector on and affected by what occurs in the organization. The management system is critical to change because it tunes in to implicate forces for change within the environment, his/her own subsystem, and the other organizational subsystems, and uses explicate means (such as participative techniques) to foster expression of the creative that leads to change. (pp.238-240)

The Environment

The economy, political pressure, legislation, availability of funds and demographic trends are all areas of changing conditions to which organizations must adapt; however, the forms through which they adapt will affect these factors in the larger environment. Schools of social work, through changes in their educational programs, might also exert a different kind of power in bringing about change. (Gummer & Edwards, 1985) If schools of social work truly made a commitment to prevention education and practice, there would be greater likelihood that national organizations and local agencies would establish a staff

position or department to promote and practice prevention. Like the Family Resource Coalition, social work organizations might then become increasingly effective lobbies for parenting training or other prevention program funding. Should prevention technology prove useful, there may be a "quantum jump. . . capable of transforming the whole system of activity." (Morgan, 1986, p. 239)

The Management Subsystem

The contingency approach to organizational design as described by Rino Patti (1982, p. 169) emphasizes concern with "finding the optimal fit between the distribution of authority in a system and the nature of the technology it employs." On an autocratic-participatory continuum, depending on the nature of the decision at hand, leadership style fosters the way in which tasks are most effectively carried out. Where technology is non-routine, authority should be delegated to subordinates to permit flexibility, creativity, and discretion. In looking to innovate a prevention program which may destabilize the status quo, management cannot maintain a hierarchical, bureaucratic form. Patti further states,

Too often, managers maintain structural arrangements and leadership styles that are better suited to relatively stable environments. The persistence of the bureaucratic form among social agencies is one indication of this. The contingency approach directs attention to the relationship between internal structure, climate, and external conditions and should, therefore, alert administrators to design and leadership alternatives that will better equip their

agencies to respond to a dynamic task environment. Among other things, one would expect contingency-oriented management to make much greater use of structural arrangements that permit quicker response time, flexible planning and cross-program integration. Task forces, teams, linking roles, and matrix organizations are some of the available options that might help agencies to be more responsive to external constituencies. (1982, p.170)

Looking at change from an even more radical point of view, the administrator, manager, or program designer must be an entrepreneur who places "value on challenge and action" not an administrator-trustee who places value on "management and control." Fraser and Leavitt (1988) describing an innovative program to prevent out-of-home placements of children which is now taking hold across the United States, state that staff need to be encouraged "to break traditions with fresh ideas and new ways of working with families in crisis (p. 168)." Yet, they further advise administrators and supervisors to exert control in the context of challenge. They are precise about the model. The goals and process of breaking with tradition are clearly determined. However, the practice and its empirically-based study and evaluation allows creativity, learning, staff commitment and success. Morgan (1986) would add that management requires "an organizational capacity for appreciation and learning. . .to influence and shape the process of change (p.254)."

Indeed, the manager might institute a task force or planning group to institutionalize "environmental scanning and forecasting" (Pfeffer, & Salancik, 1977) to keep the

prevention effort reflective of supports in the environment. At the same time, the manager must develop both a project framework (e.g., numbers to be served, staffing, time constraints) and project milestones (Flynn, 1985) that delineate commonalities in the natural history of similar projects (Tabor, & Finnegan, 1980), and progressive goals so that projects in combination become an effective prevention program. In other words, the manager might use a tight-loose approach to decision-making even within a small agency. (Sherraden, 1985, p.92) If differential patterns for subunits of the agency are encouraged (Lorsch, 1977, the "situational model"), integration of services will be an issue to be addressed. It may be key for the manager to encourage visible projects that will impact the community.

Goals and Values

While the intervention technology for prevention and treatment have many similarities at the skill level, a basic value shift is necessary before social workers in a traditional agency are able to embrace a goal of primary prevention. Morris and Binstock (1980, p. 139) contribute an important idea for overcoming resistance to change applicable to strongly held values. They recommend increasing the perception that the current situation is unsatisfactory. This may involve strategic marketing of goals to staff.

Given the dimensions of social problems and the largely untested nature of applications of technology to prevention, care must be taken to establish prevention goals that are clear, visible and worthwhile but do not promise too much. Chances of success that Sherradan expresses are increased when there is emphasis on productivity (number of people reached, accomplishments, direct and indirect); selection of visible projects which can be publicized; projects that are important to the general public; and projects that foster decision-making at the local level and are more easily integrated with existing systems. A common caveat is to resist being diverted; that is, abandoning prevention to do treatment, or so broadening the definition of what the project attempts to prevent that the goal becomes too ambitious and, therefore, unreachable.

Creative measurement tools are needed for social programs. With the campaign to reduce smoking, it was possible to measure decreases through surveys and through drops in sales. More effective parenting and its results in terms of a reduction in social problems are more difficult to demonstrate and publicize. Such advances as the recent measurement of increased health care costs for COA should lead to creativity in the ability to evaluate the effectiveness and cost benefit of parenting and other prevention interventions. (Children of Alcoholics Foundation, 1990)

Technology

Goals and values directly influence technology. However, the reverse is also true. That a variety of general and specialized parenting programs exist effects their choice as a means of reaching the goal of reducing substance abuse. However, as in most areas of human service,

As typically construed, primary prevention is a nonrational technology where operations are nonspecific, nonuniform, conducted at or beyond the organization's confines and authority. Materials and products are difficult to marshal into control, are derived from abstract and intangible goals, are unpredictable and idiosyncratic. Knowledge concerning implementation rests not upon empirical verification and evaluation, but upon intuition and ideology, upon uncertainty as to how to proceed and uncertainty that the assumed outcomes are, in fact, desirable. (Neuhring, 1978, p.463)

Oettinger and Marks (1974) point out the difficulties of introducing a mechanistic educational technology (computerized self-instruction) that shares many of the same principles of adult education used in parenting training. They warn against "scientism" vs. experimentation, stating that using the trappings of science to convince the various publics that a technology is worthwhile prevents us from using our ignorance to learn. While pessimistic about "high tech" interventions, they take an extreme, but common position among program planners that encourages diversity even if it is wasteful. Indeed, social problems require, according to many program

design authors, experimentation, redundancy, creativity and learning.

Managerial clarity, however, is essential to define the target of the intervention and the parameters of techniques to be used. In-service training is certainly necessary to implement change: both to get staff on board, able to use their skills with a new technology and, later, to ensure replicability of desired outcomes. The manager, at the same time, must take care not to foreclose opportunities for staff input and creativity. In effect, the manager has to indoctrinate staff to the "vision" he or she has of the program. While the vision may include a variety of "targets" and possible projects, it must permit others to interpret it and develop it in as yet unenvisioned ways.

To do this with any degree of success, the manager must select and assign or recruit personnel who are able to see themselves in multiple, atraditional roles. Staff who are entrenched in a treatment modality will be unable to further this particular programmatic effort even though their skills theoretically are translatable.

Structure

Structure, including division of labor, hierarchy of authority, procedural specifications and participation in decision making, includes and must support the technology. (Glisson, 1981) The structure should reflect values and goals, the agency, and the environment.

The implication of non-routinized technology that requires high worker discretion predicts the kind of alignment the technological subsystem needs to have with the structural. While parenting education can be relatively routinized in terms of what is covered, the unpredictable nature of the clients, workers and the product of their interaction leaves tremendous room for discretion. Kanter (1982) calls for the use of participative decision-making where ground rules need to be established and where dramatic change is desired. She sees the team with responsibility for a joint product that includes a recommendation, plan, decision, solution to work area problem or the output of the work as both a problem-solving method and a way to manage change. The unpredictable nature of prevention work requires feedback information to guide further action.

That evaluation of outcome is, as yet, so amorphous and knowledge about implementation rests on intuition and ideology gives further impetus for a decentralized rather than a hierarchical structure. That there is no single best solution would encourage participative management. However, a structure that includes consistent routine, commitment to goals and methods, staffing, planning and evaluation is needed to measure and apply learnings. It is also essential to work towards a fit with the existing treatment service structure whether through a matrix system with functional reporting by area--or--two separate,

dissimilar subsystems. Care must be taken to look for "integrative mechanisms," (such as common norms or values about family life to which both subscribe) to unify prevention and treatment and to avoid making them like two opposing teams on a football field. (Mayer, 1972,) This might be accomplished through a task force that examines each program for supports it might provide to the other: that is, prevention work will undoubtedly spin off needs for treatment; treatment work will undoubtedly suggest areas where preventive efforts would be most worthwhile through documentation of need toward generating new programs.

Perhaps the ideal agency configuration is one in which workers can move on a continuum between provision of prevention and treatment interventions, developing program to meet current social problems. As an integrative, participatory structure, then, it would be one in which individuals need not perform distinct roles, but may do similar tasks, focusing on the process with, ideally, full and free communication of ideas and information regardless of rank and power; reliance on consensus rather than top down decisionmaking, belief that influence should be based on technical competence and knowledge not power and authority. Conflict will need to be dealt with on rational or therapeutic grounds. (Weissman, 1973) Such a participative system bound by shared values might be more durable than one bound by exchanges. (Mayer, 1972) Katan

and Prager (1986) add that a participative style of management will increase the likelihood of organizational change that is congruent with worker interest. This can be quite positive if management and worker interests coincide; negative, if staff is not carefully selected and acculturated to new organizational goals.

Certainly, if a person is involved in making a decision, he or she will be more involved in its implementation. Many inputs are believed to improve policy and decisions. (Weissman, 1973) Morris and Binstock (1980) point out that staff shape program in any case through their acceptance and rejection of applicants; therefore, their participation is essential for carrying out agency policy. While collaboration promotes primary social work values of self-determination and respect for the uniqueness and dignity of individuals, Julie Abramson (1983) highlights the necessity to be political with respect to one's setting, not just intent on actualizing social work principles to do good.

Since the goal of management is to creatively explore new ways to define and help clients and to foster these skills in clients, participative management is more appropriate than conventional autocratic modes of control. Whether agencies can make such an enormous shift in service provision depends of the strength of the managerial system in aligning the other systems.

Psychosocial

A participative structure increases the power of informal organizational elements. To use it to good effect to develop multiple prevention strategies, it may be advantageous to provide opportunity for increased collegial aspects of work including mutual valuing, sharing of risks and concerns, giving and getting respect, and supportive affective involvement when difficult problems are encountered. For those comfortable with less structure, these can be effective motivators and rewards that lead to greater job satisfaction. Formal and informal techniques are needed to promote collegiality rather than competition within a supportive organizational culture. And, the rewards of "helping the client" need to be buttressed with material rewards (salary, perquisites, benefits) and psychic income (personal growth and development, friendship, a place to live out one's ideology and gain recognition of competence) (Weissman, Epstein & Savage, 1983) However, Walter Williams (1976) stresses that it is a problem to determine appropriate incentives. He cautions against stressing the "package" or "inducements."

Employee performance review and program evaluation are particularly critical in human service delivery systems--particularly ones which, like prevention, are not universally accepted. While accountability and evaluation are important both for determining what works and for

improving program through application of learnings, they are secondary to a vision that is shaped and given form through alignment of goals and values, technology, structure and psychosocial aspects of organizational life. Indeed, many program and personnel failures are related to misalignment of systems because of lack of clarity about their dynamic interplay or because of inappropriate leadership style.

A model, then, for an organization able to implement DN would have the features discussed above. Still, as Williams points out,

It is well to keep in mind that implementation is first and foremost a bureaucratic and political problem. Bureaucratic and political factors--not conventional technical or methodological problems per se--represent the main near-term deterrents to more effective implementation. (Williams, 1986, p.280)

Vision founded in political reality in the managerial subsystem permits "an organization (to) explore possible identities and the conditions under which they can be realized." (Morgan, 1986, p.245) Political realities dictate program choices. (Abramson, 1983) Having made wise choices, if the contingencies are well managed, organizations have greater potential to make changes to better serve clients.

CHAPTER III

METHODOLOGY

The formative evaluation of Discovering Normal in three different types of social service agencies suggested that a comparative case study would be a useful strategy for arriving at a conceptual definition of alcoholism prevention within a social work context. Since social work is traditionally performed in social agencies, how the organizational features of agencies affect the way work is conceptualized and implemented is at the core of this study. Such a methodology offers the potential for capturing the complexity and reality of social service agencies with respect to conceptualizing and implementing a prevention program.

A comparative case study method was chosen because it is unlikely that a study of any one agency would be a "critical test" that would yield a range of conceptions of prevention. A study of one agency also could not yield sufficient data to understand the complexity and variety of the organizational factors that mediate prevention. A comparative study has the advantage of supplying more compelling evidence with greater robustness than a single case, "revelatory" design. (Yin, 1989, p.52)

DN is similar to many social work interventions that

have no clear, single set of outcomes. It is expected that case studies will help explain the causal links in "real life interventions that are too complex for the survey or experimental strategies." (Yin, 1989, p. 25) Employing a holistic design, the unit of analysis is the agency and its implementation of the DN program.

The dual objectives of this chapter are to explain the relevant theoretical and conceptual underpinnings for this research methodology and to describe the procedures that were followed in carrying it out.

Case Study Methodology

Data for this study came primarily from focused interviews, conducted by the author, with eighteen administrators, workers and others at the three agencies. Interviews were taped and transcribed. The transcriptions were then analyzed.

Robert Yin (1989) that the research design "is the logic that links the data to be collected (and the conclusions to be drawn) to the initial question of a study" or the "action plan for getting from here to there (p. 27)." He describes data analysis as following the propositions that led to case study. It was expected that an empirically-based pattern of definitions and organizational features would emerge from the cases that could be compared with the propositions advanced in "Theoretical Framework" and in "Impact of Organizational

Factors on Implementation" in the literature review. In so doing, a story was expected to emerge about whether and how DN was viewed as a preventive intervention, its impact on agency mission and goals and changes, if any, in agency structure and style.

Relying on theoretical propositions and using pattern matching logic described in Yin as a comparison of "an empirically based pattern with a predicted one," (1989, p.109), each case was compared against the propositions advanced above in such a way that the critical organizational variables and definitions of prevention were identified. The "effects proposition" in relation to DN was examined, for example, in terms of changes in expression of the mission of the agency, increased use of staff for prevention activities or increased use of preventive interventions. The "no effects" proposition was supported where there were no appreciable differences resulting from the initial pilot evaluation of DN, for example, unchanged interpretation of agency mission, static staff utilization or treatment services remaining the focal or sole activity of the agency. In this way, the study addressed the salient organizational variables related to articulating a prevention role and defining prevention sufficiently to implement an ongoing prevention project. The propositions, then, provided guidance in determining what data to collect and the strategies for analyzing the data.

In a small comparative study, caution must be exercised about the kinds of generalizations that are made as a result of this analysis. Clearly, cases are not sampling units and, therefore, statistical generalizations cannot be made. Should one case fall into the "no effects" set of propositions, no statement can be made about it that would be expected to hold true for any other agency of that type. However, should two agencies have similar organizational dimensions emerge that appear to mediate similar definitions of prevention and/or similar implementation outcomes, using the principle of "analytic generalization," it may be possible to claim theory replication: that is, that particular organizational factors support the definition and implementation of a prevention strategy. If contrary results occur for predictable reasons, replication may still be claimed for the theory that a particular organizational change is requisite for defining and implementing prevention programs in social service agencies.

Ideal Type Analysis

The comparative method has a long history in sociological research. Its value in social work may lie in movement away from historical, comparative studies which apply natural scientific methods to unique historical events to develop universal laws to a more qualitative process of generalizing from events and historical figures.

(Easthope, 1974) Max Weber embodies this shift in his development of "ideal type" analysis. In the Protestant Ethic, Weber (1958) developed his ideas about the relations between religious orientations and social structure through broad comparative studies. He presented Calvin and other religious figures and religious ideas in the "artificial simplicity of ideal types (p.98)." He also created a picture of the capitalistic entrepreneur as an "ideal type."

An. . . ideal type is formed by the one-sided accentuation of one or more points of view and by the synthesis of a great many diffuse, discrete, more or less present and occasionally absent concrete individual phenomena which are arranged according to those one-sided emphasized viewpoints into a unified analytical construct. (Weber, 1949, p. 60)

Weber progressed from empirical studies to the development of ideal type theory. He sought to determine whether his conceptions could influence or shape concrete actions and social relationships. (Parsons, 1967, p. 41)

Ideal Type Analysis as Qualitative Methodology

Max Weber's method of data collection and analysis might be subsumed under today's qualitative methodologies. Talcott Parsons (1967) states that, "Weber's orientation toward analytical methods requiring comparative studies involved a sharp break with the intellectual traditions in which he was educated." German Idealism and its tradition of historical social study distinguished different or

opposed methods as appropriate to the natural sciences and to humanistic studies: "studies of human society and culture must be pursued by 'ideographic' methods, not by 'nomothetic' methods employed in the natural sciences." (1967, p.39)

Weber believed, according to Parsons, that causal explanation depends upon the employment of analytical theory in studies of society as much as in the natural sciences. "Causes of human behavior cannot be found and established without the implicit or explicit use of abstract and general concepts and propositions." (1967, p.40) Parsons further states that,

"Studies of human phenomena should delineate the development or unfolding of unique historical patterns, and attempt to grasp the central meanings of these unique patterns." (p. 39)

This study uses Weber's ideal type analysis within the context of qualitative, exploratory, comparative study of organizations. Weber's mode of thinking, dominated by the concept of the ideal type, was applied to both cultural content and individual motives. Parsons felt:

He was quite right to insist, against a background of idealistic historicism, that explanatory concepts be applicable to the understandable motives of individuals. And when we consider how often the "methodological individualism" of English-speaking social scientists has led them to biopsychological reductionism, we can see that Weber was indeed right to insist that the inclusion of cultural content is indispensable to the analysis of orientations to the great problems of meaning. But it is now possible to go somewhat beyond the concept of the ideal type, by making a more sophisticated and thorough use of the concept of system (1967, p. 75)

Parsons goes on to explain that the concept of system is more dynamic than the rigid units of analysis in their "ideal type" form.

That this study seeks to determine how an agency's conceptualization of prevention affects its implementation of a prevention program is directly parallel in rationale (not subject matter) to Parson's explanation of Weber's undertaking. Just as Weber treats religious orientation as an independent variable, this study treats organizational factors as the independent variables that determine how prevention is conceptualized and implemented.

This study follows an inductive process of identifying pertinent organizational variables. While the review of the literature was used to identify a list of the possible independent variables that might be found, those that were identified as key to conceptualizing and implementing prevention are grounded in the interview and agency data. A process of analysis, modeled on Weber's development of the constructs he called "ideal types," transformed the unique aspects or effects of these variables from each case to generalizations or abstract constructs that are "ideal types." In this form, the conclusions are usable by social agencies interested in looking at and comparing themselves with a variety of idealized prevention approaches.

Relevance of Ideal Type Methodology to this Study

Talcott Parsons and Amitai Etzioni suggest using

elements of Weber's ideal types as variables in an analytic system.

We have discussed three forms of distribution of charisma in organizational structures as three discrete "ideal types." More specific statements can be made if we see the types as representing analytical components; different combinations of these components supply continua along which many subtypes of charismatic distribution can be arranged. (Etzioni, 1961, p.328)

As the cases in this study were analyzed, it was natural to look for traits that clustered together and to which a process of judgement could be applied. Existing definitions of prevention and organizational theory, as expressed in the propositions discussed above, were foundation points around which data was assembled for reasons that are similar to those Parsons and Etzioni attribute to Weber.

Weber gave the following as his reason for seeking to characterize ideal types:

We are interested rather in something entirely different: the influence of those psychological sanctions which, originating in religious belief and the practice of religion, gave a direction to practical conduct and held the individual to it. (Weber, 1958, p.97)

Likewise, in seeking to identify ideal types of social agencies with respect to how they conceptualize and implement prevention programs, a goal of this study is to give direction to the conduct of prevention programs in social agencies.

This analysis resulted in a descriptive taxonomy of three agency types at various phases of integrating

prevention technology with that of treatment. The three descriptive entities in the taxonomy are subjective or hypothetical pictures,

typical constellations of actions and/or thoughts that although related to reality were not derived from reality. (Easthope, 1974, p.119)

They picture how an agency, at a point on a continuum of definitions and implementation expertise, might look. While no one entity in this taxonomy is more "ideal" than another, each represents a subjective assemblage of the data in the tradition of "ideal type analysis" wherein each agency is presented in that "artificial simplicity of ideal types, as they could at best but seldom be found in history." (Weber, 1958, p.98)

Social service agencies have the option of comparing themselves with the types to determine where they are in the continua of agencies devoting resources to development of prevention service capability. In so doing, it is possible "to have, as it were, experiments in the mind" whereby an ideal type can be compared with other agencies "to see in what way they differed from the ideal type." (Easthope, 1974, pp.118-119)

In summary, "ideographic" or qualitative case study methodology, including an adaptation of Weber's ideal types was used to examine the social service organizations that were the units of analysis in this study.

Sampling

The Formative Evaluation

DN was pilot tested at three sites in different states in the United States from May through September, 1990. The Children of Alcoholics Foundation contracted with an outside evaluation firm to develop instruments and monitor the pilots. The sites were:

- o The AA--an alcoholism treatment agency in an urban, inner-city setting on the outskirts of a large, Eastern city.
- o The CA--a child guidance agency with a community education program in an urban/suburban setting bordering on the Midwest.
- o The FA--a family agency that provides a variety of services including alcoholism treatment to families and children in an urbanized suburb on the hub of a large Midwestern city.

Participant groups ranged in size from 12 to 20 with a total of approximately 60 participants. SES factors varied within and between groups.

The procedure followed involved pre- and post-tests of dependent measures for family functioning, knowledge about alcoholism and COA issues, and parenting knowledge and skill. As evident from the description of pilot sites above, there was systematic variation of the location and agency auspice. Unlike other parenting projects designed to reduce chemical abuse, DN targeted and recruited ACOA not necessarily known to treatment agencies. An observer

was used to collect process data about trainer competence and compliance with the instructional design, a key intervening variable. In addition to the implementation process, recruitment and selection of participants were also monitored.

The purpose of the pilots was to provide information for final revision of DN by looking at whether:

- o facilitators could use the material with ease and reasonable uniformity (replicability);
- o participants gained knowledge and skills
- o participants felt they had gained something from taking the course (satisfaction).

The results of this evaluation demonstrated that the program intervention, DN, was successful in imparting specific alcohol and COA information, and parenting knowledge and skills. (Emshoff, 1991) Measures of family functioning yielded information about ACOA family configurations similar to that of previous studies. (Kumpfer, 1986) Changes in the family functioning measures are suggestive of movement toward greater family cohesion and less conflict. While process data confirmed expected differences in the individual style of facilitators and rapport with a participant groups, it yielded positive information about the ease of program administration and its replicability. No significant differences in outcomes related to setting, participant characteristics, or facilitators were found.

The results of the pilot evaluation suggested that DN

is a valuable intervention for ACOA that can be implemented with minimal training and relative ease by a variety of social workers with masters degrees in human service agencies. (Emshoff, 1991)

The Current Study

The careful and caring attention to carrying out the pilot evaluations and the variations in how DN was implemented made the agencies and their personnel excellent subjects for this comparative study.

Criteria for Selection of Sample

The three agencies who took part in the formative evaluation of Discovering Normal were chosen as the units of analysis for this study for the following reasons:

- o There was a systematic variation of setting which assured that any conceptualizations of prevention and related implementations of program were not peculiar to the type of agency studied. Each agency was representative of a different, but common type of social service agency serving children directly or indirectly through their families.

- o Each agency has a commitment to limiting the effects of parental alcoholism on children which made them appropriate sites for this particular prevention program.

- o Each agency implemented the same prevention program (DN) in the same prescribed way with similar participant results. All of the program facilitators had received the same training at the same time. Thus, confounding factors were limited through the standardization of variables related to the intervention.

- o DN paralleled two major social work definitions ("proactive" and "reactive" prevention which might also

be defined as "prevention," "early intervention" and "treatment" or "primary," "secondary" and "tertiary prevention") thus permitting a wide range of prevention and other conceptualizations about what was accomplished.

- o Each agency was given the option to continue using DN by the Children of Alcoholics Foundation, but they were not required to do so. This allowed study of organizational factors related to whether a new prevention program is institutionalized as a regular offering.

- o The investigator had trained the facilitators and visited each agency to observe one or more sessions of the pilot evaluation. She was known to and had rapport with administration and staff at each agency.

Within each agency, those who made the decision to pilot DN, and those who actually implemented the program were purposely chosen for interviews. Staff involved with public relations and funding development were also interviewed. When possible, other staff who were aware of DN or other prevention programs were interviewed as well.

Profile of Those Interviewed

Of the eighteen people interviewed, fifteen were human service professionals. Of these fifteen, all but four had some supervisory or administrative functions. Within the group of eight who facilitated DN, three were primarily line workers.

Four of those interviewed were male; fourteen, female. Three interviewees were AfroAmerican; one was Asian; fourteen, white.

The Administrators

All of the administrators who were instrumental in bringing DN to their respective agencies for its pilot evaluation were interviewed. They included the head of one agency and two heads of major agency divisions. Of these administrators, two have masters in social work and one has a masters in guidance and counseling. The two social workers belong to the National Association of Social Workers and also have state social work certifications. Other affiliations and credentials included the National Black Alcoholism Council, the Directors and Professionals Association of Family Service America, a license in marriage counseling and a certificate in alcoholism counseling. One of the administrators was a member of the Parent Advisory Committee that helped to develop DN.

Three additional administrators who direct programs and one supervisor were interviewed. Three of them have masters in social work; one, a doctorate in psychology. Two reported that they are members of the National Association of Social Workers; two also reported having ACSW designations. Three hold state social work certifications. One has an apprentice substance abuse counseling certification.

The Facilitators

All eight facilitators of the DN pilots were interviewed. This group included five program supervisors

and three line workers. All but one were social workers with masters degrees in social work. The one non-social worker has a masters in marriage and family therapy. The social workers varied in length of time in the field (from one to ten or more years) and in areas of expertise (child and family counseling, alcoholism, child abuse and neglect, parenting training). Seven were female; one, male. Six reported that they are members of the National Association of Social Workers. One served on the Parent Advisory Committee that helped develop DN.

All of the facilitators had been chosen by their agencies. They attended a one-day training session in New York City on April 20, 1990.

Other Agency Personnel

At two of the agencies, directors of development/public relations were also interviewed. An alcoholism counselor/adolescent specialist who had been present at the facilitator training, but who was unexpectedly required to take on childcaring responsibilities during the pilots was also interviewed.

Limitations of the Sample

The criteria for selection of the sample have been specified. However, there were some inherent limitations and potential for bias in this selection. The COAF used its Parent Advisory Committee to find appropriate agencies

to pilot the program. One advisor was a member of the foundation that funded DN's development and several programs in one of the agencies; another was a Board member of one of the agencies and a local expert on parenting issues; the third, a supervisor in one of the agencies. The funder had every reason to pick an agency that would give DN a rigorous test. One of the other advisor's motives may have included showcasing her own local agency and obtaining a new program for it before other agencies had access to it. A third advisor was a program supervisor in the agency and, while honored to be asked to pilot DN, experienced the formative evaluation and the interview related to this study as a burden. None of these factors invalidate the formative evaluation or this study. However, that the agencies were "handpicked," considered models by some of the Parent Advisory Committee members and special in one way or another must be noted since the generalizations that form the conclusions of this study are idealized types based on these three agencies.

The COAF chose these particular agencies because they represented three types of social service agencies where DN would most likely be used and because they represented as wide a geographical spread as was possible in a relatively small pilot. Yet, the agencies chosen were only three in number. They are not totally representative of all social work agencies or of all local conditions.

Research Procedures

Interviews were requested with the administrators and facilitators directly involved with DN and with development personnel by telephone. A followup letter was sent to the three agency administrators formally requesting the interviews, requesting other information about the agencies and suggesting possible dates. The nature of the study and its difference from the formative evaluation were explained. The agencies were asked for approximately an hour of each interviewees time. In the letter, individuals were promised anonymity for themselves and their agency. The agency administrators arranged interview schedules for the investigator with themselves and with the facilitators and chose the additional interviewees. (See Appendix A for a sample of the letter.)

In addition to the interviews, other sources of data were sought including:

- o Agency reports on identifying, recruiting and selecting participants
- o Pre/post tests demonstrating participant gains
- o Post-test only questionnaire about participant satisfaction
- o Facilitator process data on each session
- o Process data for those sessions that were observed.
- o Summary of results of interviews with facilitators and host organizations after completion of pilots.

These data were considered along with

- o Agency materials that convey information about the process of implementing and evaluating the program such

as letters, memoranda, meeting agenda, recruitment brochures, PR releases, newspaper and other coverage)

- o General information about the agency such as its annual report, mission statements, organization charts and brochures on programs or services.

Developing the Interview Protocol

The interview protocol was developed in such a way that it paralleled a stage model of program development and evaluation. (Epstein, & Tripodi, 1977) Critical organizational variables were identified at each agency at each of the following stages of program development:

- o a retrospective needs assessment--why and how DN was to be used
- o planning (recruiting facilitators and clients; deciding issues of fee, location, etc.)
- o Implementation during the pilot and thereafter
- o Forms of agency evaluation in addition to the formal pilot evaluation

For each stage, a repetitive pattern of questioning was used that organized replies around considerations having to do with the

- o environment (suprasystem)
- o the agency
- o the interviewees personal practice orientation

Several additional questions were included about each agency's history in providing prevention services, each interviewee's definition of prevention, how DN fit their definition and their sense of what other agencies similar to their own should be doing in the way of prevention.

(See the Appendix B for a copy of the Interview Protocol.)

Pilot Test of the Interview Protocol

The interview protocol was pilot tested with three members of a family agency in a small, multi-ethnic city in yet another state: a program administrator, a line worker and a student social worker placed there. The interviews were taped so that the entire process to be used was pretested. Final revisions were made to the protocol including the patterned questions repeated during each stage. A major learning in the pilot of the interview protocol was that presenting an overview of the structure of the questions to be covered was very helpful to interviewees. The protocol and process that was finalized in this pilot was then used in each of the eighteen interviews with some modification for the two development/public relations people.

Researcher as Interviewer

The interviewer, not the interview protocol, is the critical instrument in qualitative research. A computer cannot apply formulas to manipulate the data. All of these phases rely on the impartiality and the judgements of the researcher. Max Weber is held up by Talcott Parsons (1967) as an example of the researcher as instrument:

Weber was a scholar who avidly assembled and digested any empirical materials available in the relevant

literature

. . . . He did his unusually competent best to discover the actual facts and to correctly interpret them, over an enormous range of subject matter. (p.42)

Phrases that Parsons used to explain this, included:

--Weber attempted to interpret action "by understanding the motives of the actor from a 'subjective' point of view."

--As the investigator, Weber tried "to put himself in the actor's place."

--"This subjective interpretation does not require the complete individualization of interpretations, since there are typical patterns of meaning which can be abstracted from the individualized totality." (p.40)

The researcher, however, must elicit the individualized totality before abstracting and generalizing. In data analysis, "each ideal type. . .is determined by the values of the observer, and is therefore arbitrary. . . ."

(Easthope, 1974, p.119) Thus, the researcher is the filter through which data is collected and the processor through which it is analyzed.

The program developer of DN and researcher for this study was the sole interviewer of the eighteen subjects. Among the assets this brought to the study were status as a representative of the Children of Alcoholics Foundation, as coauthor of DN and convener of the Parent Advisory Committee which included the foundation that supported DN's development. This enhanced her credibility and welcome at each agency. Too, to be in a position to obtain facts and find empirical material, it was important that the interviewer also be able to use knowledge of DN to elicit

the range of conceptualizations about prevention and the underlying factors that stimulated them. This called on the interviewers knowledge of DN and, as a clinician with experience in a family agency and in an outpatient hospital setting with alcohol treatment, her knowledge and comfort with social work settings.

Having visited each of the agencies previously during the formative evaluation of DN, the interviewer had some familiarity with personnel and with the settings. Indeed, the interviews for this study were, in some sense, a deprogramming opportunity for many of the facilitators who had been concerned about meeting expectations the Children of Alcoholics and this researcher's expectations during the formative evaluation.

Conduct of the Interviews

The interviews were conducted from April through July, 1991. Two days each were spent at the AA and CA; three days were spent at the FA. Most of the interviews ran at least one hour. One interview ran more than 90 minutes and overran the tape. Generally, interviews averaged sixty or seventy minutes. Interviews with development staff were somewhat modified and, therefore, shorter. Sixteen of the interviews took place in each person's office and, in one case, in a borrowed office with very minimal interruptions. One interview was accomplished over lunch in a restaurant. Another, in the private office of a DN

facilitator who was no longer with the agency.

Data Analysis

In this section, the procedures the researcher followed to get from eighteen tapes to the findings presented in this dissertation are described.

Data Management

Transcription

Using Multimate Advantage II on a personal computer, the researcher transcribed four tapes and segments of other tapes. A transcriber was hired to produce the rest of the tapes and the researcher spot checked each of them. While all interviews were transferred to the Ethnograph, a computer program designed for qualitative data analysis, the program was simply used for numbering and reproducing interview segments, thus assuring the accuracy of quotations.

Generating a Framework for Analysis

There were two processes involved in data analysis. One was the use of definitions (conceptualizations of prevention) within each agency to identify key organizational dimensions that determined them. Similarities and differences within and between agencies were examined and, slowly, a sense of how key dimensions impacted conceptualizations emerged. The second process

involved sorting other interview segments by all possible organizational factors identified in the review of the literature. Key dimensions were identified by reading and rereading the data to identify the most salient material, sorting by dimension and refining each sort.

The number of dimensions were collapsed as related factors were resorted and condensed. The two processes worked together, one informing and explaining the other: how members of each agency conceptualized prevention was clearly related to specific organizational dimensions within that agency.

In this process, several outlines were made of key dimensions. It became apparent that there was a hierarchy of dimensions in which certain ones, primarily agency mission and leadership, controlled how other dimensions affected conceptualization and implementation of DN. When the key dimensions became clear, they and the related data were assembled under subheadings "Internal Workings of the Organization" and "The Agency and its Environment."

Both the definitions of prevention and the organizational dimensions provided the framework for analysis. That each agency's conceptualization of prevention roughly paralleled both the public health and the social work continua of prevention conceptualizations provided the larger frame for the analysis. Within it, the differential outcome of each dimension was discussed in relation to implementing DN. "Ideal type analysis," then,

enabled the creation of a taxonomy based on the continua of definitions and the differences in implementation of the prevention program. Each of the three agencies represented an "ideal type" agency; that is, an agency at a point along a continuum of conceptualizations of prevention and ability to implement a prevention program..

Presenting the Findings

The findings are presented primarily from the perspective of administration and staff, using their own words and displaying the raw data as much as possible. There is extensive use of excerpts from the interviews, to illustrate data collection methods, to highlight the central findings, and to convey the substance and complexity of conceptualizing and implementing a prevention program as perceived by agency personnel.

References to individuals, communities, or situations, which would violate the anonymity promised interviewees, have been deleted or disguised. No actual titles of administrators or others have been used for the same reason.

Extensive quotes are used in the findings sections in order to communicate the complexity and subtlety of the interplay between organizational factors and the way that personnel think and act. As a result, quotes are sometimes quite long. Because the interviewees often struggled with how to articulate their thoughts and experiences or paused

and changed directions, raw verbatim quotes are often unwieldy and sometimes confusing. Therefore, quotes were edited considerably to make them easier to read and to clarify the major points. Editing did not change the respondents meaning; it merely removed the "ums", "I means," "You knows," repetitions and extraneous, parenthetical comments not directly related to the subject under discussion.

Organization of the Findings

After a false start in which the cases were presented in continuous case comparison by each organizational dimension, a decision was made to present each case separately. This decision is consonant with the findings themselves in that the conceptualization of prevention is the major difference between the agencies and that it, along with the related organizational dimensions, particularly agency mission and leadership, determined their implementation strategies. Therefore, the findings for each of the agencies, were presented in the order of the continuum of existing prevention definitions, one case at a time. While constant case comparison highlights smaller differences more clearly, it fails to develop a holistic picture of each agency. Too, this case by case presentation prepares for the presentation of "ideal" cases in the Conclusions chapter.

Summary and Overview of the Cases

The three agencies studied each engage in prevention activities. They each implemented Discovering Normal during its formative evaluation. However, mission and other organizational features characteristic of each agency affected how the program was implemented during these pilots and whether or not it was institutionalized as an agency program once the pilot tests were completed. Despite their designations as alcoholism, child or family agencies, all three agencies addressed the needs of children and their families. However, the initial starting point--the adult, the child or the family--varied from agency to agency. The three agencies had two major areas in common. These were their interest in alcoholism and alcohol abuse and its effect on children and their willingness to pilot DN.

Unrelated to their differences in focus or these commonalities, the three agencies represent "ideal types" along a continuum of prevention definitions that closely parallel the public health model of primary, secondary and tertiary prevention. Each agency's mission statement reflects, as do the interviews with administrators and staff at each agency, the vision and definition of prevention held by each of the three agencies that were studied.

What follows is an overview of how the findings for

each of the cases will be presented. It includes a summary of each agency's definition of prevention to place each agency along the continuum of previously formulated public health and social work definitions. It also includes an outline of the dimensions that emerged from the study of each case; that is, the significant organizational factors that determined how prevention was conceptualized and implemented at each agency.

Prevention in the three agencies studied is defined as either:

- o a mix of treatment and education with amelioration as its goal (AA);
- o early intervention or "reactive prevention" with reduction in the prevalence of a problem (CA); and,
- o providing service before the onset of problems toward intergenerational change or primary prevention to reduce incidence (FA).

This roughly parallels the public health definition of tertiary, secondary and primary prevention. The reactive and proactive definitions highlighted in the work of Borkin and Siegel (in Bowker, 1983) are also paralleled by the CA and FA respectively.

Chapter Four, Case One, Reducing the Pain, reports findings from the AA whose use of DN may be seen as closely allied with "tertiary" prevention. Chapter Five, Case Two, Healing the Wound, reports findings from the CA, an agency whose work with DN closely parallels "secondary" or "reactive prevention". Chapter Six, Case Three, Breaking the Cycle, reports findings from the FA, which parallel

"primary" and "proactive" prevention."

Each case begins with a physical description of the agency, its organizational structure and mission. These descriptions affirm the notion that agencies have a particular environment--social, physical and operational--that:

influences the nature and quality of the services provided by its staff. By "environment" is meant not only the physical setting but also such aspects as purpose and sanction, regulations and procedures, and social climate or atmosphere. (Maluccio, 1970, p.156)

This is followed by definitions of prevention formulated by administrators and workers. Each agency is distinctly different from the other. Within an agency, similar definitions can be heard in the words of administrators, development personnel and the workers. The more strongly an agency's mission is articulated by those in leadership positions, the more clearly a similar definition is expressed by other levels of staff within that agency and the more clearly prevention goals are communicated to staff.

The internal organizational factors related to this conceptualization of prevention and to the implementation of prevention programs are presented using the following dimensions:

- o Leadership and the Interpretation of Agency Mission to Staff
- o Flexibility of Organizational Structure
- o Intra-agency Communication and Cooperation (Internal Turf Issues)

- o Flexibility of Staff with Respect to Technology
- o Research and Evaluation

Those dimensions that pertain to the agency in its relationship to the external environment--potential clients, other agencies and funding sources--are presented next using following dimensions.

- o Social marketing
- o Relationships with Other Community Agencies (External Turf Issues)
- o Response to funding constraints

A final dimension defies categorization because it neither belongs with the inner workings of the agency or the organization's relationship with its environment. It is--Commitment to Social Change. This dimension is integral to social work and, therefore, to any discussion of prevention activity. Indeed, this dimension captures the meaning to practice of each agency's conceptualization of prevention and implementation of Discovering Normal as a prevention program.

Each chapter closes with a summary noting any unique aspects of the agency and any unique occurrences encountered in the process of implementing DN.

There were three objectives for this chapter. The first was to explain the theoretical and conceptual underpinnings of case study and ideal type analysis, the methodology used

in this study. The second was to describe the procedure followed in conducting the study. The third objective was to give an overview of the findings chapters which follow.

CHAPTER IV

CASE ONE -- THE AAReducing the Pain

The Alcoholism Agency (AA) is located in an urban center outside of a large, Northeastern metropolitan area. At the time of the pilot evaluation, the agency was housed in a slum building on a dark side street just off of a well-traveled downtown avenue. Clients and staff used a rickety elevator to reach the fourth floor offices of the agency. The alternative, a dark, uninviting stairway, appeared to be more dangerous than the elevator. One agency worker described the the building as "druggy." Indeed, people loitering on the street floor presented a frightening obstacle to reaching the agency upstairs.

On the fourth floor, offices and group rooms were located along one long corridor painted an institutional green. The walls were hung with posters taped to them that displayed messages about fighting alcohol abuse, the dangers of driving drunk and recovering a future. The receptionist appeared to be protected from clients. Her office was separated from a small waiting area by a window with bars. The group room in which DN was presented was large in size. It contained a sofa and mismatched vinyl cushioned chairs. While it also contained equipment such

as easels and flip charts, it felt less than full even when facilitators, clients, and an observer were present.

Clients who participated in DN were 80% AfroAmerican which reflected the population of the agency and, probably, the agency's catchment area. While the physical aspects of the agency were typical of underfunded, demeaning surroundings often associated with services to disadvantaged client groups, the warmth of the staff and the camaraderie of the clients and staff mitigated the depressing surroundings. The director of the agency greeted clients by name and took the time to talk with them. She had long been negotiating for new, more adequate space. By the time the interviews reported in this study were conducted, the AA had moved to new, light, airy, spacious surroundings in a well-kept, well-located building that also housed many other community services.

The AA is licensed as a treatment agency through its state's division of alcoholism. Originally, the AA was under the auspices of a county community opportunity program, the fiscal agent of the social services department. In conjunction with its move to new quarters, it is now associated with a local hospital, serving as its outpatient alcoholism service. This offers the AA the enhanced ability to obtain increased Medicaid reimbursements and to have an inpatient resource for

detoxification.

In 1986, despite the treatment orientation of the agency, the AA developed a program for young people, ages 5 to 18, whose parents are problem drinkers or in recovery from alcoholism or other chemical dependencies. The program was developed to "break the cycle" of chemical dependency and, while clearly preventive in intention and effect, it is described as including "children. . .in the treatment" of their parents. It was also a means to encourage parents of those children in the program to enter treatment. While this program mainly recruits children of parents in treatment or of those referred to the agency for an alcohol education program as a result of a DWI (Driving While Intoxicated) conviction, it also takes referrals from school counselors, social workers, child protective service and other mental health treatment agencies, a youth committee of the local community service council and a group called Network for Youth. The youth program has become extremely profitable for the agency.

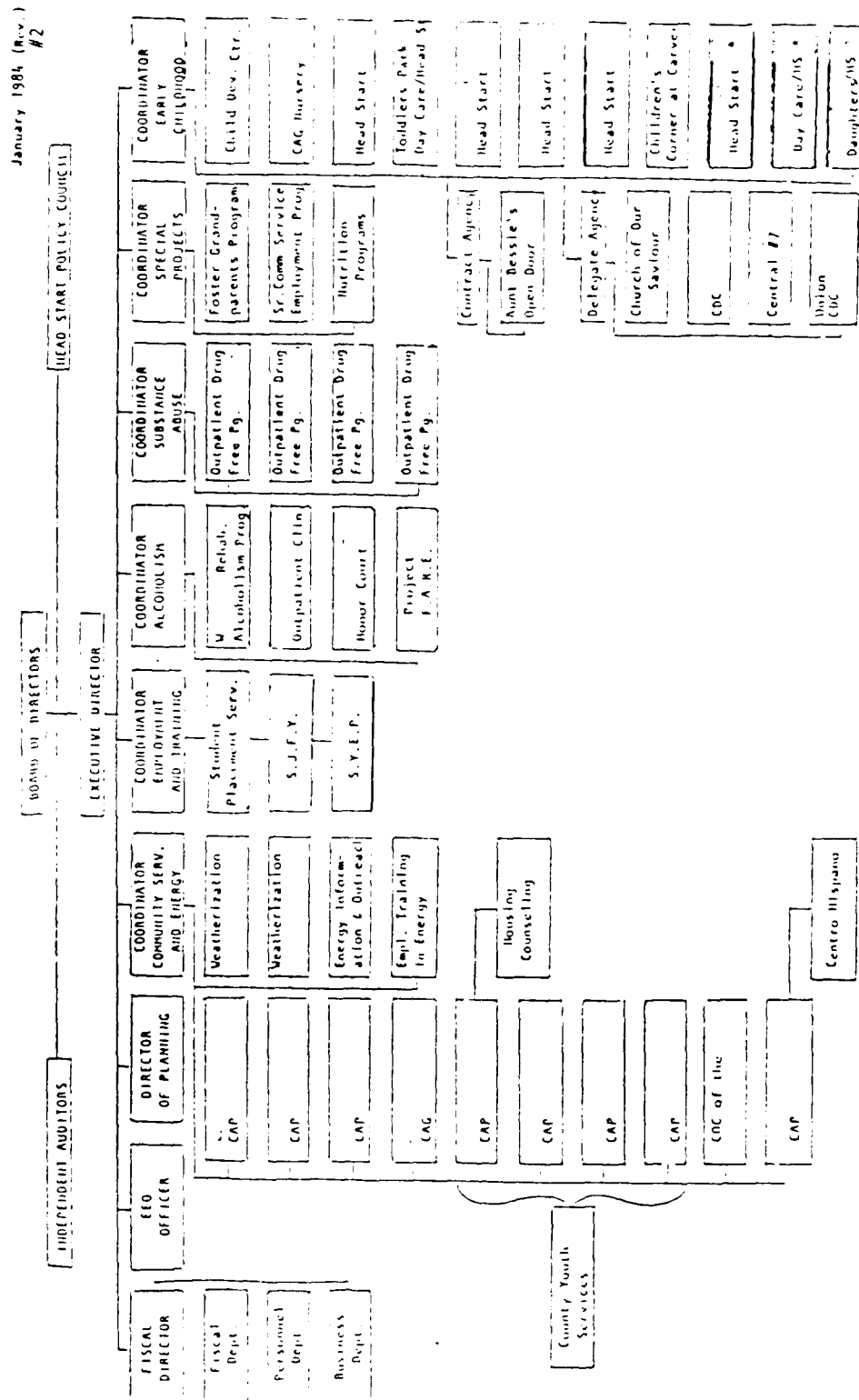
In their new quarters, the AA offers a safe, upbeat environment and a more central location. The other community agencies that are housed in the building include social services, child protective services and mental health. Within the AA's 11,000 square foot floor through space, there are several handsome group rooms, a large

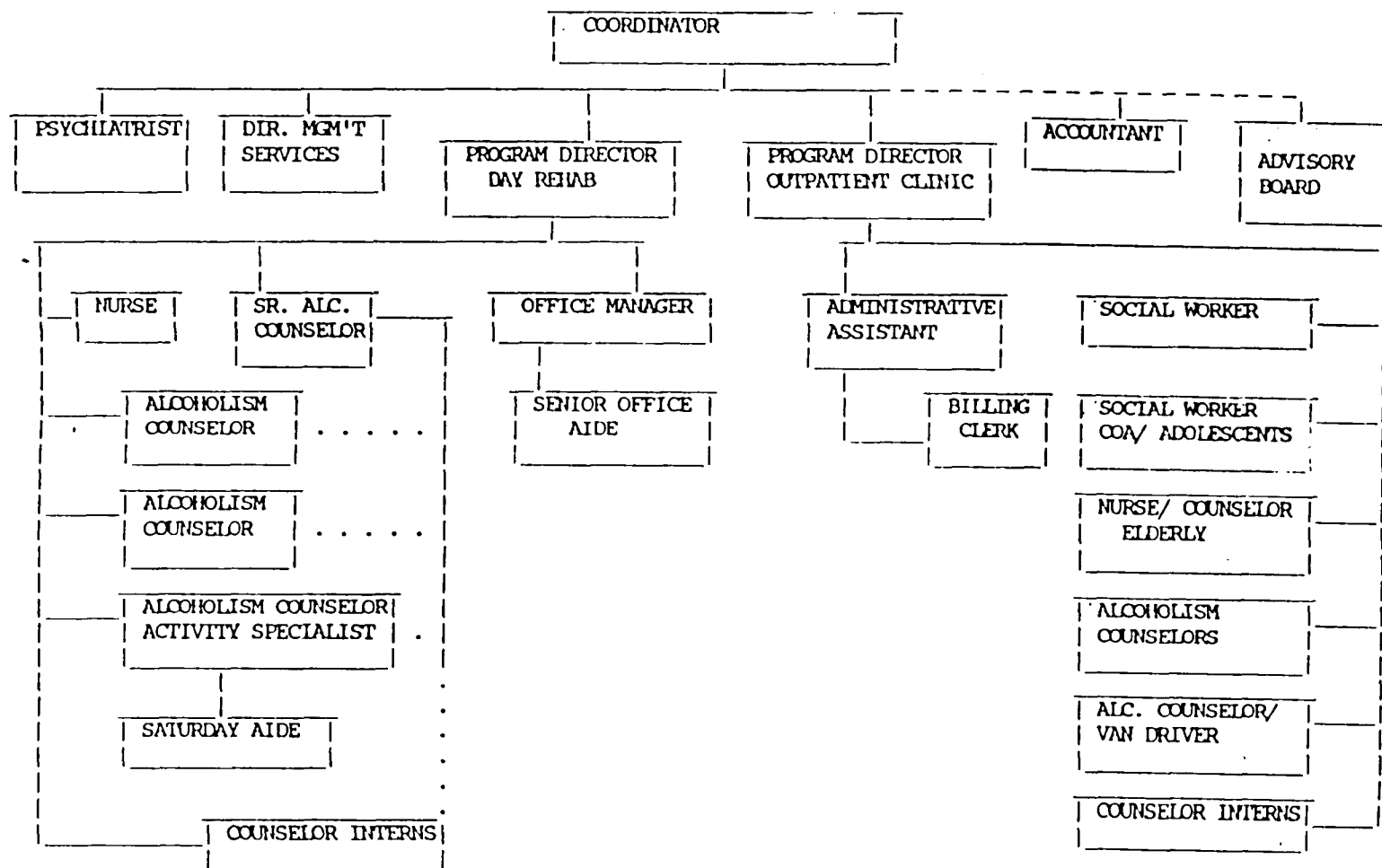
waiting area with a receptionist behind a window, and an "executive suite." Cramped for space in the old quarters, the new quarters offer many possibilities for programming small and larger group activities. Staff members no longer share offices and can offer clients services in an ambience similar to what a less disadvantaged population would expect. While some of the furniture was brought from the former location, everything looks brighter and better. Evident in the responses of the director and others observed in the waiting area, warmth and concern for clients has carried over from the old location to the new one. This is an agency that has fought to provide the best possible treatment services to its clients.

Formal Organizational Structure

The first organizational chart for the AA (below) shows how the AA under "Coordinator, Alcoholism" related to the other divisions of its umbrella agency at the time of the pilot evaluation of DN. The second chart sketches out worker positions, or summarizes them within one box. Boundaries for programs are not shown and the children's program does not warrant its own spot.

The AA and Its Relationship to Its Umbrella Agency





The AA, Outpatient Clinic
and Day Rehabilitation Programs

Mission

The AA most closely conforms to tertiary prevention in that their primary goal is to prevent relapse by providing treatment and other ameliorative services to those who already suffer the disease of alcoholism. In the words of a worker, the AA's mission is to help clients "get or stay in recovery." Their mission statement says,

"Traditionally alcoholism treatment has focused first on the recovering alcoholic/addict and second on the spouse or parent. But it is only recently that children have been included in the treatment."

Indeed, the focus is treatment to limit the effects of the disease. Since the agency adheres to the disease theory of alcoholism which holds that there is no cure, it is impossible to state that treatment reduces prevalence. That alcoholism is believed to be genetically transmitted casts the work with children of clients as also ameliorative (tertiary prevention). However, the AA's work with children of clients also may be interpreted as a preventive effort to reduce the incidence of alcoholism (that is, accomplish primary prevention) or to reduce the prevalence of problems related to parental alcoholism.

Definition of Prevention

The AA is at the far, or "tertiary" end of the prevention definition continuum. At the AA, prevention is defined as part of ongoing family treatment and amelioration of alcoholism with the "prevention part" delivered primarily through education. Prevention in the form of education is seen as an adjunct to treatment. The work of the agency centers on reducing the effects of the disease. Glimmers of more wide ranging notions about prevention are seen in the words of various agency personnel, but they are fragments rather than a fuller conceptualization of prevention. While the high quality work accomplished at the AA is performed with commitment, it is conceptualized primarily as part of treatment.

When asked, "How would you define prevention in a way that is meaningful to the practice in your agency?," most respondents had to stop and think. Often, they reflected that this was a very good question as they bought time to come up with a response. An administrator said,

Prevention is--. I see it as the sharing of knowledge and that's usually through education. I guess I pretty much see it as education, sharing the knowledge so that clients know where to get the help when they need it. Its educating them about the disease of chemical dependency and alcoholism so that they can pass that on to their families, again, pass that same education on. We try to alleviate addiction, you know, within their families.

The problem of alcoholism is always present and recovery is an ongoing process. The goal is to lessen its impact which can be primary prevention or early

intervention when children are the focus. The same person gave the following example she felt was typical of her work:

I did a piece at PTA (Parent Teacher Association) on COA. . . .The school was like why do you want to talk about children of alcoholics in an elementary school? After the meeting, I had three parents come to me in tears and say, "I'm an ACOA. Everything on that film that you showed looked like my family and I'm in pain." --So, its that kind of thing. Its overwhelming. That's prevention. I do prevention nonstop, everywhere I go. And a lot of my staff do the same.

The same leap to early intervention (treatment) is evident also in the words of another administrator, one of the facilitator's of DN, who sees education and prevention as part of treatment:

Well, these children would be the future alcoholics or addicts of tomorrow. So that that's one aspect. But also, just the emotional, their mental health. Understanding, having a chance to talk. We're preventing them from all the illnesses and emotional problems that children of alcoholics or addicts have. Its a sad thing with the population because we're mainly working with children of addicts. There's a big crack problem in (our city). Most of the children are living with grandparents. They've been exposed to so much. They're--its a sad thing. I know they've been compared to holocaust victims. And I really think the intensity from the time they are born is, I mean, we're working with, like, post-traumatic stress disorders with these kids. So, I'm not saying that the program is going to change the world or anything like that, but that's why I think the attendance is so good. It means a lot to them.

These words are more reflective of secondary prevention or reducing prevalence of problems related to living with an alcoholic parent. They also fit Borkin and Siegel's

social work definition of "reactive prevention." (Bowker, 1983)

At the AA, workers below the supervisory level are less clear in their definitions of prevention. Indeed, they do not define their work in terms of prevention despite their assignment to the children's program. One worker said:

Prevention means education and awareness: tools to cope with challenges and . . . (unintelligible) in an area that (has) primarily a population infested with drugs They don't view their surroundings as anything unusual. And that is part of the awareness and education. . . . I think the people need to learn to cope with the environment. And to participate and use whatever is there that helps them.

While there are glimmers of a more encompassing definition of prevention, it is fragmentary, not part of a shared conception. This worker goes on to explain that as "education and awareness," DN should be mandatory to "educate parents to stop the cycle" as "part of the prevention package for children." Another, who co-facilitated DN, said:

I guess I don't think of it so much as prevention. I guess I don't think in those concepts. So I think of it more as therapeutic. If I can get them to change a little bit of behavior. You know, I consider that therapy. I think (of) the word prevention related to kids, and I think about that more to educate them about alcoholism and drug addiction so that when they are confronted with it, you know--. I think seven and eight year olds are a little bit away from that, but then I find out, every week, that they are not. . . . I see the education part as the prevention part. And I see the therapeutic part as the child getting to talk about his feelings and know what a feeling is.

These worker's definitions of prevention may also

reflect that the state-of-the-art in alcoholism services uses an ameliorative or rehabilitative model. One is always in recovery, in danger of relapse. The goal of preventing relapse adds to the lack of clarity about what prevention truly is. In the words of an agency administrator:

We keep clients in treatment after they get sober because we want to prevent them from relapsing. You know, so people will say that's the aspect of treatment. And somebody else will say well that's prevention. A relapse prevention group. I mean that's a clinical treatment group. But the emphasis is on preventing another episode of chemical abuse. So that we build in prevention.

While planning includes prevention activities, the focus of professional and self-help treatment on relapse prevention may account for this muddled notion of therapeutic prevention similar to that expressed by Florence Haselkorn, "in social work's ounce of cure lies a pound of prevention" (1967). Too, the AA deals with a disadvantaged, inner city population where problems of addiction are complicated by poverty and related social ills.

The Internal Workings of the Organization Leadership and the Interpretation of Agency Mission to Staff

The AA's mission to provide treatment to combat alcoholism and other addictions is clear. Yet, the top administrator has broadened services beyond this mission

through the addition of a program for children. It was within this program that DN was piloted. While the agency mission continues to embrace treatment, its administrator articulates a prevention goal, and actualizes it through children's groups and the parenting program. Yet, the relationship of these programs to prevention and to treatment is ultimately unclear.

Well, technically, being a licenced treatment program, technically, we're not prevention, but being the only licenced treatment program in this catchment area and in (this city) which is a community that is so desperately in need of services, and there not being a licenced alcohol and drug prevention program, we have taken on the responsibility of doing a lot of that. A lot of that (is) my own personal philosophy as well as (a) commitment that I don't think we can do treatment without doing prevention. And when I ventured into opening up our service delivery system to include the family, the significant others, and especially the children, then we knew we knew we were embarking on prevention automatically. The work we do with children and families is prevention. It is treatment to the point that they are codependents, but our goal is also to prevent children from becoming chemically dependent But our philosophy as a program has been educationally based. We do a lot of education. The family ed. series. . .chemical dependency education that we do, so that some clients that are referred here that normally would probably not end up at a treatment program, would say that we don't have any real conclusive evidence that they have a problem I would say that they need to be here for prevention reasons.

This administrator's interpretation of mission enabled the hiring of someone who shared the same vision:

And, we were doing a lot of family work in our agency. So, actually, with the children, there is an element of prevention there because, alcoholism, chemical dependency is a genetic, you know, can be inherited, so we were definitely trying to prevent them. We know they'd be the future alcoholics or drug addicts. We are a treatment agency, though. We're licensed by the Division of Alcoholism as a treatment agency. We're

not on any grant. We get paid fee for service, for treatment, so, basically, we're treating the effects of living in a family with alcohol and drugs, with addicted parents. So that was our primary thing. Whereas the prevention was something that was, you know, something that came along with the package. . . .

I don't think that many agency directors are like (mine). I mean most of them, they're interested in productivity, the children's program, particularly in the alcoholism, the drug field. . . (is) not seen as a priority. The priority is the alcoholic or the drug addict which, certainly, is a priority in most programs. But, she and I feel also that the children are the most profoundly affected. And they're the future alcoholics and drug addicts. I feel very strongly about this. And luckily I have her complete support.

The AA's Children's Program was designed primarily for children of its treatment clients. However, its excellent reputation has attracted other children, brought by those already in groups and referred by teachers and other community sources. The fact that it may receive the largest amount of reimbursement of any agency program helps its ongoing evolution and expansion. While the AA articulates a definite prevention philosophy and accomplishes prevention work, it is limited by the necessity of its treatment focus.

Flexibility of Organizational Structure

That DN was implemented within a "treatment" context, so constrained it that there was little spillover of it as prevention to other parts of the agency. Indeed, although DN was seen as a useful addition to the Children's program,

it was not offered after its pilot evaluation. Instead, workers who facilitated DN reported that they use parts of it in treatment of individual clients rather than offering the program in its entirety to existing or new clients.

Participants for DN had been recruited from within the agency to offer additional treatment to those who were already clients of the agency. Perhaps clients new to the agency were not recruited to avoid a massive amount of work to satisfy the agency requirement that all prospective clients undergo formal assessment.

There was little evidence of flexibility of organizational structure at the AA. Occasionally, temporary loans of treatment people were made to the Children's Program. Generally, the division between treatment and education did not permit crossing over from one service to the other. Those who worked in treatment resisted assignments to children's groups. Despite this rigidity, new programs apparently cause some shifts in an agency.

We have more staff members in the ACOA program. I don't know if it (relates) directly to DN, but it probably played some part.

With the move to new quarters and the increasing commitment to educational programs, there was a push to hire more staff and to assign more staff as group facilitators in the Children's Program.

Intra-agency Communication and Cooperation (Internal Turf Issues)

At the AA, treatment services are kept very separate from those based on psychoeducation.

Well, I've only been full time for a year and I was a student and a part-timer (in the) the family program. I would say the place is divided off into. . . . two (parts). The family program is (a) DWI family program. . .and there's a chemical dependency. (My supervisor) does an education (piece). . .she does a session on alcoholism as a disease concept. . . .The other part of the clinic is. . .I don't know too much about the rehab. . . .

There is a lack of permeability between clinical and educational services along with a weak formal structure for communicating between them.

Flexibility of Staff with Respect to Technology

Resistance from treatment staff to working in the Children's Program was reported. However, there is a shortage of staff and a large client base. An example of a clinician overwhelmed by case responsibilities may explain a part of this reluctance. Often, student trainees and volunteers are used to co-lead groups. A new, male worker was assigned to co-lead several groups. The following conversation about social workers' preference for treatment was a response to a question about the kind of work most agency staff prefer.

To be therapists. Yeah, rather than all around social workers I remember in school, if we ever had a class in community organization or anything like that,

they'd come out during a break, you know, "BORING. This is awful. Can you believe how terrible it is?" And I was loving it. And it was like a required course. And I couldn't believe they had such a negative attitude. They were there mainly to become therapists and have private (practice). I was at (a social work school with reputation for its focus on clinical work). Very clinical program. . . .And what my idea of being a social worker was like working in a welfare agency. That was what I had in mind. And, I think I was the only one at (the school). So anyway, what happened is, its very intellectually stimulating. I was taking advanced psychopathology, borderline psychology and you get caught into it. And I loved it. . .but then, when I went to work, I reverted back to my true character. (laughter). . . .I like a combination. That's why I would never give up working directly in the children's groups and just do the supervision. I like to be in there in the group with the children. I also like to do counseling. So, and I have a few clients. I always try to keep the balance. . . .I think the reason the children's program is a success is because they got a person in there who really wanted to do it and I was able to do not only clinical but the development, curriculum, the outreach. And I have the support of my administration. Good combination.

Research and Evaluation

Administrators conveyed a sense that DN's implementation enhanced the agency's reputation in the community. Apart from the evaluation that was part of the pilot, little was said in response to questions about the AA's evaluation of its programs. Rather, the agency appears to respond to outside requests to try things out, but does not have a research agenda of its own.

However, this is an agency in transition. It recently absorbed a change in auspice and location. As one worker reported, she and her co-facilitator had planned to present DN at a staff meeting, but the AA's move to new quarters "disrupted everything."

The Organization and Its Environment

Social Marketing

The AA presented DN to existing clients with whom they felt it was quite successful. When asked if they would use DN to attract new clients, the reaction was one of thoughtful surprise.

Yeah. We could do that. That would be an idea. . . .We could spread the word to some of the other agencies that we were doing this family program.

One worker attempted to explain the reasons DN was not used to recruit new clients:

Maybe she didn't do that because the people--because of that rule about the people having to become part of (the agency). So there might have been an issue where you couldn't take a client from another agency section. . . .I'm not sure it was a rule. But I do know that we were doing intakes of therapy that eliminated, and maybe people. . . .I don't know. Maybe it was too much trouble. Maybe it would have taken a lot of research. You have to clarify that with her really. But I'm sure there were some external reasons for it.

Too, there was some question that was raised about whether DN, without either modifications or different facilitators was sufficiently sensitive to the AfroAmerican culture of the majority of the clients.

Relationships with Other Community Agencies (External Turf Issues)

In an article published in the local newspaper, one of the facilitators painted a positive picture of interagency collaboration. She wrote that referrals to the agency come

from school counselors, social workers, Child Protective Service and other mental health treatment agencies.

Often children are seen by several agencies, and we do conjoint treatment. (The city) is fortunate in having a group called Network for Youth which is made up of people from various agencies who collaborate on difficult cases. We also have an excellent Youth Committee which is part of the Community Service Council. This organization also brings the treatment community together in (our city).

AA administrators gave examples of struggles with other agencies in the community and also of cooperative work:

We just started a pilot, well we didn't start it. There's a pilot, its between (us), child protective service, a mental health agency and the department of health. And its for high risk, women, drug abusers. And, what we're trying to, we're going to meet twice a month and carry these cases in common so that they're not going to slip (into) the cracks. So if a woman is referred, you know, the call comes in through the child abuse hotline, we tell them that this is a pilot and they know that their case will be part of this joint group. And, so we're just starting that May 1. . . .So that's preventive programming.

and

Also a lot of times, what is happening is that they would be referred to mental health which certainly they have mental health problems, but if they're drinking or using drugs, they need very specific treatment. And so, and it was just a mess as far as the coordination goes.

When an outside agency with authority requires coordination of services, agencies may more readily be able to work together as is evident in the following:

Well it came from the top. (laughter) So, it was the Department of Mental Health, I think that orchestrated it.

On the other hand, many attempts to work together met

with opposition as in this attempt to obtain referrals of women who are drinking when pregnant. When asked if the resistance encountered was related to " turf kind of thing," an administer said:

I wonder. . . I wanted (a staff member) to go to a couple of meetings. There's a task force and I just got the notice of the meeting again. So I'm sending (a staff member) to the meeting. And they may just talk about teenage pregnancy. And you just sit and listen for awhile and, every opportunity you have, you remind them about the chemical use. I don't care if they send them here or where. Acknowledge that these women need treatment for that too. So I just wrote a small grant. March of Dimes is giving money in order to increase the number of healthy births. And one of the categories they were looking at was, to women who are substance abusers, young teenage parents. And its just like four or five thousand dollars so I just wrote a proposal to get some dollars to do some education around that issue, with teenagers mothers, around alcohol and substance. But the resistance of the coordinator of that project was UNBELIEVABLE.--I've seen her at a couple other meetings and, whenever, its "I'm going to call you." "We've--we gotta reschedule," "We gotta meet," "I have so many women" and all of this. I say, "We'll come to you." I have sent workers to the hospital to do outreach. To the health center. For two years, I had a worker assigned to the health center a half a day and had her assigned there two days. I cut back to two half days, then I cut back to a half a day. But the health center was saying we have so many people walking in intoxicated. All these people and they never send them to us. Again, you know, they can treat them and I can treat them on the same day and medicaid'll pay for both of us. So what's the problem? We don't do health care. So we're not going to take over. Even being being part of the hospital, (the hospital) is not licensed to come in here and do primary health care. So we're not going to do that piece of it. So what's the problem. I don't know.

A program for pregnant teens that lowers the possibility of FAS (fetal alcohol syndrome) is essential. Yet finding a way for a health agency and a substance abuse

agency to work together is difficult. Cooperation is problematic although both agencies can see the same patient on the same day and each receive reimbursement for treatment.

Responses to Funding Constraints

One prevention grant possibility was alluded to at the AA, namely the program for pregnant teens who abuse alcohol with the March of Dimes. Fee for services, rather than grants, appear to be the major source of funding.

One reason for the change in auspice from a social service bureau to a hospital was to increase medicaid reimbursement which went from \$34 to \$69 dollars per visit. Upwards of seventy children a week are seen in the COA programs for "treatment" related to living in an alcoholic family: "Even tho not a priority, a money maker." " A lot of income into the agency."

Commitment to Social Change

Social action is undertaken at the AA. The agency administrator describes her work:

I do two to three lectures a month, be it the community, the county or through out the state, and several times a year nationally, about prevention. A lot of the prevention piece that I do is prevention of chemical dependency in African American communities cause (our city) has a large African American and NO ONE is doing prevention from a culturally based model. Most of the children in our program are African American children so I have a personal commitment and interest from that standpoint.

I think we need to be, on all levels, doing education and campaigns. I'm about to write an article about this new Powermaster brew that's coming out. And, (at) every level, I've been speaking out against it, about the billboards in the community. Every level of education. Every substance task force that's in this community, or in this county, I probably have served on in a prevention role. And that's what it's all about. Education, being the voice for our patients, being the eyes and ears for our clients. They don't know what's harmful. We do. We have to be the ones out there. To lobby for or against the harmful elements. Cisco. Cisco is sold in the grocery stores here. The little bodegas, the little community grocers. 20% alcohol and it's marketed as a wine cooler. You go across to the white neighborhood . . . you don't find Cisco at all. Just here in the Black community. Kids can just walk into a store and buy it like soda pop, you know. So I had to scream up and down and make copies of articles about it and circulate it and do that. That's prevention. So there's lots of pieces we can do. We just got to realize that that's our responsibility.

While this involves advocacy on behalf of clients using a prevention strategy of supply reduction, the AA's overall definition of prevention, is most consonant with that of limiting the effects of a disease entity through treatment, that is, tertiary prevention. The "education part," is called prevention and it is reactive. Yet, when education is defined in relation to children and "breaking the cycle" of addiction, there is a glimmer of primary or proactive prevention. On the whole, however, prevention is not conceptualized clearly. It becomes a vague term that is applied to many activities and strategies of the agency. The problem of addiction is not located exclusively in the client or in the environment. Rather, like the conceptualization of prevention, problem formulation is somewhat fluid.

Summary

The unique qualities that support the level of prevention efforts in this treatment agency are found in leadership's expansion of the AA's mission--the commitment to the whole family which brings a prevention dimension to the work with children.

Too, the AA is a relatively new agency, and it is at a transitional point in its history in a new location and under new auspices. It is also developing a culturally-based model for its work with the AfroAmerican community despite limited staff and limited financial resources and overwhelming need. That reimbursement is for treatment obscures prevention efforts and prevents commitment to the kinds of prevention strategies that might affect all parts of the agency. The limiting factor, indeed, is that prevention must be conceptualized as a part of treatment.

Contact with the AA approximately one year after the interviews reported in this chapter revealed that the agency has several new, large grants to work with a homeless, addicted population. There have been no new efforts to offer DN.

Chapter V

CASE TWO -- THE CAHealing the Wound

The Child Serving Agency (CA) is located on the outskirts of a highly urbanized city. It recently constructed a new building which allowed housing three once separated services in the same structure. It consists of a therapeutic nursery, Outpatient Services ("the core of the agency which treats children with mental health problems") and a Community Services which has provided consultation and education for 18 years. This unit recently began to offer groups for children whose families were undergoing divorce or had been identified as having an alcoholic member. Traditional parenting classes are offered also. Generally, they are contracted for and presented out in the community.

The three different services are located on separate floors. An elevator or staircase serves both to access them and to keep them separate. While the other services are focused on treatment, Community Services, in which DN was piloted, tailors the overall agency mission of early intervention to "promoting healthy child development through work with parents, teachers, health care providers, supervisors and managers who affect the lives of those who work with them." Community Services provides preventive

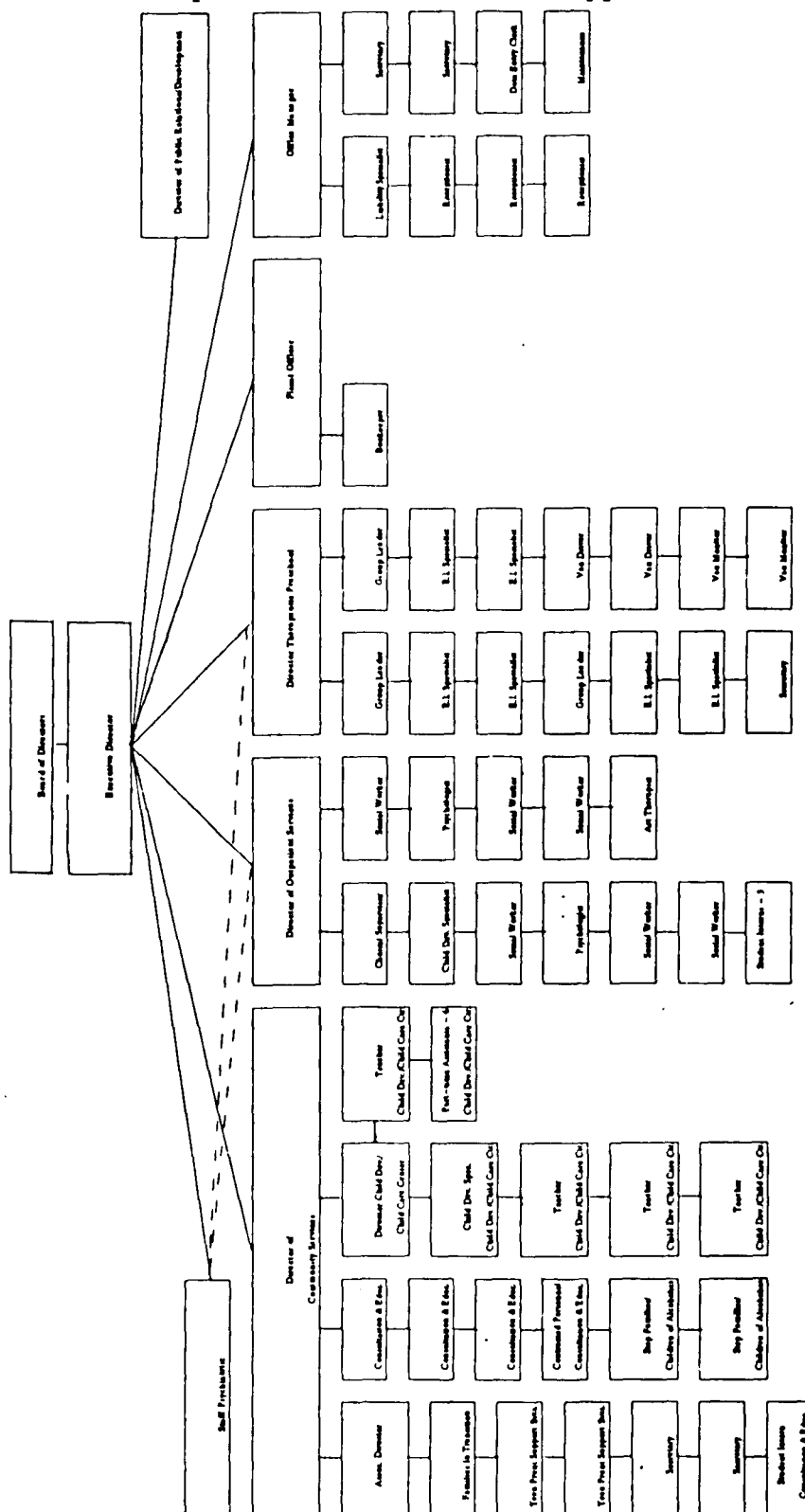
mental health services.

In contrast with the AA which was teeming with clients, the CA was quiet, orderly and serene. There is a formality to interactions. Appointments are carefully scheduled. Professionalism and caring were evident in the helpful, responsive reaction to the pilot implementation of DN. Yet, the same desperate concerns about financing programs and services encountered at the other agencies are also evident at the CA. The overall atmosphere, however, is one of calm and orderliness.

The CA is licenced by its state's Department of Public Welfare, Office of Mental Hygiene. It is affiliated with its county mental health and mental retardation Program. A private, nonprofit children's mental health agency, it was founded in 1957 in another area of the city.

Formal Organizational Structure

The organizational chart for the CA (below) vividly displays a hierarchical, departmentalized structure. Programs and functions are alluded to in the entries under Community Services. Yet, the number of staff, their assignments and reporting relationships keenly reflect divisions and controls within and between departments.



Mission

The CA mission can be inferred from its statement that "The power of prevention builds upon itself as more and more people learn about healthy emotional development and early identification of potential problems." Its formal statement of mission is "to identify and treat emotional difficulties in children from 2 to 18 years of age in order to prevent mental health concerns from becoming crises. The treatment plan always includes parents. . . ." This agency recognizes that most problems that families encounter affect children. The Community Services division of the CA identifies these problems as transitional phases and seeks to offer services to children and their parents, at the earliest possible moment after a family trauma is recognized. The CA, then, seeks to reduce prevalence, a "secondary" or "reactive" prevention effort.

Definition of Prevention

At the CA, the definition of prevention is closely aligned with their expressed mission of providing service for the emotional difficulties of children "in order to prevent mental health concerns from becoming crises." Prevention at the CA has clarity: It is defined as intervention at the closest point to a trauma or crisis and it is implemented primarily through Consultation and Education services and the specialized programs around loss both of which are housed in Community Services. That the

program offered has to do with the lives of children, particularly young children, defines it for many at the CA as prevention.

As at the AA, education is the "prevention part." At the CA, however, education is generally used as an early or reactive intervention to prevent further damage in families made vulnerable by a specific crisis such as divorce or alcoholism.

As at the AA, CA personnel also were surprised by the request that they define prevention. Despite the need to come up with a definition on-the-spot, there was greater consistency between each staff member's definitions than there had been at the AA. The long time administrator of Community Services, an educator by background, responded:

Oh, wow, what a wonderful question. I've never tried to do that. It is that which takes a vulnerable family and makes them less vulnerable in the future or takes a family that is fairly healthy and prevents it from being vulnerable at a later time, or prevents the children from being vulnerable. When I say vulnerable, I mean we make them less vulnerable to mental illness, less vulnerable to addiction, less vulnerable to suicide. . . .I think that any family led by parents who are COA who have not had significant treatment or help in plugging the developmental losses, I think are probably fragile, what I call fragile parents. And, if we can help them see where their developmental losses were, and if we can re-parent them to some extent, they have to be more adequate parents in the end. Vulnerable still, but less vulnerable, I think.

The facilitator of DN with a masters degree in marriage and family counseling gave the following definition:

Prevention for me means educating people, educating someone about what we know about what happens with a certain kind of experience. Where that leaves one vulnerable. Where that leaves one or one's children more a risk. Because of the vulnerability, because of

old wounds. And giving them some support and encouragement to have that awareness to not judge themselves, you know, finding some ways to help them look at it and not club themselves over the head, but move forward, get more information so that they can make more sense of what they've come out of, what they are in now, what they may be providing. You know, what's the environment they have created for their kids. And giving them some more choices about what they want to do. So that they expand, you know, and expanding their repertoire, for how they are parenting or how they are going to look at a particular problem or particular experience or what have you. So that there is some kind of breaking up of old pattern or helping people get unstuck because they have had some supportive kind of validating kind of experience that's not judgmental that gives them the energy to really take another step forward and look at some things that--they might not have even been aware of. They might just be starting to be aware that they ought to be taking a look at. I guess that is what prevention would mean.

When asked how her definition fit DN, the worker responded,

It does require that a parent already identify themselves as an adult child or an alcoholic or of a dysfunctional (family) or some other kind of dysfunction. And starts to give them a place to hookup.

While she clearly states what this activity will do for the parent, it is not immediately clear how it will help his or her child; that is, what will be prevented.

The second facilitator, an MSW, defines prevention more specifically and also stresses the goal of intervening as early as possible. She adds a statement that recognizes the possibility of prevention before the onset of problems.

I'd like to get in there before the person's 30, before the person's 35 and going back and digging through all the debris. I think when you help a person, the closer

you are to the wound, the better you have a chance of actually healing it. Not just slapping on bandaids or helping the person just cope. So, prevention is if you can give the parent information that will literally prevent the wound in the first place. If you've got an alcoholic parent, this isn't even just alcoholic parents. . . .Lots of things that parents do are exercises in demoralization and in wounding of the self-esteem. So prevention is how can you inform parents so that they do what they intend to do in the first place which is to be the best parents they can be. . . .So, first level prevention is to prevent the emotional scarring in the first place by educating and helping the parent. Then I guess, second level prevention would be stopping it as soon as possible.

A public relations person affirmed that prevention at the CA takes place in Community Services, and she defined prevention in terms of the age of the child affected by the services given.

We call this our prevention department, you know, loosely. And I think (the administrator) and her staff are out in the community presenting many, many programs. Not only those that are held here. . . .And someone said they are trying now to reach the very young children in elementary school because that program could be called prevention. And once you get into the secondary schools it becomes intervention. So that that is stressed in the department with all the programs. . . . And one of our mottos, so to speak, is to be able to identify and treat problems before they become crises. And that would hold true in most of the services here. So you might, in a way, say that all of our services are preventive. But I think that is focused upon much more in this department. And perhaps some of it is unsaid, the nature of the subjects that are presented would indicate that, well, this is the way you do it so you don't have a lot of problems in the future. I can't say that it is strictly preventive because a lot of people who come here for a similar program may have all kinds of different problems. They may be at different stages of their problems. But I think so many of the programs in this department are geared to young children, parents of young children. So in that respect, I think that they might prevent some problems that might occur.

There is additional evidence of awareness of earlier or primary prevention. During a discussion of a priority

funding program from United Way, a teenage pregnancy prevention program was described:

Its pregnancy prevention but. . .its a three fold concept. One is to encourage the teen mother to have training, education, job skills. One goal is parenting and child development. And one goal is an intergenerational goal because what we know is happening is that most of the kids who are teen parents, have parents who were teen parents. And we want to break the cycle. And the only way to break the cycle is to get a better intergenerational communication going. So we've had some success with that. Not as much success in pregnancy prevention as we would like. We've had a number of repeat pregnancies in our program.

On the whole, the CA defines prevention as "secondary" or "reactive." While "primary" or "proactive" prevention is acknowledged and, perhaps, accomplished, early identification and intervention ("treatment") is the primary way in which prevention is conceptualized. This mission and definition of prevention has enabled the CA to choose problems and clients that they wish to serve. Since the focus is on early intervention around specific problem areas, they target a mobile, relatively well-functioning population who have insight into the fact that divorce or chemical abuse might cause difficulties for children. Since DN is seen as plugging a developmental loss suffered by ACOA, it becomes a tool of early intervention with ACOA parents to help them do better with their children. That DN may be conceptualized as a "primary" or "proactive" prevention intervention for the children of these parent is not a focus of their definition.

The Internal Workings of the Organization

Leadership and the Interpretation of Agency Mission to Staff

Community Services is synonymous with prevention at the CA. The public relations/development staff member was asked whether the agency advertises prevention goals. She said:

No, I have not done that except for the fact that we point out this particular department as being concerned about prevention. However, in all of our brochures, no matter what we print anywhere, whether it's in our golf program book, or if it is something for a PTA group, we always state our mission, which is to identify and treat emotional problems in children before they become crises. So that is always up front. But, no, I have not done that.

The administrator of the community services division is very clear about how services are advertised and targeted. She spoke initially about her frustration in working with a disadvantaged population and, then, the relatively more advantaged group seen in the agency:

Yes you look for tiny little steps. And cheer. We do work though with lots of other populations in our consultation and education work. Lots of middle class populations who pay for the programs that we offer. And it is very encouraging to see. Because what we know is that people are marrying later, having their first child later, having fewer children. And these parents that we are coming up with now are parents of what I call new generation: people where there were already lots of two career families, lots of separation and divorce and that sort of thing. Just when those statistics were escalating. So they don't have many parenting models going in. And their own parenting sometimes simply because of family conditions left a little to be desired. And it is wonderful to see them now seeking out the information that they need in order to be solid parents. We do a lot of that. We do a lot of work with parent teacher organizations.

When an agency wishes to target specific problems (such as losses related to divorce or abusive drinking), they can also target specific populations. While staff may be highly committed to program, the programs can easily exclude those populations who have difficulty traveling to the agency. Provision of education and early intervention can become a selective way to offer services. Staff are aware of the ways in which services are targeted. Only when asked directly about the kinds of clients the agency attracts and the kinds of needs that exist in the community, do they talk about reaching a more disadvantaged population who presently do not come into the agency for services.

Flexibility of Organizational Structure

While the CA was able to institutionalize DN, it is constrained by its desire to target the program for a particular population and by its relatively small staff. Over the last 18 years, the staff in Community Services has increased from 2 to 14. Income has increased from approximately \$13,000 to \$85,000. Yet, there was insufficient staff to mount DN as an evening, rather than an exclusively daytime, program. Funding is being sought to hire part-time staff within Community Services to redeploy staff to provide more evening accessibility. There is little indication, however, of agency-wide

flexibility. It is doubtful that DN can be offered to the general population or that staff from other parts of the agency can be used to present it as an agency-wide offering. Indeed, divisional lines are quite rigid. Only clients are shared by services, staff are not.

Intra-agency Communication and Cooperation (Internal Turf Issues)

A lack of permeability between services along with a weak formal structure for communicating is apparent in the words of this CA worker:

There are agency-wide staff meetings, one of which happens today. But that only happens a couple of times a year. Agency wide meetings. So, no there aren't really joint staff meetings. And, we are pretty much different services. This is true. And there are times when we're sharing clients, because I may refer to outpatient or outpatient may, and they do refer to us as well. You know that's interesting because they, I can think of lots of referrals to (other programs) And again, I think it may just be getting it into the stream. I don't personally recall whether or not anyone has been referred to DN. But, there are back and forth in both directions. Yeah, there are. Yeah I do think the commitment is there.

The physical setup of the CA reinforces this separation:

. . .matter-of-fact I feel good because I know, I participated in a number of services in this unit. Now I do parent family consultation, I've done (the children's program), I do DN, I do separation and divorce, I'm involved with step families. So that's pretty good, but that is still Community Services. That's all still the second floor. I have contact with different people from upstairs particularly when I'm referring or when there's that unusual circumstance when you're sharing a client, sharing a case. . . . You know, I do think we do go, we do go our own separate ways. And I, think that, we used to be in three

different locations. . . . It was fairly recent move: Two years so I think that probably more could be done to have us be more aware of what's going. Not more aware. That isn't what I want to say. To be more integrated.

At the CA, inter-divisional referral is tentative, slow to build to a meaningful level, but it does occur. The divisions are quite separate. It takes time to communicate availability of a new program and time to develop cooperation between the different units.

We have gotten referrals from therapeutic preschool. We've gotten referrals from consultation education as well as outpatient. So I think the word is out. And there was some new people that have come on board to outpatient. . . I guess. . . my style is really to do informal networking, that I just try to get around . . . just getting to know whoever is up there. I know the people who are up there, except for maybe some of the new people that come on board, a student or whatever, but they refer to (my program) or I've referred for outpatient services. So there is some carryover. So I think there's some knowledge in the agency itself. I think there are some referrals. And there can always be more. But in general, I think it is pretty good.

and,

Let me see. I don't know. I think that we certainly try to keep outpatient aware of what is being offered formally and informally so that we are getting some referrals.

Flexibility of Staff

Of the three agencies studied, the CA had the least flexibility, perhaps related to the small number of staff in Community Services and the rigidity with which the separate services were brought together under one roof, yet kept administratively apart. Too, the carefully organized and ordered way in which the work of the agency is planned

and executed contributes to maintaining existing structures.

It should be noted, however, that the workers in Community Services are flexible in their way of working and, in fact, believe that their clinical, treatment background is essential for doing psychoeducational work. One of the facilitators described how she struggled to understand the technology when she first interviewed for a position in Community Services:

It wasn't therapy and it wasn't education. I remember her looking real frustrated at me. Because I just didn't get it. And then making the transition, you get all of these -- I think it is changing a little. But when you are in grad school and when you do treatment, you have a certain network of readings and journals and it is very treatment oriented. And you come into an environment such as this one, which is preventive, early intervention. And it is stuff more grass roots, more informal. . . .so that therapists aren't necessarily doing education and stuff. If I didn't have the educational pieces that I have, when I am functioning in a clinical way, I have so much more of a range of what I can do clinically because I now have a stronger understanding of what intervention -- you know, what education is, what's prevention. And certainly being a clinician absolutely you need to do that to do. My advice is I think you need to be a clinician to do psychoeducational kind of work and make it.

Research and Evaluation

Negative notions held by many about research and evaluation with prevention programs is echoed in these words:

The sad part about it between me, you, and the gate post is that you never know what you prevented. See, that's the elusive part of prevention is that you never know what the family would have been without your intervention. . . .

When asked about evaluating DN, the administrator

conveyed that informal means are generally used; that is, feedback about how the program is regarded by the agency staff, by clients, and the wider community is usually sufficient.

Well, the only things that I can say about it are that, if anything, it's enhanced our credibility in the community. I rarely look back at, I usually look ahead. If there is something wrong with a program, I would say, wait a minute, we are not going to do that anymore. If I got a lot of negative feedback about it or something like that. So the very fact that I'm looking at how can we build it says to me that along the line I've gotten the impression that it is a very credible program, that it is a very productive program for the participants. That it is being viewed positively by the community.

I would tell you in terms of evaluation. I can't remember whether (the facilitators) used any evaluation but your own. I think they used only yours. And that's pretty typical of this agency in the first year or so that the program runs. Because I want to hear where staff is with it and what staff thinks about it and so on. And then about the third or fourth time something runs, then I begin to survey the people who are involved. And the reason that I do that is that I think with the new program, staff needs to do it two or three times before they are doing it so comfortably that people then are maximizing what they get from it. So I don't think that I even encourage them to do any survey beyond your evaluation.

It is evident that, despite the real and imagined difficulties in evaluating prevention programs, agencies are constrained by what funders want which is primarily quantitative results.

The good news here in this county or in (the) Southwestern (part of the state) is that United Way is beginning to look at the importance of prevention, and they are beginning to say that numbers don't always mean that a program is successful, that we need to look at different kinds of goals and how we are going to assess whether or not we met those goals. And they are

also beginning to say that the programs have to go over an extended period of time in order to be evaluated. . . .If they request a full proposal, then we will be expected to tell them how many people we will serve, where they are going to come from, how we are going to evaluate. And when you state your goals, you have to state them behaviorally. For example, in our teen parents support services program we said in 80 percent of the families that we serve, there will be no child abuse after the first so many weeks; In 75 percent of our families--; In 40 percent of--. . . .And those are the things they come back to and ask.

The Organization and its Environment

Social Marketing

Marketing for the pilot implementation of DN was accomplished by a mix of networking with professionals and use of media. Marketing, however, is seen as a burden as well as a necessity:

And because we have so many things going and not as many staff as we'd like to have, we are only now beginning to do a planning process that will carry us over the next two to three years and that will have a marketing component. And people here who have never marketed and don't want to market, and are really resisting that, are going to have to market if they want programs. And if we don't have programs, we don't need as many staff. And I've begun to take a fairly hard approach to that where I think that people are more capable of marketing this. (My workers) can better market this program than I can because they know more about it. They can go and discuss it more intelligently. I'm willing to open the door for them. But they have to go and do that. . . .And part of what has been going on here has been largely due to a lot of marketing that I've taken responsibility for doing over the years. And now it is too big a program and I can't do all that marketing myself. And so anyone who is hired certainly will know that marketing will be part of what they will do.

Increasingly, marketing and development functions are taken over by specialists from that field. The in-house PR person describes her role:

I was involved to the point of promoting the program The first time around, we sent a news release to the media, and that's a copy of it. . . .And then I think the second time. . . .Then in August we promoted it one more time for the September, the second session And I also devoted the lead story in our annual report to it. . . . We did have, I think, a couple of radio interviews.

And,

I don't know the reasons exactly because we never know when we sent out promotional materials or information how they're being received. But I understand that the first session had a very good enrollment. I think the second, either the second or third (had lower enrollment). . . .And I know she has told me that people will sometimes sign up and then can't make it for whatever reason. So, I'm interested in it, and I may never know the answer, as to why the enrollment has diminished. I'm not really sure about that. I know that (the facilitator) said the item in the newsletter generated a lot of inquiries.

From the worker's point of view, it's a mix of traditional networking style with community therapists and a more media oriented method:

I'll try and talk to the people I know informally. I spend a lot of time on the phone with parents who are calling in. . . .I'll get calls where there was somewhere in the initial conversation with the office manager the word alcohol. Okay. So they may not know what it is they need or want. They are not familiar with DN or anything. So, we'll get talking and they'll get the information. . . .They may or may not be appropriate at that point for the program. But they'll take information. I may get a call later. So, there is certain amounts of, I don't know, informal marketing. I mean, it just like happens. Or friends telling other friends, or, whatever. There is no formal marketing. I haven't sat down with a marketing person other than (our in-house person) to talk about timing of press releases or making a brochure. There was quite a bit of time spent on developing the brochure.

Another facilitator reflects a similar point of view:

I think that. . .it was through the news media with (the PR person) putting things on the radio and. . .sending out flyers, putting things in the newspaper, putting things on the radio and then I think a letter also went out. . . .I think things also went out to, I remember when I was doing my Gestalt training program Most of the people wanted the training program to learn how to do Gestalt therapy were already therapists of some sort and they would be telling me, "I got your letter," "You're doing a parenting program." So we sent out letters to therapists. I think that was it primarily and always talking around just to your own clients.

Relationships with Other Community Agencies (External Turf Issues)

The CA is described by some of its staff as one of the most prestigious mental health agencies in its greater metropolitan area. No examples of conflicts with other agencies over funding or services were given. Well developed networks of cooperative relationships with schools, physicians and private therapists were mentioned. However, both facilitator's commented on persons in private practice who wanted to obtain DN and to offer it to their own clients in competition with the CA.

Responses to Funding Constraints

Like other agencies, the CA seeks funding for new programs as well as to keep ongoing programs in operation. Funding is never secure.

Funding for preventive programs, generally, are on the wane. Particularly in the (state). What's called community services in the mental health/mental retardation system is the preventive arm of mental health. And they've decreased funding for community services consistently every year. Except to this agency. . . .Now I'm not sure why they've continued to fund community services in this agency. Every base

service unit--we're divided up into like nine base service units in (our county). And each of them had, over the years, asked to use their moneys in other ways. So I think they didn't really take that money away from them, but they allowed those monies to be converted to direct care monies, direct service monies. We've maintained the community services unit. And so far, and we don't have this coming year's budget yet, but so far, they have not reduced our funding. Our director is very concerned that eventually they will.

The agency's development person, who talked about the attraction of children ("love the idea of kids") to individual donors and larger funders, said,

And (our administrator) has done a lot of grant proposals. . .for seed money or continuing funds. Outpatient, I guess, falls under general operating costs. In my experience, no one has ever sent a donation and said, "This is for the outpatient."

As in the other agencies, there is frustration with funding constraints that constrict services or prevent development of new services. For example, that the CA could not afford to provide baby-sitting severely limited the ability of some parents to attend DN.

She was just saying, "Maybe I . . . ought to write a letter to your boss. . . .You know, how can you offer a program where there is not child care." No question, that is (not) unfamiliar to us. She wasn't angry with me personally. She was just very frustrated. And I think as we had spent some time on the phone, she was talking, laid back. I said, "Look, I said, you know, it's so hard not to be defensive. But it is very much reflective of what is happening on a local and state and national level around funding." I mean, there is just, I mean, "Why can't you run it at night?" Well, you know. So, where do I quit all of that. I think that's the other, I think this frustration, I don't think it's personal. I don't think the agency ought to necessarily take it personally. But just that frustration of where's the values, the emphasis being placed in terms of what happens fundingwise.

and

. . .In addition to our regular United Way funds for the last three years, we've had what they call a priority funding program. And its called Teen Parents Support Services. Now we made our final report to them on the priority funding of that package about three or four weeks ago and they will decide now whether those monies will become a part of our basic allocation. . . .So that before we started this program, we got about \$70,000 a year from United Way. And they will decide now whether they're going to go back to the \$70 or whether they'll give us the \$104, \$105 that it takes to include the Teens Parents Support Services program. We find that a very valuable program. And if its not continued, then we will have some difficulty with that.

In some areas, such as family preservation work, the CA chose not to go after funding. A judgement was made that it would be overwhelmed by the multi-problem population targeted for service. While funding might pay for the initial crisis intervention, if the family had a subsequent crisis and needed help, there would be no additional staff or money for providing supports.

Once Community Services has mounted a program that provides a manageable, needed service that is respected by the community, they actively seek funding from private and public sources. This was the stated intention with DN which had itself been funded by a foundation located in the CA's city.

Commitment to Social Change

The way services are carefully targeted at the CA reflects a decision about where they can make a difference which is, generally, with problems that can be located in

the client's family system. There is awareness of societal needs, but a reluctance to commit resources if they assess that goals are unmanageable. An administrator in the CA analyzes problems as follows:

What we are seeing in our base service units is that they are constantly called on to serve what we call the chronic population. . . .I guess I see that in the preventive milieu, there are some maintenance things that we can offer these families. One of them is the home behavior management that we offer. But I do see maintenance stuff. I see helping these families continually find new strategies to accomplish the same goals. If it is a chronic family, the strategies tend to wear out real quickly. So we can help to maintain much more than prevent. Now, if we get some prevention out of that, I think that's a bonus. Like I am dealing with a really chronic family, I teach a parent a new skill and four years from now, that parent says, oh, remember what (she) said when she was here? And they try it out again and it works. That's prevention. But I'll never know whether or not that happens. . . . Well, not only are chronic families going to be with us forever, but the emphasis of the system now is on working with those families instead of what they call the walking wounded. See they differentiate now. They have these little pet terms. There is first the community inappropriate population. That's population that you can't maintain in the community of retarded and mentally ill. There is no way. Those folks have to be institutionalized. Every now and then I hear agencies talk about that. I don't know that anyone ever defined that term, but that is what we say. Then you have all those people that institutions have discharged over the last few years, that they believe are appropriate for community based living. And those people by and large have come from chronic families. And they are saying, work with those chronic families, work with that person in the community constantly to prevent him from being institutionalized because it costs less money to work with them in the community than to institutionalize him. And it's too bad that it all comes down to the money. And then we have the population that we call the walking wounded. That's maybe the mental health client who is having enormous pain over a separation or divorce. Enormous pain over the loss of a child. Enormous pain over a child's misbehavior or addiction or whatever. These are called

the walking wounded, the neurotics. Sometimes. . . it is people who are kind of chronically neurotic but who can get enough out of individual treatment that they can handle their neurosis. And they are saying, we have to take our focus away from the walking wounded. And that's going to be something this agency has to address.

The lack of resources and the feelings of hopelessness about working with the "chronic" population makes this agency tailor its service for those it believes it can better help. Worker ambivalence to this narrow agency reach may be seen in the following statement.

I'm one person who can get very isolated in just doing what I do here in this unit. So I wouldn't want to pass myself off as a be all and end all of analyzing this place. I think whatever can be done to make services for kids in conjunction (with) whatever is being offered to parents will invite portions of the population that may not be able to come in because they can't afford child care or whatever is going on. You know, just try to be mindful of that there are a lot of single parents out there. There are a lot of people who are very, very strapped for resources. Who isn't? But, I mean, there really is. I don't know. I don't have a real feeling of -- that this agency -- I think this agency does try to pay attention to doing preventative stuff. Probably to take services more out into communities would be helpful. But, again, it is just like -- this is for families in transition. . . . And they have, you know, we have a hot line. People who can have us available even if they physically can't get in. And I certainly wouldn't ever, I can't imagine that I'd turn down a home visit. If that's what is needed, I would do it. And other people would also do it. . . . But there is a movement and there is a task force that's recently been started with runaways and homeless youth. And specifically looking at how that all interconnects with drug and alcohol addiction I'd really like to be on it. But that there may be some places where the whole issue of homelessness or runaway or I don't know if that is getting addressed anywhere in this agency. . . . It needs to be addressed. . . . What would be great is if there was more flexibility. Which I don't know if you can blame anyone. But just more availability to do groups at different hours or have concurrent children's groups would go a long way to broadening how many

people could have this accessible.

When asked whether her definition of prevention would change if she broadened her comments beyond the work of the agency to a more disadvantaged population, the other facilitator said,

I'm not sure. I think it certainly means that you've got to watch your expectations. That you may have to start slower, that there are physical realities that you are gonna have to deal with. . .that population may not as easily initiate services for themselves, that there may be more of a protectiveness in the lack of trust and seeking outside help. Particularly if they've gone through lots of systems and had not such great experiences. It's going to leave them a little wary. So I think that's got to be taken more into account. I don't know if. . .my definition of prevention would change, but I think that the steps there might be more middle steps. . .I think prevention can take on and even enlarge it for those populations. And take on other things that maybe don't happen so much, whether it is runaway stuff or it's kids already abusing alcohol or drugs and other drugs or physical, you know, whether it is mental or physical handicaps that then make certain services or certain ways of being able to live not so accessible.

When asked what all child guidance agencies should be doing in the way of prevention, the same worker began to invent a community network that provides parenting training prior to the onset of any problems:

There are agencies that, well hospitals. You know, there are basic courses, things that get taught to parents at the point of the pregnancy. And that's really, I think, where you would want to start. You want to start giving the agency Day One. I mean, it's so interesting to me to see these new mothers reading Parents Magazine and reading all of these things, that they're motivated, they can get their hands on This is families that traditionally would be from the multiproblem family. They care. They're reading these things too. So, it would be start as early as you could start. And it would be to invest the money. . . .It might even be--, oh why did you ask me this, your tapping. . .the old social activist in me, (laughter), you know, it just seems like, I

wouldn't want it to get lost in this part. I started to say that they might even, if people, if they had the money, might even invest money in looking at, to do an evaluation of what was needed. . . .I think that community service would be better to begin with. Things in the community. But, o.k. everything can't go in the community. I remember working when I was in school, to get my M.S.S., I did a field placement in a maternal infant care unit in a hospital. And there were lots of things that we tried to do just as students that I think there is room there. And it may be happening now for all I know. I don't know what's going on there. Its like what's possible. These parents are coming in here on a monthly basis and you've almost got a captive audience when they're coming in. And, I mean, you've got nine months there DN is only seven weeks. So I mean what could you be doing like on this visit?

She goes on to fantasize a network of services out in the community that provide family support through professionals and others to a wider audience than can be accommodated in her agency.

DN and many of the early intervention programs with children that the CA's Community Services offers reach a mobile, reasonably well-functioning population. Some of their past and current programs target less advantaged groups, but DN and the children's early intervention programs are the showpieces of Community Services and the agency. Change goals, then, may or may not take in larger social issues. Services are not always directed to those with the greatest need. When confronted with questions about the reach of prevention and treatment goals, workers verbalize a level of concern beyond their immediate program goals and begin to apply prevention ideas to broader populations.

Summary

Work is carefully planned and executed at the CA. The clarity of mission and consistency of defining prevention consonantly with its mission give excellent direction to the work of the agency. At the same time, this clarity also gives rise to rigidity so that the CA is relatively inflexible in its staffing patterns and fails to foster the kind of program development that might be expanded to larger populations.

Fiscal responsibility and great caution are exercised. This leads to limiting the reach of the agency to those clients at risk to manageable problems and who are able to easily access the services. While the agency reaches many who are in need of service, it does not target a more disadvantaged population except when it chooses to provide specific contracted services. The CA is a treatment agency with a continuum of services that address increasingly severe problems. But, even if the treatment offered is truly prevention or the earliest intervention possible, there is qualified commitment to reducing the number of cases needing intervention in the general population. The CA is reactive primarily to those who can come to the agency.

In a conversation approximately one year after the interviews reported above, the CA obtained a grant that

will permit it to offer DN in the evening and, possibly, to supply childcare.

CHAPTER VI

CASE THREE -- THE FABreaking the Cycle

The central office of the Family Agency (FA) is located in a new building in a commercial section of a Midwestern suburban town just outside of a large urban center. The agency has five other locations in nearby towns. One enters a large, pleasant waiting area that serves the entire agency. Wide, well-lit halls are decorated with donated artwork. Offices are pleasantly furnished. Pride in the new headquarters is evident. A visit to one of the more suburban offices revealed a similar setting.

The FA is a private, nonprofit social service agency serving families and the community since 1921. Prior to 1954, it was funded totally from voluntary contributions. Currently, more than one half of its funding comes through client fees, contracts and third party insurance coverage. The goal of the FA "is to develop, provide and promote superior services to individuals, couples and families so that their lives and relationships are improved, and the quality of community is enhanced. Essential to this goal is (a) historical commitment to deliver family-focused services to all members of the community, including those who are less advantaged."

The agency is a member of Family Service America, the

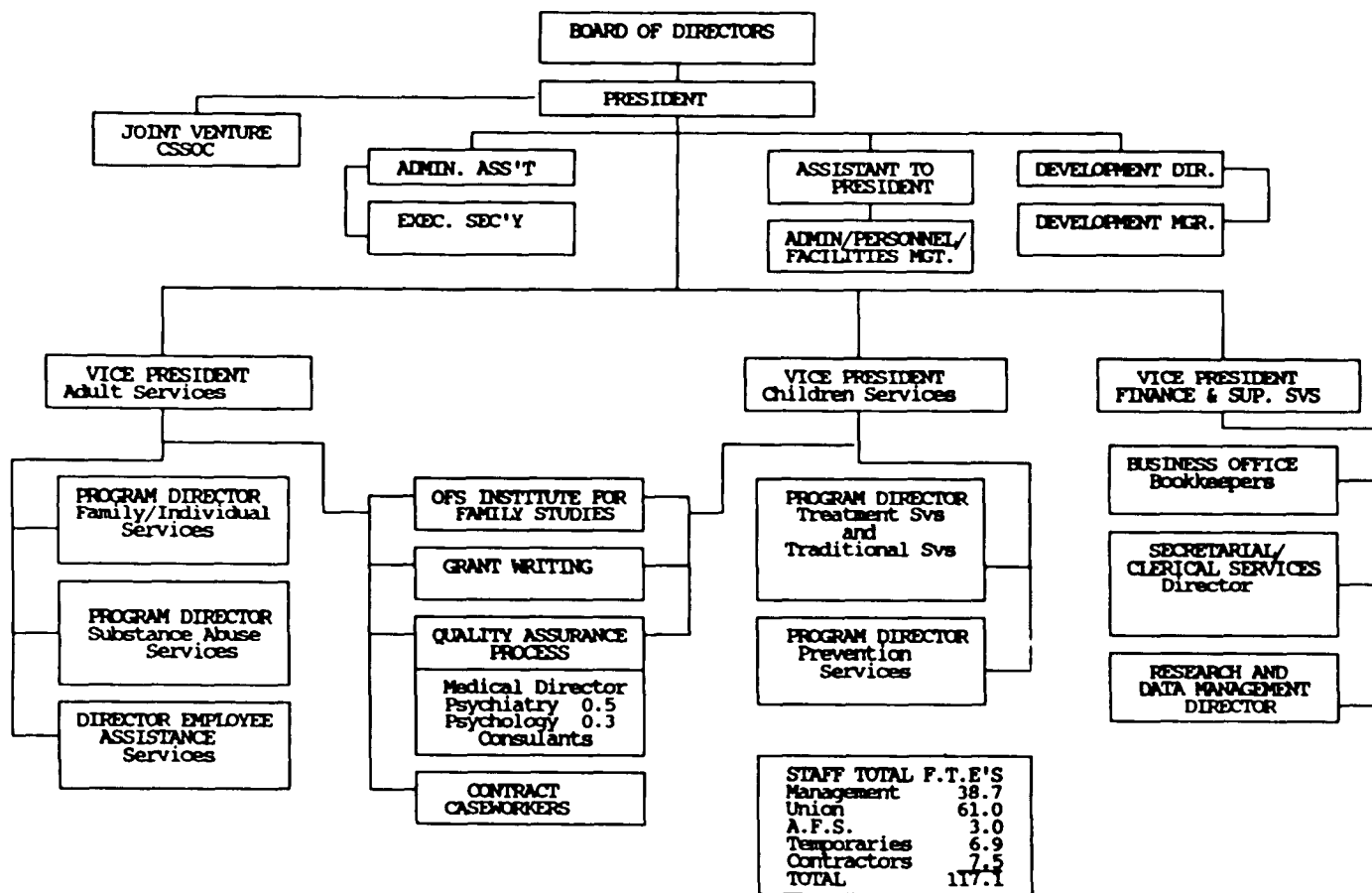
Child Welfare League of America, its state's Federation of private Child and Family Agencies and its Alcohol and Addiction Association. It is also licenced by the State Department of Public Health-Substance Abuse and by the Department of Social Services-Care of Children and Prevention Services and accredited by the Council on Accreditation for Services to Families and Children.

Reflective of these memberships and licensures, the FA is divided into Children and Adult Services each headed by a separate administrator. Adult Services is further divided into a Family Unit (supported by self and third party payment) and a Substance Abuse Unit (supported by contractual payment for services). Largest of the three agencies studied, the FA uses its extensive staff to develop programs around a variety of funding initiatives. With the support of a development person, staff members have varying degrees of experience and success in writing and winning proposals and, subsequently, developing new programs. Piloting DN became an opportunity to apply for and gain a "venture grant" for new program implementation.

Formal Organizational Structure

The four organizational charts (below) that describe the FA are structured to highlight programs and functions, rather than staffing. It juxtaposes "Treatment Services and Traditional Services" with other agency programs which

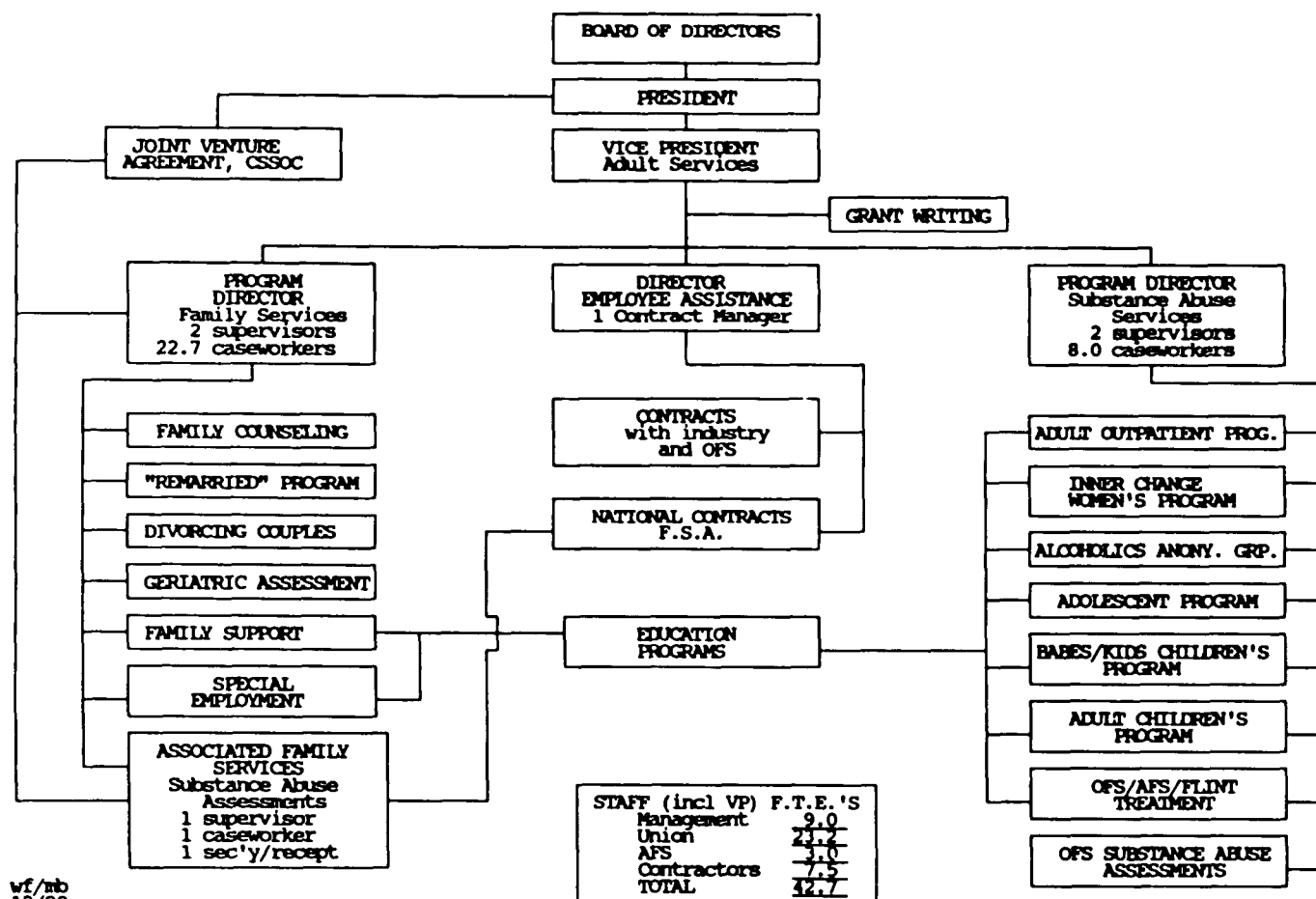
include "Prevention Services." These charts reflect the FA's flexibility, for example, to meet new funding initiatives or otherwise identify and target a community problem.



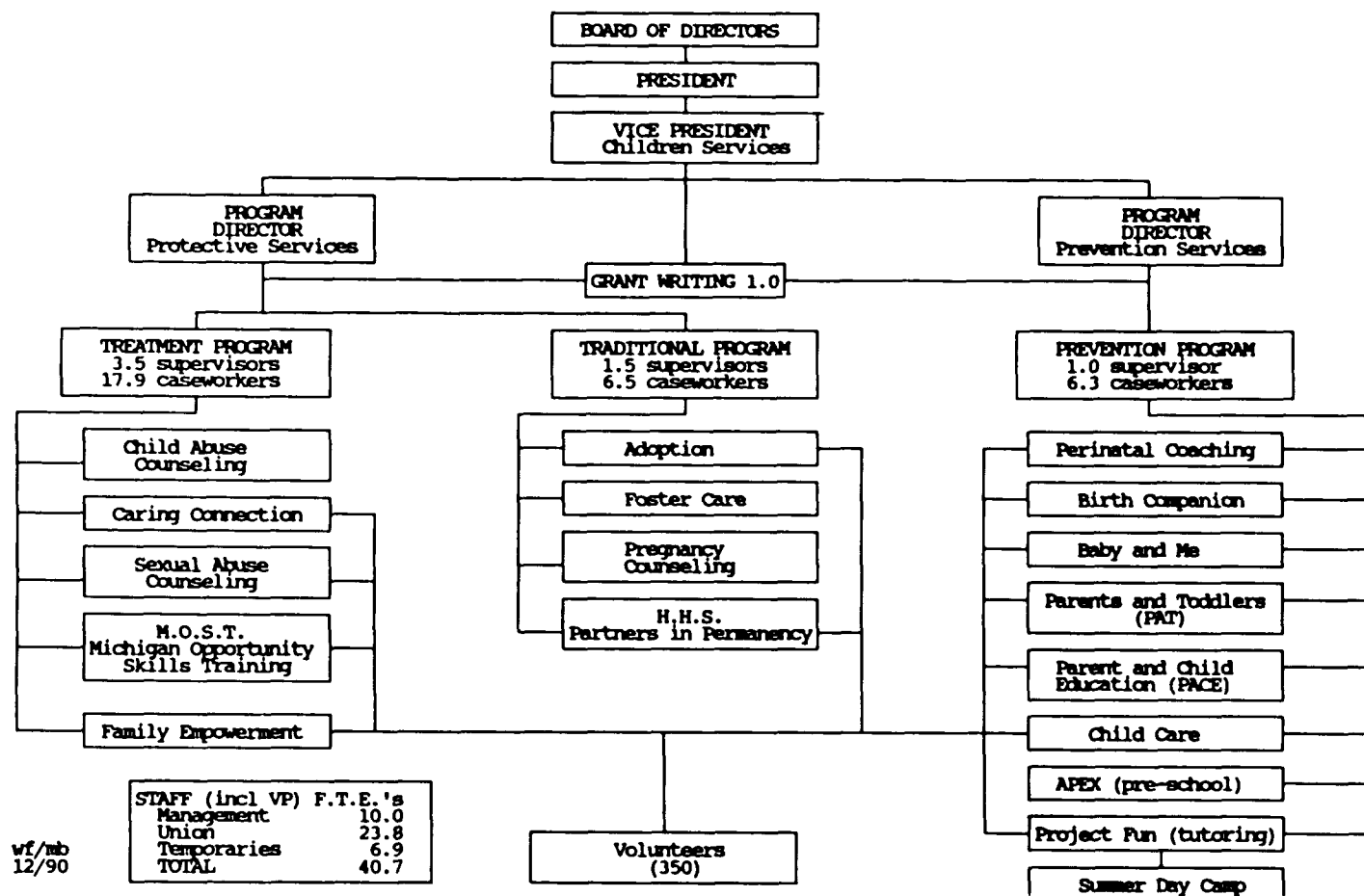
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The FA, Administration

The FA, Adult Services

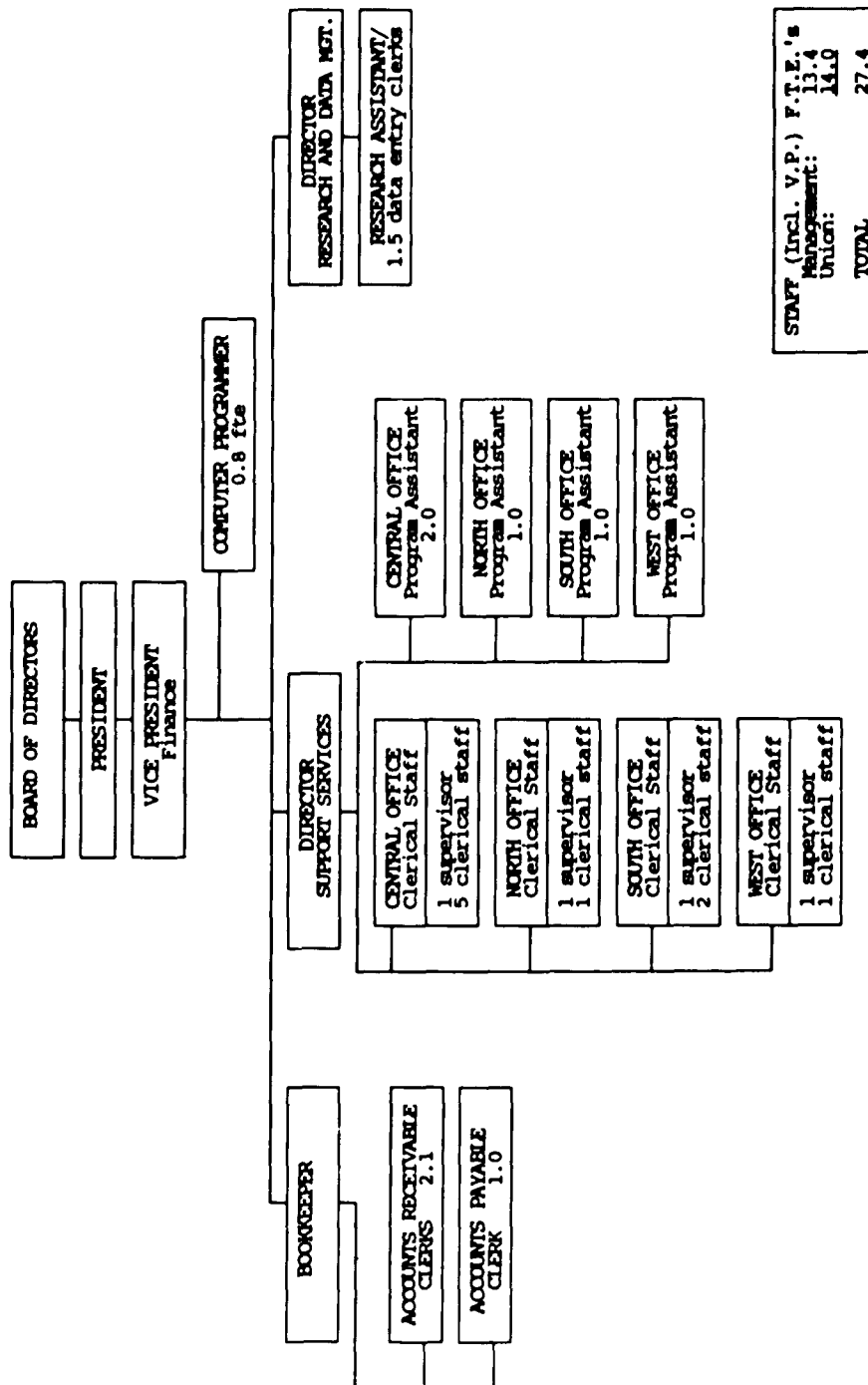


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The FA, Financial and Support Services

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Mission

That the FA is the most visionary and closely allied with primary prevention is evident in their mission statement that begins, "Building better tomorrows. . . . Many people will never realize the happiness of normal family life because of intergenerational neglect and abuse. The child of an alcoholic is more likely to become one. The child who grows up in a home where there is physical, sexual or other abuse will probably become the abusive parent of tomorrow. (FA) is dedicated to ending this cycle of hurt, helplessness, futility and despair through a variety of services for both children and adults." Indeed, the FA has developed a variation of the public health "primary prevention" definition to a more prospective, health oriented one that is consonant with social work. Prevention might be defined at the FA as breaking intergenerational cycles of problems through provision of services that decrease the need for treatment in the future.

Definition of Prevention

At the FA, the predominant definition of prevention is the interruption of the intergenerational cycle of a problem. Early intervention also has a place in some of the prevention definitions offered by agency personnel. Education, too, has a part in some of the definitions. Most staff members, however, regarded early intervention

and education as subtopics within the overarching definition of breaking the intergenerational cycle of a problem. As in the other agencies, mission and definition merged. In this agency, however, DN was seen as expressing the mission of the FA as agency leadership interpreted it. DN has since become an active, ongoing agency offering with its own administrator and with several staff and contract workers released to it.

It was striking that most of those interviewed at the FA were more prepared to define prevention than those at the other two agencies. The question was not unexpected. Staff, on the whole, were more articulate and, indeed, most had already formulated a definition. It should be noted that the staff of the Alcoholism Unit within Adult Services were an exception. They responded in a way that was similar to the staff at the AA. This may mean that there is a separate culture related to alcoholism or to the state-of-the-art of alcoholism services that affects how workers conceptualize what they do.

Apart from the Alcoholism Unit, there was consistency between the definitions of workers from the other parts of the agency. In line with the more predominant FA definition of prevention, the words of the administrator of adult services who was instrumental in carrying out the pilot and, indeed, institutionalizing the program as an agency offering immediately afterwards, sets the tone for other staff.

It is the interruption of a defined cycle that which has led in the past to an unwanted outcome. And to me that fits with the notion that you change systems. The system produces what it is supposed to produce. And if you want it to produce different, you have to produce a different system. And I think prevention is a systemic intervention. And in this case, intergenerational.

The facilitators of the pilot defined prevention in the following ways:

Any process that intervenes in the generational cycle of pain and prevents it from recurring in the next generation. And that's how I live out my work. And I assume its what the agency's viewpoint (is) because they let me do it.

So it--either prevents future occurrence or reduces significantly the impact. . . .I see it in all kinds of problems. Yeah. It is sort of generic for me. I think we prevent, for example, marital problems. We probably reduce the negative impact by increasing communication skill between partners, something of that nature. . . .(DN) will significantly reduce the negative impact of familial alcoholism, parent-child conflict in all kinds of other ways.

In responding to a question about whether she had a sense of the history of prevention programs in the agency, one of the facilitators of the program responded:

I would say I do have a sense of it in terms of my involvement in the agency. . . .view of prevention. And our main focus of working with. . . .the three generations of family: aware that previous generation affects the present and future generations. That's kind of the thread of our focus in talking about programming.

She goes on to define prevention as,

Well, prevention would be a form of treatment reaching a population that has potential for dysfunction and educating them, preparing them, and offering them services, if the preventive services don't work obviously. But a form of treatment for a population

that has potential for dysfunction or serious deterioration in some way or another. . . .I see DN fitting that because it identifies a certain population, sort of hones in on a group. And this group, parenting group, affects the future generations. And the adult child, being aware of the problems that their own parents had in parenting and having the option of making changes in their own style.

The public relations person echoes these responses:

Our society wants to throw dollars at a problem for short term and then they believe it makes it go away. Well, it doesn't work. What we try to do as an agency. . .is get involved and provide the long term support that is necessary to help the people that have been involved in the cycles of abuse, whatever spectrum that encompasses. And we believe that if you provide this long term support, you are affecting the lives of. . . the current generation and all future generations. And that's what we try to do, and that is our prevention aspect. We know it works. We have seen it work for many, many years. And so our philosophy of the agency itself is to get involved and to change the intergenerational cycles. . .from then on, every generation we have impacted. . . .Because they will never be the same no matter what when they come to us I suppose that is what is unique about our agency is that it truly is a philosophy of this organization that we want to get involved and change the intergenerational cycles. And we do.

Several workers and administrators who were not involved directly in DN responded similarly:

I would say either early intervention or pre-emptive . . .like in Perinatal , it's early intervention. It is in the seventh month of pregnancy before the child is even born. And in family support, it's not really early because it has been going on. But I would say . . .it may pre-empt or change the course; something that is aimed at changing the course.

As mentioned above, those from the alcoholism unit of Adult Services gave definitions that were closer to those from the AA than the others who were interviewed at the FA. While there is some allusion to primary prevention,

alcoholism workers stressed education and reactive prevention rather than the more pervasive FA definition of interrupting a cycle to bring about intergenerational change.

I guess prevention is the ability to communicate to others information and an attitude that promotes healthy living. That's good. Because it is bigger. It is bigger than all the little issues. I mean, not little issues, but the issues that we deal with. It is a whole fundamental attitude.

and:

I think prevention really deals with education in making a person aware of the issues that exists for them at that point. By making them aware of the issues at that point, then those issues don't have to become more serious in the future before the person gets into treatment. So, for example, you know, the kid who is dealing with those issues of his role in the alcoholic family structure, in the future you don't have to deal with an adult perhaps who is seriously depressed, and maybe in need of hospitalization. So I really think that prevention is. . . part of education. Perhaps a more efficient way of getting to a person's mental health needs. Well, for example, I think the parent who takes the course content becomes more cognizant and aware of their own needs issue, can't help but impact on the kids. So in that sense it becomes a prevention for the parent. It also becomes a prevention for the kid too. Because the kid is not going to own that parent's issues in that sense. Since they don't have to own that parent's issues from shame; consequently, it reduces the need for treatment in the future. Or if the kid enters into the treatment, it really becomes shorter duration. .

However, the dominant agency view and the theoretical framework and strategy from which they operate is best expressed by two administrators. The first incorporates the metaphor from the alcoholism field of "raising the bottom," which parallels other metaphors such as Eli

Bower's about the "turning off the tap" and learning "to turn the faucet down or off." (1961, 1987)

We met with him (Dr. Ray Helfer) in that process. . . . They could identify a cycle of events which once it got started properly would issue in child abuse. And, I think that was the first exposure I or anybody else here had to prevention. And so when we came back here, it was talking about developing some kind of program that would. . . anticipate situations that would be likely to produce abuse or neglect. And it started out with what eventually became the Perinatal Coaching Program. And, what it intended to do was address first-time parents who were at risk to become abusive parents. And. . . I guess the whole concept of prevention is that in a lot of ways to me depended on being able to identify the steps in a problem that recurs and that's probably intergenerational. And. . . to be able to single out in some way or another events that mark progress toward an unwanted outcome. And then prevention is an intervention to interrupt the cycle. I don't know how you can have prevention if you don't have a pretty clearly defined problem. And I find people talking about preventing things that they don't know what they are preventing. So I think. . . it's an earlier start that grows out of rehabilitation programs. . . . Well, the rehabilitation takes people who. . . have already reached the unwanted circumstances. . . . And you try to get them out of that. And then (in) the process of doing that, you learn how they got there. . . . And then, you step back another time and say, "We can't keep picking them up at the bottom of the barrel. You don't have to hit the bottom. You can raise the bottom. . . ." And I think prevention's funny because if it's successful, what you want to prevent doesn't happen. But how do you know if you prevented it. Ha. I mean, you just have to make some assumptions. . . . And I think that's the value in having a tracked-out problem like when you go the steps that you all produce around families where there is alcoholism. And you look at it over an intergeneration and you can begin to see clearly that there are kinds of things that happen. And they have to be altered in some way to break the cycle. I think most of this stuff that I've seen in terms of programming is that it's too short term. You can't fund a program for a year or two and expect to see results on some of the kinds of things we do.

And, a second administrator:

Well, I guess the one definition that comes to mind is preventing problems before they occur. And the one

little gem that I picked up from Ray Helfer is to not try to measure the absence of the negative, but measure the presence of the positive. And I think that is a real good statement about what we do in prevention. Because you can't really look at what's not happened yet to say you are doing a good job. But you have to look at what you can do and what you can build on in terms of parenting skills and self esteem and social supports, reducing isolation, and giving people the information and supports that they need to do a good job. And our primary prevention approach, serving the general population, hopefully means we will be getting to those who may, in fact, be at risk for abusing as well as those who may not. And that also has a value because they will take the same information and spread it throughout the community in their own ways. That's what our volunteers do as well. On this real grass roots community education. Just through their own increased knowledge. So I guess that the definition of prevention is building on the strengths and positives and trying to prevent family dysfunction before it occurs by intervening at different points. Such as during the pregnancy, during the newborn period, toddlerhood is another challenge for parents. Again we have an intervention there. When there is a sick or handicapped child in the family, we have an intervention there. So being at the right place when families have what I would call a window of opportunity when they are willing to get new information and have that support.

These definitions highlight the interruption of an intergenerational cycle of problems. They resonate with the goals and methods of social work as taught in the last quarter century. (Perlman, 1957; Hollis, 1964; Germain & Gitterman, 1980) That the FA's notion of prevention looks to "accentuate the positive" and "build on strengths" is most consonant with the methods and goals of social work.

Internal Workings of the Organization

Leadership and the Interpretation of Agency Mission to Staff

When program is consonant with an agency's mission, as

evident in the following statement about DN from a top level administrator at the FA, a shared vision is articulated throughout the agency just as the definitions of prevention were shared.

(Presenting a parenting program to ACOA is a non-stigmatizing way to help those). . .who may have worried about what they learned and what they will pass onto their children. And rightly so. . . .The other thing is that it fit exactly with our own mission which is to address families. And the intergenerational nature, I mean, the family is an intergenerational unit. That's part of its unique character and part of its impact. And to impact family, you have to deal with those issues, and you have to deal with them over more than one generation.

And, from another administrator:

Well! I think that we have a very creative and innovative agency and that that message comes from the top, from the president and the board on down to have a commitment to prevention programs. And it has been a critical part of what I would call a continuum of services that we've tried to develop. And our work starts prenatally in prevention programming: To strengthen that family relationship and family's development from the beginning. Which for us begins in utero.

This philosophy is one that has been developed over time. That it filters down to the line level is evident in the comments of one of the facilitators.

I think that. . .because this is 70 years old, this agency, over the years. . .went from kind of traditional kind of social work background to providing treatment and then from there into prevention. And the issue was that the family was seen as probably the healing force and the hurting force at the same time. We saw intergenerational patterns of abuse, whether it was child abuse or substance abuse. . . .All the different things that you see through family histories. And we had numerous clients who had been in our system for generations. The mother abused the child, the child grew up and abused their children. We had one family that we saw for three generations. . . .So out of that a knowledge came the attitude about prevention and developing prevention programs.

It is possible to target DN in such a way that it reaches a large segment of the population. The FA has offered DN at several of its offices and in local churches reaching different groups. Programs like DN have the flexibility to be adapted creatively to reach different populations who may have needs for prevention services.

Flexibility of Organizational Structure

Within the framework of mission and leadership, it is both the agency and the workers that create a culture that permits change in services and in how they are offered. In an agency free to develop programs with a preventive thrust, it may be necessary to have autonomy of unit heads and even of workers. One of the facilitators of DN describes the flexibility of the FA in terms of its history.

This agency has a very long and knotty history because its merged and divided a number of times. And it also has a history of taking advantage of opportunity, which is what we did. So sometimes something will swell suddenly and cause it. It seems to fit at the time. I think that is one of the reasons why we are still alive as an organization is because things that don't work and don't fit are dropped. And things that do work and do fit, are picked up. There is real change here which can sometimes be very comfortable and sometimes its not. . . .And we've changed the way we conceptualize what we are doing in my unit at least two times almost catastrophically to the point where people left because they weren't comfortable with the change. And there's been a slow process of change all along. (My administrator) who has been with the agency for 20 years is very, very committed to prevention. And she has sort of a global view of violence in society that she works on in almost every area of her life.

This shared understanding permits encouragement of

staff to seek funding and to reorganize program:

Well, when I set it up (a program for parents of chronically mentally ill adult children), things had significantly changed. At the time I found it, I was a supervisor in a program. And the director at that time was somebody who was. . . pretty overloaded, somebody who was approaching retirement. And, I think that those were factors. Plus trying to cope, maybe (he) had some sense before I did that the contract was in jeopardy, so was really not looking for new ideas, was looking to survive. And so when that contract ended, indeed the person did retire. And then. . . they created a new position in the agency and made me the director or gave that position. It was in that context then that. . . I was in a position to do this. . . . And (the head of Adult Services) was my boss then. And I had no resistance at all. He was extremely supportive of it. And so really, once I was in a position to develop that, then it was all green lights from then on.

The development person also speaks to a similar entrepreneurial stance:

We got a venture grant out of United Way. . . . We ran your initial (pilot), and then from the success of that, then we applied to United Way to-- what they are called venture grants, which are specialized grants for very unique and progressive programs. And they funded us. Then we also approached (a corporation). . . and they gave us a grant for this.

There is also a mutual responsiveness between worker and organizational goals.

Yes. They encourage creativity. And that's in my own position has changed dramatically from when I was first hired in. And because of my own direction I wanted to go, and they allow that to take place. Oh, yeah. It's nice. It breeds creativity. . . . My own direction, my thoughts were to go onto more individual therapy and to do parenting therapy. Mostly with the parents. Sometimes with the parent-child in the room. It depends on whatever the situation calls for. And to deal with any issue that affects the child, even if it is marital therapy. But my focus, my underlying goal is to improve parenting skills. . . . And they've gotten grants where my goals have fit right in.

Such flexibility and creativity can also create problems. It becomes difficult, at times, to track costs and income when workers from one service perform a function that does not automatically belong in that service. The ongoing implementation of DN caused a number of accounting problems.

I think that. . .on the funding source level, there's a lot of settling out of exactly how this is going to be handled on the books. Who my time is going to get charged to, and who's going to get the benefit of the fees that are generated. . . .Its a pig trying to settl(e) all that out. So there was a little backing and forthing. It wasn't as clear-cut as it was last year when I knew that I was going to be working on (the pilot) and that my time was going to be charged to (the pilot) and that there would be no fees generated Well, this is all internal agency jargon. DN has a computer code. . . .and my parenting program has an internal code. . . .And it gets costed out to my, well this ones our problem. I mean it took a while for (everyone) to work out all those issues with (our administrator). But. . .I don't know that there was a problem.

Such flexibility and creativity allows use of prevention strategies and technology, ones that may "turn off the faucet" to reduce the flow of repeat and of new cases.

Intra-agency Communication and Cooperation (Internal Turf Issues)

"Crossing lines" between services at the FA occurs with increasing frequency. Communication between services was described as deliberate, more formalized and more regular than at the other two agencies.

Well, as I said, this agency has been tremendously supportive from the the board and the president on down

to keep our services going and to highlight us as much as possible. Our vice president, for example, comes to every volunteer training that we have. . . .And speaks at the first session. So even the volunteers who get the positive message from administration that they are important and we want them here. And they are a very critical part of what we do. And then the ongoing education of the staff. I often speak at what we call our general meeting, which is once a month where all the staff are present and try to keep them updated and informed about what's going on. Because, again, in the initial few years of the program we were sort of viewed as this kind of fluff service. Not the really important stuff, but sort of an adjunct extra, kind of thing. And I think that has changed tremendously and they view us as a very important clinical piece of the agency.

A worker confirms the formality of mechanisms for exchange of information:

Yes. We always get a memo that lets us know what groups are starting up and when they are starting up. And that if we have clients that we feel would be interested in those groups, we always refer 'em to them.

There is a conscious attempt on the part of administration to integrate services, indeed, by seeking out programs and staffing them in such a way as to accomplish this. This can be seen in the words of one of the senior administrators who describes the impact of DN on the agency:

Everybody is busy. And it is hard to understand. If there isn't administrative support or understanding it doesn't happen. But I haven't seen that kind of interest (in DN) among the staff in a long time. . . .We've written several grants since then that involved substance abuse staff and children's services. So it's had a good impact, good impact from that point of view integrating. There is a valid emphasis for children and adults. That that's not, not as much as we separate them.

A worker describes it as:

. . . .I don't know, internally, I think there's always this backing and forth between children's services and adult services which is a little bit of a turf issue. And slow communication. In this case it worked all right. Cause (my administrator) didn't have a problem with my offering this to the community as opposed just to. He usually doesn't have any problem It just took awhile. Well I've heard that since. That there is, nobody's quite sure what's children's service and what's adult services: how the interaction is supposed to work. Well, that's because they don't know. And I don't think it will ever get settled. Because as soon as it gets settled, somebody's going to do something innovative and then they're going to have to work it out again. And I think that every time, this agency rectifies structure. . . , then somebody does something creative and it all has to be redone The strength and the weakness of the agency are the same. We have therapy clients, they have therapy clients. Basically, if the therapy client presents with a sequelae of trauma issue, then they tend to get referred to us, but not always. And if the client presents with an acting out child or a marital problem, they tend to be referred to them. Not always. To Family, Adult. Or if they present with a substance abuse problem, they get referred to Substance Abuse. That's the most consistent. And the funding. I mean, its stupid for us to take them because we don't have the (substance abuse) funding. And the agency is much better off if we get the (substance abuse) funding. So, its. . .a crap shoot. And, sometimes it works, sometimes it doesn't. The territory. . . . Can you imagine the upheaval if they said this is stupid, we're all one agency? We're not going to be divided up like this anymore?

Another worker describes more specifically this creativity in action. The Substance Abuse and Prevention Units would combine treatment and prevention programming to offer existing services in a new form to a group of clients.

I've always gotten referrals from Substance Abuse and Family Counseling Programs as well as volunteers from those folks. I think though we have integrated a lot of

content information in what we do. For example, in volunteer training now we usually have (two staff members) come in and do a couple hours on substance abuse because it is such a pervasive issue in families. So we cross lines in that way. We are hoping one of these days very soon to get our project which we have developed with substance abuse to serve. . . substance abusing pregnant woman. And we have written several different versions to the state and to the Feds. And we are hoping that we will get that funded very soon. And that would combine substance abuse doing the outpatient treatment part and prevention offering a perinatal coach and birth companion to those pregnant women. And also some parenting education to them.

But, even in an agency that has a mechanism and the flexibility for cooperation, there are limitations. Often these limitations have to do with accountability requirements or funding issues. Too, when a program such as one involving work with ACOA or "dysfunctional families" has great cachet and attracts for clients, the service that has developed it is tempted to keep it for its very own. These factors are evident in these words from a staff member of the Alcohol Unit.

Like for instance, we had an issue with children services because they are running substance abuse groups in their camp. And under our license, we are responsible for whatever goes on in the agency. We need to know about it. So that became an issue. It is still an issue. There have been -- I guess that is a good example. We have other things, we wrote a grant with children's services recently to do programming with pregnant substance abusing women. And if we get funded, which it looks like we will, that's going to be like who answers to whom. And is it substance abuse program or children's program or what. So there is definitely turf issues. . . . The other thing is that when people come in for intakes, they don't get assessed by a therapist. They come in. And we get a phone call. And if they say, "I have substance abuse problem," they get funneled here. If they call and say, my husband is a jerk, they go to the family unit. Well, maybe he is a jerk because he's a substance

abuser. That wouldn't ever necessarily find its way over to our unit which probably should be. And so that comes through quality assurance Depends on the therapist too. How open they are to sharing. . . .One of the problems we had was a program for women who were addicted. And so we can take referrals. Their primary care worker might be in protective services. But they come into one of our recovery groups. Actually that's worked out pretty good. I think it is probably more administrative boundaries than it is actually case workers. Although there is probably some of that too, depending on the person. But I know that for me, I'm pretty protective of our boundaries. And I don't, some people think that I might be kind of rigid about it. . . .But, we have very stringent licensing requirements. And we get audited more than anybody else. You know. And it's very popular to do substance abuse work. . . .So there has been some desire on other parts of the agency to do the ACOA things. You know, we kind of want to keep it.

Flexibility of Staff with Respect to Technology

Although the FA has moved from exclusively traditional clinical work to other forms of helping clients, reaction is not always positive. The dichotomy between clinical work and prevention technology is clearly seen in the words of many workers who balance traditional treatment against a program development approach that includes the psychoeducation usually associated with prevention services.

Well, prevention is a different view. And I think we've done a lot of good education of the agency staff. But one issue that we run into sometimes is that the other clinicians are trained to look at the pathologies of the family, sort of from a problem orientation. And in prevention you are looking from a different perspective, from a preventive perspective. And trying to build on the family strengths, and looking at their well sides as well as trying to deal with the pathologies. So that's the only thing. I would say generally here we have a positive experience with the agency in implementing a prevention service

and that it does compliment the work that we do as a whole.

An administrator in Family Services described a psychoeducational program for the parents of chronically mentally ill designed to prevent rehospitalization and the kinds of professional resistance it encountered both inside and outside of the agency:

It was not only turf issues, but it was also, you know, professional training. This was like a new computer coming in, you know. And so some people felt like we were telling them that their treatment was obsolete and they were sitting there wasting their time because talking wasn't going to do it. And where we reconcile that, that mentally ill people have mental health issues too. And they react to stress. And you can deal with them around some things. But we maintain that talking to them is not (the sole answer).

When asked how his personal practice orientation fit development of this program, he responded:

Well, my practice orientation changes, you know, every few years. And I'm not doing direct clinical practice. Right now, I would say that probably the biggest impact that the program had on me was, because I had been steeped in traditional mental health thinking, and I've worked in substance abuse initially in the 70's. . . .so I used to do those lectures for the alcohol programs and so on. . . .And then I got away from that, graduate school. . . .took me into different things. And actually, but let's see. Probably it brought me back to what is significant impact education can play. And, like your Discovering Normal, this is sort of -- this is discovering normal in the midst of abnormality. . . .And really the jumpstart is the education. So I think. . . .a lot of what I'm doing now (is) looking at projects that have that kind of component. That therapy, in traditional therapy is fine, but it's not the first place to start. And what we see with these families in the psychoeducational thing, is some of them, they come in for the education. And then they get some support. And then they get, after support, in terms of the consultation or counseling sessions, they get, it is really more coaching than getting into internal processes. It is coaching around the coping skills and

it is more directive. And then as the directive stuff takes hold or it doesn't, if it doesn't take hold, then we get into examining why it is not taking hold. And then. . .there is some of the grieving and so you get into the grieving and then we, you start to resolve some of that. And then. . .in order to get through the grieving, you get to. . .where the couple blamed each other. . .and then you look at the, issues of the marriage and how they withdrew or they weren't supportive or one has feelings of guilt and one has blame. . .so the counseling and therapy certainly play a role in it for some people. And that comes down the line. But that is not the place to start. So what I'm finding is is that I'm shaping other programs or thinking about how I want things to go. I'm starting . . .in a different place.

It is not the technology itself, but staff reaction to it that must be worked through.

I guess the other interesting thing which we wrote about in the replication manual was bringing up prevention programs into a traditional clinical agency. And I wasn't here enough at the beginning of the program, but when I wrote this I interviewed people that were here at the time. There was a tremendous amount of resistance from the staff, particularly with the notion of using volunteers. The staff felt very threatened about volunteers being involved in a clinically based program. That somehow it was going to usurp their role or have some type of interference in what their work was about. When in fact, as we evolved, it has tremendously complemented the work that the agency does. And particularly the volunteer piece brings something to the family that the professional cannot get. And it's brought a very powerful message and we feel has -- I can't think of the word -- has helped to speed up the changes within the family. We feel the combination of professional treatment combined with the right volunteer can be a very powerful change agent for families. And in fact now we don't feel any of that resistance. In fact now many professional staff refer their friends. In adult services now they're looking at the function of using volunteers in some programs because we have seen the positive effects of it.

Technology can become enmeshed in turf issues, in relation to referring clients as well as taking advantage of learning opportunities. A staff person in Adult

Services gives an example of resistance to sharing and using self-help and psychoeducational techniques.

Hmm. I think a lot of people saw it as a very beneficial program, but I -- I'm thinking now about therapists, and I had people stop me and say, "Tell me about Discovering Normal," and I would. And they would say, "Oh, gosh, I've got somebody who really needs to be in there. I'll talk to them." And then we never would hear from anybody. It was sort of like when I was trying to start AA meetings over in (main) office. I think you need referrals internally from therapists who had substance abuse clients. . . and I set AA meetings early in the evening, at 6:00 o'clock so that people could come in for sessions or afterwards, or groups and all kinds of things. I never had a person, well, maybe one, who was referred. I think, number one, people don't understand 12 step recovery programs in general. And don't see them maybe as that important. And therefore they just don't take it. And we tried to do an open meeting over there and tried to get all the therapists to come and I was the speaker. To let them see what--hear it in a different way. And we only had two show up. And they weren't even from the (main) office. I mean, it wasn't even two therapists. One therapist and one PA, program assistant. . . .I think that part is resistance, lack of knowledge. . . .and maybe the program was not sold that well, too, internally first. Maybe there would need to be something else done. Maybe it would need to be marketed inside in a better way.

Another worker tried to explain the difficulties those with a psychotherapeutic, family dynamics orientation have in working in group programs with a psychoeducational bent. She struggles with providing services to those who are Court mandated to get help.

I think that. . . that some of the people that are hired in Family are not thinking of themselves as being prepared to work with people who basically have the issues of personality disorder. And they also don't think of themselves as working in a program that has quote involuntary clients. I see voluntariness as a continuum. And that every client that actually gets his body through the door has an element of voluntariness in him.

The FA has an environment in which staff are encouraged to experiment and to use appropriate graduate and life and work experience to develop prevention programs. The attractiveness of doing prevention, and doing it with difficult populations, is an issue related both to staff flexibility and to social work technology.

Research and Evaluation

The extent to which any program at the FA is evaluated depends on the commitment of unit administrators and their staff to research and on whether there is a contractual requirement for evaluation. As at the CA, apart from the pilot evaluation requirements, there has been little formal evaluation of DN.

The extent and variety of research can be seen in the following administrator's comments about evaluation of the agency's program for families with a chronically mentally ill member:

We evaluate it by consumer feedback. We have that. And we. . .we distribute a questionnaire at the end of each workshop to find out, you know, we don't have a pretest. But it is. . .a post test without a pretest. . . .We just want to make sure they have the fundamentals. So we have in our post test, the fundamentals are there. . . .We have a consumer survey. Our consumer survey, we do that. One (thing) I have wanted to do and wasn't able to do because the county system is not sophisticated yet, but I understand they will be in another year or so, is I wanted to actually track the hospital days. Because what we get now is word of mouth. And when we get discharge summaries and stuff, we have some of that. But what I wanted to do is to take a control group, see, because everybody in the county system that is

diagnosed is registered in the computer. And they follow them. What I wanted to do--then there is the state hospital which is a separate system from the county. What I was hoping to do was, through the county computer system, was to track a control group of people diagnosed with schizophrenia (with) similar demographics and see what they did in terms of public, you know, foster homes or hospital days, and track our group as they go through the system. And see what that looks like. Couldn't do it. Because of the layers of bureaucracy between a state hospital that operates outside the county system. Effective Oct 1 of this year, I think. . .this county is going to go to a full management system so that the hospital will be turned over to the county. And then once they are able to integrate that and get it set up, we may be able to do that kind of stuff.

When asked how the agency wants accountability tracked, the same administrator responded, "I think, in that regard, I'm the agency".

The Prevention Unit at the FA engages in the most formal evaluations of its programs.

Just because we've had them and we've had the ability to research on them. And in each of those projects, we've used external investigators to do that research. I think probably other programs do a good job of their own statistical analysis. Part of ours has been funding driven though, that when we get these big dollars, these big three years grants, it is funding driven that they want this research.

Evaluation services are often supplied on a contract basis. Outside, university based researchers are likely to be used.

Universities, yes, have been our best resource. So I usually have used folks out of the school of social work or out of the school of nursing. I've also been fortunate with our birth companion project, that was a research project that was done by the (state) medical school where one of the pediatricians who was a teaching faculty had to do a certain amount of research and publish. And he came to us and he said, "Hey, I've got dollars and I've got time and I've got

students." So we had terrific outcomes on that. So the universities have absolutely been a tremendous resource. That's worked out really nicely. And the other thing I've done is I also supervise graduate students from the school of social work. I happen to be an administrative track person in my masters program. So I take administrative students and they are always in on the research when they are here. This year with our infant mortality research, I have a professor from the school of social work, and a grad student from the school of social work. . . .So that works out great. Because then she is able to work with the graduate student around coding and some of the analysis. Fascinating. It's terrific. In fact we were just doing our coding on second year. So I am really excited to see our outcomes. . . .In the last couple of years, though, we have been fortunate to receive several three-year grants which has been much more helpful. The other twist that we've done has been to do research with the program which we've now done at three different points in the history of the program. And we are currently engaged in a joint infant mortality project with the health department. And we are entering the third year of that project. And it has a research component to it. . . .It's connected to perinatal. Perinatal and birth companion is our piece of what we do We are doing a comparison of the people, our joint clients that are in our services. And also we see the services of a health outreach worker. And comparing that to general population.

A few staff members were excited about research. Not only did it accentuate the positive, it quantified it and articles were published.

. . . .The research has shown very significant health outcomes: that we've had fewer hospitalizations with the infants, that most of our infants have been up to date in well baby care and immunizations, less injuries in that first year of life. So we've had some marvelous (results). In fact, in our two years with the infant mortality project, we've had no infants deaths. That is very good. And out of the 165 families that were surveyed, at least in our year two data, we've had almost three who had been involved in some kind of child abuse neglect reporting: What we call protective services. Which we feel is also pretty positive. We've also finished research on our birth companion service. . . .But birth companion was an outgrowth of the perinatal program where we utilized volunteers to be present during labor and delivery, the

theory being that those who had a positive birth experience would be able to build a more positive parent child relationship. Versus, if one has a very negative horrendous birth experience, that could potentially negatively impact how they view their child. So we did a two-year research project where we provided 60 folks with a birth companion. And then we also tracked 60 folks in a control group that did not have a birth companion. The results of that research showed that those who had the birth companion had labors that were 50 percent shorter than those who did not have a support person present. That we had much larger birth weight infants consistently in the service group. And that we had significantly much less maternal depression in the service group. So real positive results.

When asked if such research will help maintain funding, the response was:

We hope so. And that got published in a journal of medicine. So I got, you know, some interest there. We've gotten real support, not so much from the OB medical folks, but pediatricians because they are the folks that are dealing with the aftermath.

The notion of giving programs time to iron out the kinks is raised in discussions about evaluation, alluding to the fact that we often expect too much too soon. There is even some optimism that, through research, prevention will prove itself as a valuable technology. The administrator who was instrumental in bringing DN to the FA described how over time one could track changes in how many children become alcoholic or, for example, have school problems.

You can define the history. You get an incidence: you have a whole fact sheet on. If you grew up in an alcoholic family, what difference that is likely to make in your exposure to alcohol or you are likeliness to marry an alcoholic. Or a whole bunch of incidence figures. Well, those are fairly consistent over a

period of time. Or if there is inconsistency, they get worse. What I would expect over time is that those kinds of statistics would change. If you engaged in a program to interrupt that, like DN. And, I think it would. . . . I'm also convinced that if you could get and mobilize a national effort like I was imagining and get off a fairly simultaneous launch from a bunch of agencies all over the country (of DN), I believe you could impact the incidence in this generation. I mean, you wouldn't have to wait a long time to see a difference.

He then went on to describe what family agencies ought to be doing, linking preventing alcoholism and problems related to it with the documentation of successful efforts to prevent smoking.

And I think this fits in with what family agencies ought to be doing. To me it's incredible the kinds of things that they have done to limit and alter cigarette smoking habits. And alcohol has managed to escape. That is just incredible to me.

The Organization and its Environment

Social Marketing

Marketing of services is quite sophisticated at the FA. In effect, as at the CA, it is the agency that is marketed along with a particular service. And, marketing is tied in with the funding of the program. The development person said:

And when I heard about DN, this little, I can describe it as this little lightbulb went off in my head. That told me this was the perfect vehicle that I was . . . looking for to promote the agency. It was a non-political, non-religious, non-conflict type of vehicle that once we got the grant, it was something that we could really promote for the agency that would be a wonderful community service to begin with. And second of all, because of none of the other items that I have mentioned, it could really put us in a good

position. So I started pushing. Because I just knew that this was the type of vehicle.

and a program supervisor,

It is real interesting. Now what is taking place is that there is a shift. And what we need to do as a unit, this is what people are saying. What we need to do as a unit is to develop some real good marketing strategies. We quote need to go into the community, make ourselves more visible, etcetera.

One of the facilitators describes how she worked with the Adult Services administrator:

Well, the decision was to market it to the public. And that was not my decision and I didn't have much to do with it. . . . (The administrator made that decision) as I understand it, (he) and, I think, maybe some consultants that. . . are members of the Board--and they marketed it through newspapers and radio, and, I think, some of the people, I think. . . appeared on T.V. or on radio. And, it worked real well. We got enough for two groups right away. My group had 17 people in it. That pretty much stuck. I mean it wasn't like starting with 17 and down to 12. The other group had 12. And then, I think, there was a lagging in pursuit of intake. And what I've chosen to do to market THIS group is, I've. . . written to newspapers, T.V., radio, press release last week. And I'm also going to send it to churches in (several nearby towns) for the church bulletin and also for the pastors to make referrals. And I'm going to put brochures in each of those for them to hand out with my card. And the pastor of the church where we are going to hold the meetings. . . is already making two referrals from what I understand. I figure we'll probably have an overwhelming intake. And we'll probably have to schedule another one.

So just on those kinds of considerations, where. . . we have (it), and are we going to offer child care. We decided not to offer child care because it was a more high functioning population than the one we usually offer. And really, the way I did it was like I lent myself to the Discovering Normal Program rather than doing it as I would do it in my own program. I was going to do it with my own program, I might say, "Okay, this one is for the state," and call the state. And market it to the state and have people sent under contract to do it and get paid \$180 a session for it. So that's another way I could have marketed it. And there were lots of things we didn't do and haven't done yet because of the constraints of being an experimental

program, but there is lots and lots of things we can do.

The FA has clearly engaged in trying multiple ways to recruit clients. There was the traditional networking with other professionals, but also, creative use of a public relations firm, and learning from past mistakes:

The main thing was getting the word out, getting the awareness part out into the community and the . . . places, those people who would see those people who would make the referrals. The gatekeepers. . . .The neat part about doing the pilot was that you were not concerned about the fees. That was sort of nice. And by this same token, it may have involved us in because our response was so good. I think by using the PR that we did in hooking in with . . . (an advertising agency) They really put a neat package together for us And we weren't out there trying to get it on a fee basis. Identifying that was really not all that difficult. . . .But what happened, and I talked to (my boss) about this later, which was when we tried to put another one together later on. . . .a fee basis, and we did a lot of the same things with the exceptions that. . . .we didn't do any newspaper work. It appeared to be the difference. And I sat down and he and I talked about that, and I was trying to figure out, what was the difference in this time than the last time, other than the money. People called us. And they didn't know about the money one way or the other the first time. . . .and they wouldn't have known this time either. So what would have been the difference? And the difference I think was. . . .that we did a lot of mailouts to agencies, I sent letters to AlAnon and ACOA groups, and all that sort of stuff. . . .but what didn't happen the second time, really in this case, maybe, it was the third time, was that we didn't do anything with the newspapers. . . .but that seemed to be the critical thing in this area. The people responded, as I recall, the first time, from newspapers.

. . . .Well. . . .helpful side of that, again, was the ability to go outside and get to an advertising agency to set all this up. I mean, that was like using the cream of the crop. (a prestigious agency). . . .And yes, what I did, not a whole lot, but they probably did somewhere in the neighborhood, if they billed it out, close to -- between \$10,000 and \$15,000 worth of work. But even after we had done that, the hinderance was -- I have to go back to the . . . is that we didn't do the

same thing. It worked. And we sort of did some of that. But again, not with the same push and the emphasis that came off after the pilot was done. I think it was almost a resting on our laurels kind of.

Yet, there is never enough time to devote to marketing:

Aha. Well, the agency, once it is going, it is pretty supportive. I mean, I haven't experienced it in a negative way. The problem has been marketing, I think. We have some good programs, but we don't have people marketing them. And that's a hinderance. I think that is the main hinderance. Sometimes, the nature of the service and its

reimbursement (as in the Alcoholism Unit) preclude aggressive marketing.

Nobody has got time. . . .To let the community know. Everyone is pretty overworked. . . .And our funding comes from purchase of service. So we are tied to the office. So for me to send somebody out to do marketing for a day, I could never do that. . . .Because we are allowed so many dollars per year. And our budgets are based on that. And it's secure money. So we have to generate that. And that helps feed other parts of the agency that are less secure. So it's a Catch 22 in some ways. So we've been looking at how to market. How can we do this so that we can get a broader range of clientele?

While it is not easy to take the staff time, on the whole, the FA goes a step further than the CA and the AA in developing and marketing programs.

Relationships with Other Community Agencies (External Turf Issues)

The struggle between cooperation and competition with other agencies is clearly evident at the FA. While other agencies can be looked at as competition for scarce funds, they may be looked at also as partners and as resources.

The FA cultivates many community agencies as sources of clients and as partners in programming.

Well, again, keeping the community referral sources informed about what is happening in the families they are referring to you. The other thing that we've done very nicely was establish an advisory board of some of those folks so that they can continue to have input into the design of the program as well as those are my folks that have identified those community issues that we now can build on to get those new funding dollars to keep us going. And they are trouble shooters. And we do have issues which come up when you are utilizing volunteers or professional staff. They've also been wonderful in helping us iron out any glitches.

and

I was determined from the start that I was not going to alienate them, I was going to work with them because funding cycles go around. And if you have grass roots organization behind you, you have a better chance of getting your funding. . . .So, the Alliance invited us to their monthly meeting to talk about our program.

and:

(Our city) is a kind of funny city. It is not very well coordinated. Like in (the major nearby city), the services are very well coordinated. People know what other people are doing. And they have networks. That's not true here. So you find people over here doing something and people over here doing something. And it is a much less easy-- it is difficult to find out what the right hand and left hand are doing. . . . It's mainly turf issues. The more we get into the community the more we see it. And (our city) is part of the turf issues. . . .we have competed for dollars. And some of it has been the same dollars and some of it has been different dollars. And they have tried to have like a community sense and it hasn't worked very well. And we have a new administration this year come in. And that's made it even more difficult to know what is going on. So that's been part of the problems They were (trying to set up services). They had a task force that was suppose to do something. And the task force met for two years, and they ended up having a fair, like a drug awareness fair. And that is what they did. . . . And it took them two years to get that together to do that. So it has been a little disconnected. And the (city) schools. . .are just beginning to have student assistance programs. But the

schools have not all been. . . knowing what each other is doing. So, for instance, we can go into a school and do a program and the administration doesn't even know we are doing it. But the principal invites us in and says, please come and do it.

Coordination is difficult. Much of what happens in substance abuse is seemingly very haphazard. It can be difficult to plan services when many agencies want to take advantage of funding opportunities. The FA took a proactive approach to this.

So we decided we would get on the task force, which is still meeting. And there is a task force in the schools. And we followed it. At those meetings there is hardly anybody in treatment at the meetings. Hardly anybody that is doing substance abuse work goes to the meetings. And they are making all these decisions about what the treatment and the whole perspective should be. So it is pretty interesting.

There is the additional problem of introducing new technology that may be threatening as with the program to prevent rehospitalizations of chronically mentally ill:

It was also, in terms of the impact on the community, it was a significant threat. . . . Because up in the administration at CMH (Community Mental Health), they can set any kind of a policy they want. But what actually shakes down to the front line caseworker or front line supervisor is a very different story. And we had considerable resistance in the front lines because people for one reason or another saw this as interfering with their treatment. They were steeped in traditional mental health thinking and felt that the parents really were to blame. We encountered significant resistance. . . . I remember, one presentation the staff reported back to me. They had gone out and were presenting to the staff the concept of the program, and one person, one staff person said, "I've got a young woman. Would this be the kind of case I could send to you?" And before our staff could respond, the supervisor said, if you send that woman to that program, you'd be signing her death warrant. . . . That was probably the strongest, but it was that kind

of resistance. Which is not, I mean, it is to be expected. I wouldn't say they, I'm not faulting them. I'm just saying that when you are introducing something new like that and it is going to destabilize the system and it did. Well, there was the resistance from the professional community. There was suspiciousness from the families.

All in all, the FA has been careful and clever in forging an important and respected role in the community.

Responses to Funding Constraints

The FA responds to the lack of consistent investment in human services forthrightly and with creativity.

And we wish we could get foundations or governments to understand that when there is a quality program that is effective, it is important to have some long term funding for that instead of one year categorical kinds of funding, which has been the trend. In the last couple of years, though, we have been fortunate to receive several three-year grants which has been much more helpful.

While it must be particularly discouraging when successful social programs lose their funding, response was creative:

So we have a woman. . .who's a real fierce grant writer, who's gotten two federal grants to do group work with clients who have chronic neglect, and then people whose children had been placed in foster care. Basically the same. It's group work twice a week. Its FLE (family life education). It's basic life education. How to wash your house, how to wash your clothes. And some parent-child interaction. . . .And she's the person who started the parent education. And the parent education program used to be a program where we very assertively tried to engage people. In fact, this whole therapy program used to be a program where we very assertively tried to engage clients who were very resistant. And, now we have more money then we ever had and it seems like less to both us and the state. And so the choice the state has been making was

to not try as assertively to engage those that don't respond. . . .To let them, to some degree, fall into the cracks. And what C has done, and she very grumpily gave up the supervision of the PE (parent education) in order to have enough time to do the grant writing and these other two programs, is to create programs that are funded elsewhere. But the problem then, after the initial three years and \$300,000 for the 40 families in the original family empowerment program, then it's getting a second band of funding, a second shot at funding for it. Then what we call partners in permanency, which is the foster caring one. Again, that is a demonstration grant. And it's going to be a problem getting further money. But it is not really expensive if you prove what you get, compares to some other -- it's like partial day treatment, really, is what it boils down to. It breaks down isolation and creates a support group. (This is a very disadvantaged population.). . . .And you won't have believed. . . .seeing them walking in a hall, what changes were wrought in their behavior and appearance. . . .By the time they finished the program, they would walk up to a stranger and say, "Excuse me, have you seen (so and so)? I need her for such and such." You know. And good eye contact. No smell. Good grooming. . . .Well, I think this government that we have now has no commitment to services. Quite the opposite. They don't believe they should be offered. They believe people should give them on their own. And so the funding for public works is really -- I mean, even like road repairs, it is not what it used to be.

The FA, however, maintains its commitment to seeing a program up and running or to seeing it continue.

I think dollars is always a problem. I think whether, I don't know which comes first. But there is also an attitude, I think, of indifference to that kind of thing. Because it doesn't seem exciting or it doesn't, it isn't clearly articulated to other people in the agency. And they have projects that they want to happen. And, it really takes somebody who is really committed to seeing that it is going to happen. And who can bear the indifference and the snide remarks and whatever. The stingy dollars and all of that. . . .And that can happen. That is interesting because I guess in retrospect now that you have gotten me talking about it, I'd put committed folks first. That if you can find committed people, you can make it happen, dollars or no dollars. Because they will give the time if they are sold on it.

There is certainly a need to be creative with funding.

Often, managers had to give an exciting, new twist to the program. When asked whether the funding for their oldest prevention program was secure, the administrator of that program replied:

Well, yes and no. The first few years because it was innovative and creative and new and there weren't too many folks doing it, we had lots of interest. Now that we are 13 years old, it is not a new project anymore. It is difficult to maintain ongoing funding. What we've been able to do, though, is develop some specialty areas to continue the funding. For example, we had years where we've offered the perinatal program to teen parents and gotten funding under a teen parent umbrella. We are now getting some funding under the area of children at risk for developmental delay. We've also started a new project this year which is an NICU support project in neonatal intensive care unit. Where again we are working with sick babies and their families.

The FA has tried many strategies to "get some new capital according to the development person."

Especially after 10 years of the program, we've had to really be much more creative in how we do that. . . .So we've had to be somewhat flexible because the perinatal program has really been the base or the entry point for the continuum of services. So it is important for us to keep that component going somehow. But private foundations want new projects or new services.

A program to prevent infant mortality was a spinoff of the perinatal program project using birth companions. The response to a question about whether this program was separate from perinatal was:

Well, kind of. It's the same thing. It's a creative

way of packaging perinatal program. But in order to continue funding, we had to go in a broaden the spectrum. And target not only the prevention element but also to address the infant mortality that was in the County area. And it was kind of a creative way that the staff went about getting funding. To continue basically in the perinatal but, as I said, on a broader basis. Then, I want to say ten to twelve years ago, United Way contacted us to start a child abuse treatment program which we did so. It was a small grant. Unfortunately now it is one our our largest programs. We have the only contract in (the) . . . county through the department of social services to provide treatment in this area. And from that there are many spinoffs that have been developed which are prevention work. We (do) an awful lot with children, for example, to keep them in school. . . . They did one on one with these (dropout prone) kids. They worked with the child, they worked in the schools, they worked with the families. . . . It was a very, very successful program. Unfortunately it was not funded. We have developed a new program. We've applied for (a) Federal grant that is an expansion of that because we know it works.

Indeed, funding constraints are reframed as opportunities to do new prevention programming. A successful program is renamed or retargeted to a slightly different population or problem. This agency goes after funding to keep a successful program going in one form or in another.

Commitment to Social Change

Many workers at the FA locate problems in the larger society rather than in individual clients. One worker expresses this clearly:

I think that there is an attitude that the problems . . . that people experience are symptoms of a larger picture. And there is an understanding of that in the agency that it is really societal problem, not an individual problem. And so you've got to prevent it. Treatment is a lot harder than prevention. And I think that we know that because we see that. The effects of

not having prevention all over the place, here. . . . I guess I am really tired of picking up pieces. You know, people's lives. . . and I feel really sad about children, you know, that get born into families that you can see the handwriting on the, you can see what is going to happen to them in 15 years. And I've always had (the) attitude that people don't necessarily need to change, but that society needs to change. So I guess that that's like a prevention kind of attitude. People also need to change, but that's not, lots of people can change and we are still going to have problems because of the way our society promotes drugs and alcohol. How we live our lives essentially in America. It is a drug culture.

and:

I see prevention as anything that is going to improve and facilitate growth in any human relationship or any individual growth. My own focus is to prevent child abuse and neglect and just to improve parent child relationships. As an agency on the whole, I feel their focus on prevention is in every aspect. They are open to every aspect of preventing. Whatever. If it's preventing adolescent delinquency, or (working on) family functioning, whatever we can come up with that we feel is going to affect society in any way, you know, we are trying to do that. . . . I think the key to any agency is creativity. Along with flexibility. And once that's there, people start to see the patterns that are going on in families. And you can pick out some key components and then develop programs for those. You know, like birthing moms and working with infants, and infant mental health. Focusing on the very beginnings of the relationship. . . . I think it is just, you know, starting from the very beginning and working your way up and figuring out what families need. And being open enough to be able to supply those. And getting funds and applying for funds with flexible guidelines so that you have that flexibility in the kinds of programs you develop.

In line with its mission, the FA tries to provide a broad spectrum of services to all of the population. Their in-house public relations person expresses the difficulty of aiming service at the disadvantaged and retaining donors.

And one of the things we've had to deal with is they figure we just do charity cases. Those are the down and outs. They are the ones that don't want to help themselves so why do they want to contribute to those kind of people. Where in fact, that is not the case. Many times circumstances have controlled what they are involved in. And it may be generations of problems. But if you don't break the cycle and you don't let them know what is available and help them through the process so that they become strong and independent and can stand on their own two feet, they will never break that cycle. They will always be stuck in it. And I think people in the wealthier communities don't always recognize that because they are not from that kind of a background and they don't understand what is involved in it. But our biggest thing is we have to tell them we are not a county function. Because of the name, it sounds like we are part of the county. And that we do provide services to everybody besides just the real needy. And what we try to do, for example, when we are thinking of wording in our fund development letters, we tell them that your dollars help us provide these individuals so that they can become a strong community member. It is a way of getting around that, so that they are temporarily helping the people become strong. And that's how we word (it)

Summary

That the agency and its staff locate problems in society and not necessarily in individuals gives a unique flavor to the FA's mission and operations. Rather than targeting services to a narrowly defined problem area or to small segments of the population, they reach out more broadly. They try to creatively develop and adapt programs as they uncover needs and seek out funding opportunities. Constant innovation breeds organizational change which includes crossing lines between units and services. While this creates administrative difficulties in areas of accountability, it apparently results in responsive prevention programs.

Prevention which is proactive as well as reactive takes place within the context of breaking the intergenerational cycle of a problem. It is a goal shared by more than one division of the agency.

In a followup with the FA approximately one year after the interviews reported above, despite turnover of significant administrative staff, the FA continues to offer DN at agency and community locations and it has recently received a grant to adapt DN for pregnant, addicted women.

CHAPTER VII

CONCLUSIONSPattern Matching "Effects" and
"No Effects" Propositions

The key organizational dimensions, particularly leadership's interpretation of agency mission, had a decided effect on the ways that the AA, CA and FA conceptualized and implemented DN. There are parallels between the propositions put forward under Theoretical Framework above and the outcomes for the AA, CA and FA, respectively, with respect to conceptualizing and implementing prevention. They were:

- o Neither DN or other prevention programs were implemented after the pilot implementation.
- o DN was grafted on to existing services with little or no organizational change.
- o DN stimulated clearer articulation of mission, definitions of prevention and growth of prevention activities using DN and/or other programs.

The propositions appear to parallel the findings for each agency. Yet, there is insufficient data to affirm or deny the underlying premises which are repeated below. However, the FA appears to most closely resemble several of these premises.

1. Agencies with a view of the larger picture of social need and commitment to stopping the flow of clients in need of services will enlarge their mission and goals and seek out prevention programs that target specific populations or the population-at-large with resultant changes in the structure of the agency.

Staff and other resources will be assigned.
New funding will be sought and/or fee structures
will be revised.

Other similar (prevention) programs will be
institutionalized.

Staff may participate in deciding the targets,
types of program, or other aspects of preventive
intervention.

2. With a beginning conceptualization of prevention as
something that is different from treatment as embodied
in DN, workers will use their unique skills for
prevention.

Workers will recruit participants who would
otherwise not seek out agency service.

Workers will use a traditional means to recruit
clients.

Workers will adapt DN to local needs and
conditions.

The propositions against which the cases were compared
assumed effective leadership to foster staff commitment and
creativity to bring about a reallocation of internal and
external resources for prevention. Management, then, was
thought to be responsible for or must delegate
responsibility for analysis of client need, problem
definition, and leverage for change to mount a continuing
effort to raise the capability of their organization to
carry out prevention programs. Leadership was found to be
one of the key dimensions, if not the key dimension, in
interpreting agency mission to increase prevention
programming.

The AA

The proposition most nearly matched by the AA is that

Neither DN or other prevention programs were implemented after the pilot implementation.

While the AA has a strong commitment to bettering the lives of those who suffer addictions, it lacks a "gestalt or global vision" about services for its disadvantaged clients. Rather, it fine tunes treatment technologies for which resources are allocated. It works in a linear way, adding treatment services for more widely defined segments of the addicted population. Clients are viewed as needing treatment. Therefore, more treatment is provided. While it has articulated a role vis a vis children, it cannot fully develop a prevention program because of the way funding is obtained. Without articulating such a role, despite the presence of its children's services and despite its successful implementation of DN, prevention activities were primarily ad hoc at the time of this study. Unlike the other two agencies, DN was not implemented again. It had little or no permanent effect on the agency. While the AA has bought into the national agenda in mounting a program for children of alcoholics and addicted parents, the lack of a cohesive, preventive stance appears to block organizational change. In effect, like the children's program, DN was grafted on to existing treatment services. Mission goal and structure remain relatively static.

Mutual adaptation, the interplay between programming and organizational factors, has not visibly taken place.

This was a time, however, of great change for the AA in auspice and location. The AA may be at too early a stage in its evolution as an organization for a process of institutionalizing prevention activity to begin. The children's program yet may become the vehicle through which prevention activity has increasingly greater effect on the organization. Milbrey McLaughlin (in Williams & Elmore, 1976, p. 11) discussing organizational change in schools, stated that it was necessary to give tools rather than be the tool for change to occur. If she is correct, without changes in the structure of the agency, new practices become "more of the same." They are unlikely to lead to much significant change for clients.

The CA

The proposition most nearly matched by the CA is that

- o DN was grafted on to existing services with little or no organizational change.

The CA's Community Services has a strong commitment to early intervention for children where a crisis such as divorce or alcoholism threatens optimum development. There is a vision of what is needed for healthy child development and an ability to capitalize on aspects of the national agenda to fund programs such as its groups for children

with divorcing parents or with alcoholic parents and DN. However, outreach is limited to clients who can access the agency. At this point, there is limited commitment and, therefore, little action to reach less mobile populations. The CA, too, works in a linear way, adding services to existing services when funding is reasonably secure. Its view is to provide services where problems already exist at the earliest possible point of intervention and for a relatively advantaged population.

While there is certainly an overwhelming need for reactive services, there is no "gestalt or global vision" that presages a lessening of need for these services for any segment of the population. Indeed, the more emotionally and economically disadvantaged are seen by one administrator as incapable of change and needing ongoing maintenance services.

While this agency does not distinguish prevention as different from treatment, it has steadily increased its early intervention services. It has institutionalized DN as an agency offering and expanded its availability, through new funding, to the evening as well as to daytime programming. Staff is not involved in decisions about how programs are funded or implemented. Yet, new funding was sought in order to assign staff to additional offerings of DN.

Perhaps in the CA's case, its weakness vis a vis

prevention is also its strength: leadership's strong commitment to programs of early intervention have brought about a strong, cohesive effort. However, only those programming and financing opportunities that fit this mission are undertaken. As a result, important, careful work is accomplished. The way the work is structured does not challenge management or workers to address the entire community in need.

As with the AA, DN was grafted on to existing treatment services. Mission, goals and structure remain relatively static. Adaptation of organizational factors has not occurred despite successful and ongoing implementation of DN. In the CA, a new program is institutionalized; however, it becomes "more of the same."

The FA

The proposition most nearly matched by the FA is that

- o DN stimulated clearer articulation of mission, definitions of prevention and growth of prevention activities using DN and/or other programs.

The FA has the most clearly articulated conceptualization of prevention and, in addition to continuing to implement DN, it has adapted it to attract wider and different populations in varying settings and parts of its catchment area. As a result, the underlying premises about changes in staffing, seeking funding, participation of staff in decision making, targeting

clients and adaptation of programs are most true of the FA.

The FA's definition of prevention as interrupting the intergenerational cycle of a problem is voiced by the leadership and by most staff who become entrepreneurs in expanding programming to widening groups of clients. While the CA's notion of early intervention is cohesive, it is not "global" in that it embraces only those who already have some "wound." The FA's vision, on the other hand, takes in those who are not yet "wounded" along with those who are. As with its perinatal (birth companion) program, many of its offerings provide tools to clients that are designed to interrupt the cycle of problems before they occur. In that it more fully embraces "primary" or true prevention as well as treatment, it might be said the FA's vision is more truly a "gestalt or global" one.

Prevention Approaches

The three agencies are sufficiently different from each other and, respectively, parallel existing public health definitions of prevention:

- o primary, preventing new cases from occurring--the FA;
- o secondary, reduction of prevalence--the CA
- o tertiary, ameliorating further ill effects--the AA.

The categories "primary" and "secondary" correspond to "proactive" and "reactive" which attempts to define prevention in a way that is more meaningful to social work. Rehabilitation (which is not considered prevention) is offered as the equivalent of the public health notion of tertiary prevention. (Borkin and Siegel, in Bowker, 1983)

The FA seeks to work proactively although, like the other two agencies, also mounts programs that are reactive. The CA defines itself as reactive, carving out early intervention as a niche for its community services department. While the AA is engaged primarily in rehabilitation, it manages to do prevention work that falls somewhere between proactive and reactive work with children of alcoholics and addicts. The AA and CA target their activities to particular individuals and problems. The FA targets some programs and offers others to the total, rather than to a defined at-risk, population.

Each agency, in their mission and organizational

characteristics, may be seen as an "ideal type" against which other agencies might be compared both in terms of their work in the area of prevention and with respect to creativity and innovativeness. A discussion of the dimensions examined in the three preceding chapters is presented to set a context for the results of the ideal type analysis.

Definitions of Prevention

The continuum of public health prevention and social work prevention definitions embodied by the agencies studied were not the only ones to emerge from the case studies. In many of the interviews, the notion of interrupting the intergenerational cycle of a problem was alluded to and, at the FA, it was synonymous with prevention. A definition that presages the possibility of a new conceptualization of prevention for social work might well be based on this notion. Such a conceptualization might clarify the important differences between provision of treatment services for those already experiencing problems and anticipatory, proactive work that may decrease the need for future treatment. It challenges the social work field to define prevention and treatment so that they are distinct from each other in goal and, in so far as possible, in activity. To do so certainly has implications for elevating prevention to the level of importance

treatment has had in social work.

Leadership and the Interpretation of Agency Mission to Staff

How prevention was defined in each of the agencies was consonant with each agency's depiction of its mission. In this dimension, each agency was distinctly different from the other. Within an agency, similar definitions were heard in the words of administrators, development personnel and the workers. The more strongly an agency's mission was articulated by those in leadership positions, the more clearly a similar definition was expressed by other levels of staff within that agency and the more clearly prevention goals were communicated to staff. Too, agency leadership determined whether this interpretation of mission was applied to the whole agency or only to a segment of it. The expansiveness of outreach by any program was also related to how mission was articulated by leadership as when the prevention strategy chosen involved the total population or targeted a smaller, specific at risk group.

Flexibility of Organizational Structure

Within the framework of mission and leadership, the agency and its workers may create a culture that permits change in services offered. In an agency free to develop programs with a preventive thrust, there was generally some

autonomy of unit heads and even of workers. Flexibility of organizational structure, while complicating issues of accountability and cost allocation, appeared to enhance implementation of new prevention programming through staff availability and client referrals.

Intra-agency Communication and Cooperation

An agency poised to implement a new program--particularly a program that might be accomplished in several divisions of the agency or one that employs new technology or direction--is an agency with good cooperation and communication between its services. Permeable divisional boundaries appear to be an asset. Workers too need to be flexible about ways of working with each other. Internal marketing of services must be encouraged and supported so that clients receive the most appropriate service even when it is not an offering of the department in which they were first seen. Agencies may only approximate this. Often, they may inadvertently discourage intra-agency cooperation because they lack formal and informal mechanisms for such communication. Fear of confusing who does what or allowing funding sources to determine boundaries may underlie and reinforce separation of workers and programs.

Too, new programs can redefine divisional boundaries or, at the least, fruitful ways of crossing them. But,

programs are most effective when there is a culture of acceptance and openness that is agency-wide. Many dilemmas are not easily resolved. With DN questions like the following will continue to plague administration: Where should a parenting program that targets both parents and children be housed? Who should do ACOA work? Those who work with adults? Those who treat alcoholism? Those who see children? New programs challenge agency culture as well as accountability procedures.

Flexibility of Staff with Respect to Technology

Flexibility of staff in relation to technology is also a noteworthy factor when implementing a new program. Despite movement to a generic social work methodology widely taught in the schools, most graduate social workers do treatment. The number of practitioners entering private practice gives credence to this. More workers prefer to work individually using a psychodynamic orientation despite the widely taught ecological systems model. The enchantment of social workers that began with Freudian theory to the detriment of more strength- and community-based models may still hold sway. This dichotomy between psychodynamic and psychosocial, between deficit vs. strength models will be seen clearly in the words of many workers who balance traditional treatment against other technologies for program development.

Encouragement of staff to experiment and to use appropriate graduate and life and work experience appears to be key in using prevention programs innovatively. If there is little encouragement of staff to go beyond current programs or the clients these programs were designed to attract, prevention efforts may be limited. Too, the attractiveness of doing prevention, and doing it with difficult populations, is an issue that is also related to staff flexibility and social work technology.

Research and Evaluation

Research and evaluation can be a means to obtain and retain funding for prevention programs. Yet, research has only begun to be seriously undertaken in social work agencies. In the past, it has not had a high priority. Research in prevention may be rarer despite a growing body of literature and technology for its accomplishment. The notion expressed at the CA and FA by several staff members was that prevention is nearly impossible to evaluate. How can you demonstrate something that doesn't happen if you successfully intervene? Often, funding sources that require evaluation are the impetus for the conduct of research.

The larger system in which the agency finds itself determines how successfully new services can be undertaken and institutionalized. Funding resources, cooperation and

competition with other agencies, and recruiting clients all play important roles.

Social Marketing

Marketing of social services is a new concept in which social workers are gaining sophistication. Public relations and marketing as used in for-profit business adapted to the public service arena are ways to position an agency to gain funding and expand clientele. (Bourgeois & Helm, in Winston, 1985)

Relationships with Other Community Agencies (External Turf Issues)

Relationships with other community agencies (external turf issues) often have a great deal to do with funding, reimbursement and with how agencies go about implementing a new program. Agencies seeking to expand their reach may be somewhere in the process of converting conflict to cooperation and mutual endeavor.

Response to Funding Constraints

Prevention programs are often experimental. They lend themselves to venture and seed money grants as well as to creative ways to continue financing them. The more innovative agency not only use prevention programs to seek new clients, but also to gain new funding. Often, a slight change in a successful program or a redirection of it to a

new group of clients will enable a program to keep going even after it loses its original funding.

Commitment to Social Change

Personnel in all of the agencies studied are well aware of the impact of societal problems--poverty, drugs, abuse and neglect--on individual clients. It cannot be said that staff in any of the agencies lack interest in social change. However, agency mission and administrative interpretation of it in the face of limited resources, force choices about how services are developed and offered. Whether services are offered to the general population or to a specifically targeted group was closely related to how prevention was defined in each agency. These factors determine ultimately how workers feel about the contribution they are making to social change. Change goals, then, may or may not address the least advantaged: Services are not always directed to those with great need. When agency programs are contrasted against underserved populations, workers are able to talk about social concerns and to apply prevention ideas to broader populations.

A Classification of Prevention Approaches

While the case studies demonstrate how prevention is practiced in social agencies today, ideal type analysis of the factors discussed above goes beyond the realities of

the agencies to a classification of model agencies along a continuum of approaches to prevention that parallel the various conceptualizations of prevention and implementations of DN. Studying the three actual agencies led to the following taxonomy of ideal types with respect to prevention which has implications for creativity and innovation in addressing social problems.

It should be noted that ideal type analysis is a way of assembling the most salient characteristics that distinguish one type from another. It does not confer a value judgement of "good," "better," "best," but, rather, differences in orientation, characteristics and outcomes. All three types have as equal a likelihood of doing important work. However, the kind of work is not the same.

The first type that is described most permits a vision of proactive work and an entrepreneurial stance that allows staff to make and/or take advantage of opportunities in the external environment. Proactive work is likely to create changes in the configuration of the agency. The second and third types might also be called treatment: early intervention and late intervention. These two types use prevention in a looser, more ambiguous way, with less conscious or less deliberate intent to intervene before problems occur in prospective clients or in successive generations of prospective clients. The three types may be seen as points

along a continuum which represent agencies at various stages of conceptualizing prevention and evolving ways to implement prevention programs.

The major differences in organizational dimensions of the agencies, then, helped generate the descriptions of ideal types that follow although neither of the three agencies studied or any other agencies will exactly fit one type. As with COA, a child may appear to be the "family hero," "lost child," "scapegoat" or "family mascot," (Wegscheider, 1981) but that child will also share some of the characteristics of another type or may evolve from "mascot" to "hero" over time. This typology of agencies may be predictive of an agencies interest and ability to implement a range of prevention programs. It may also reflect developmental stages in social work's evolution of prevention work in its agencies.

Characteristics of a "Proactive Prevention" Approach

All agencies that address prevention issues and devote resources to prevention may be innovative. Those that seek to address those at risk before problems occur may have the following characteristics.

1. Commitment to social change and defining prevention as ending an intergenerational cycle of a social problem: e.g., breaking the cycle of poverty, breaking the cycle of alcohol abuse.
2. Provision of a clear vision and a philosophy of prevention that is consonant with the agency mission and organizational culture.
3. Adept handling of the vagaries of funding sources: i.e., retooling or reframing existing successful programs to obtain new funds. Viewing funding constraints as opportunities for creative program development.
4. Development of an interrelated set of programs; building in new ones and augmenting old ones as new needs or funding constraints occur.
5. Addressing interagency turf issues: e.g., playing a leadership role in area task forces; proposing on joint programs with other local agencies.
6. Confrontation of internal agency "turf" issues and resistance to prevention by more traditional "treatment" service givers.
7. Familiarity with research on prevention programs; ability to disseminate information about own successful programs after it institutionalizes the program.
8. Conduct research to show effectiveness and cost benefit.
9. Frequent informal intra-agency communication about programs and the opportunities they represent for existing agency clients as well as new clients.

10. Encouragement for staff to experiment, use graduate and work or life experience in developing program.
11. Creation of organizational staff positions that recognize prevention: e.g., Director of Prevention Services
12. Agency mission permits a wide problem, developmental focus; e.g., not solely alcoholism , but the interrelated problems a family may encounter at different life stages.
13. Aggressive social marketing.

In general, prevention is seen as an opportunity for growth and change and a means to bring about change. Implementing a prevention program may be a new way to seek funding to attack a social problem within the agency's domain. It may be an opportunity to foster new staff relationships across agency divisions toward greater intraagency cooperation. It may also bring opportunities for interagency partnerships.

Characteristics of a "Reactive Prevention" Approach

Agencies that seek to intervene to limit or end the effects of problems at the earliest opportunity may have the following characteristics.

1. Commitment to reactive prevention for a targeted group of clients already experiencing a problem. This approach is used for a narrowly defined problem such as a specific life cycle crisis (e.g., divorce, impact of alcoholism on children in a family) to reduce impact or prevalence. May be best used when the problem can be isolated and worked apart from a nexus interrelated social problems.
2. Provision of education and early intervention to offer treatment at the earliest possible moment to a targeted group or for an aspect of a larger problem.
3. Viewing funding constraints as roadblocks rather than as opportunities for creative program development. Interest in fee for service, with some ability to find funding for programs that clearly address goals and targeted clients.
4. Development of a limited set of programs related to the same problem focus and clients.
5. Building own reputation in the community; little attention to "turf issues" with other agencies.
6. Little confrontation of internal "turf" issues with strong barriers between various agency services; little client flow, or shared caseloads between departments.
7. Little attention to research, evaluation, or dissemination of own successful programs.
8. Use staff and client feedback to evaluate programs once they are institutionalized.
9. Infrequent formal communication across agency divisions.
10. Little encouragement of staff to expand current programs or target new, different clients who might benefit from them.

11. No special designation of a staff position that recognizes prevention although staff may see themselves as doing psychoeducation rather than treatment.
12. Agency mission narrows problem focus to one stage in the life cycle.
13. Sophisticated social marketing.

In general, prevention is seen as an opportunity to enhance the growth and change in a group of clients. Implementing a prevention program may be a new way to address the same or related problems of a wider cohort of similar people to those that the agency already attracts. It may have little effect on the organization or functioning of the agency as a whole.

Characteristics of a "Ameliorative Prevention" Approach

Agencies that seek to augment treatment services for clients and their families through education and other prevention technologies may have the following characteristics.

1. Commitment to ameliorating a particular social problem and defining prevention as reducing prevalence or preventing relapse.
2. Interpretation of agency mission reflects some effort to reduce or eliminate a problem before it occurs despite the overall treatment focus of the agency.
3. Viewing funding constraints as justification for staying with fee for treatment service reimbursements. Some effort to obtain funds for small pilot programs.
4. Prevention activity represents an isolated program unrelated to the major work of the agency.
5. Awareness of interagency turf issues with some ability to confront them.
6. Acceptance of traditional treatment services which remains separate from and superior to prevention services.
7. Familiar with research on treatment of the problem which is the focus of the agency. Work is evaluated in terms of numbers of patients seen for treatment.
8. Little or no research done.
9. Little intra-agency communication about programs and the opportunities they represent for agency clients.
10. Some encouragement for staff to do prevention under the rubric of "treatment".
11. No recognition of prevention through creation of organizational positions.
12. Agency mission forces narrow problem focus on treatment of a particular social problem (alcoholism).

13. Little or no social marketing.

In general, prevention is seen as an opportunity to offer additional treatment to clients. Implementing a prevention program may be a new way to treat the same or related problems for existing clients of the agency and, incidentally, to prevent problems in the next generation. It has almost no effect on the organization or functioning of the agency as a whole and agency constraints overwhelm ability to institutionalize it as an ongoing agency offering.

Implications for Social Work

Toward A Social Work Definition of Prevention

Social workers need to conceptualize prevention and treatment as distinct and separate endeavors. The public health definition may be appropriate for application to disease entities. It is not applicable to a field that derives its sanction from building on individual, group and environmental strengths. Social work definitions of prevention and treatment should address a vision that social workers have for the people we help. Our definitions of prevention and treatment should be more attuned to the goals of our work.

This study is only a step towards defining prevention as intervention that precedes the onset of a problem and halting its intergenerational cycle. While this definition may include public health's "primary prevention" and social work's "proactive prevention," the modifiers are unnecessary if we are clear that prevention seeks to interrupt a defined cycle of problem such that there is no reoccurrence and the incidence of this problem is lowered and eventually eliminated. Treatment, on the other hand, responds to problems that already exist. It includes the public health notion of "secondary prevention" and social work's "reactive prevention," but ceases to use the word prevention in this context. Attempts to reduce the severity of a problems, in public health terms, "tertiary

prevention," are neither able to reduce incidence or prevalence may be defined as amelioration or rehabilitation. Treatment, then, is conceptualized as reactive efforts to reduce the prevalence or the severity of a problem. Some programs will address both prevention and treatment at the same time. Yet, it is possible to be clearer about prevention and treatment goals.

Using these definitions, Discovering Normal is a treatment program for parents who learn communication and other skills that enable them to function more adequately. They seek to eliminate those deficits learned in their alcoholic family of origin. For their children, Discovering Normal is prevention. Ideally, they will never develop those problems associated with growing up with parents who experienced familial alcoholism and its related deficits.

Social workers do prevention, treatment and rehabilitation. Their work in each of these areas is important and needed. However, the profession lacks clarity about when it prevents, treats, or rehabilitates. In most social work settings, these three functions are treated as one. At worst, this lack of clarity holds social work in thrall, enmeshing it in the problem. At best, social work gets little credit for its work to limit and end the need for treatment. Social workers are not seen as part of the solution to problems.

Social Workers

Many social workers do treatment because that is what they were trained to do in their graduate programs and in the social agencies they became part of. Too, many social workers leave the field because of "burn out." While prevention work is not a panacea, it offers an alternative to the perception of the helping professional failing the old, Cornish test for insanity by carrying bucket after bucket to be emptied rather than finding the wrench that will turn off the faucet.

Social workers, through dedication that is overwhelming, inertia and fear, become agency-bound, set in ways of helping, and anguished about larger social need that is not touched by their work. As one social worker at the CA said in response to a question about what she would do in the way of prevention if she could,

. . . Start as early as you could start. And it would be to invest money at, it might be, oh why did you ask me this, you're tapping me, the old social activist in me. . . . I wouldn't want it to get lost in this part. I started to say that they might even, if people, if they had the money, might even invest money in looking at, to do an evaluation of what was needed. I mean, what kind, of like what I said, I think that community service would be better to begin with. Things in the community. But, o.k. everything can't go in the community. I remember working when I was in school, to get my M.S.S., I did a field placement in a maternal infant care unit in a hospital. And there were lots of things that we tried to do just as students that I think there is room there. And it may be happening now for all I know. I don't know what's going on there. Its like what's possible.

In recalling the hospital based prenatal program for pregnant women that she'd experienced as a student, this

worker got in touch with her own vision of what social work might be. This experience and creativity is there in many workers waiting to be tapped.

Social Work Education

Education provided in our schools of social work reflect the lack of clarity in the field about what should truly be called prevention. That prevention has no special place in most social work education leaves workers without training in use of their skills for prevention work. Very few graduate social work schools or departments have coursework or placements in which prevention concepts, strategies or programs are used. A "gestalt or global vision" of prevention that links up with social policy as well as with treatment technology is lacking. While knowledge of the life cycle, social environment and treatment informs about where we might intervene to do prevention, it is not sufficient encouragement prevention program development. If social workers are clearer about the continuum of services that their work can address--prevention, treatment, and rehabilitation, we may begin to make choices about how resources are better allocated. This can only begin if we examine our educational goals and, perhaps, obtain a better balance in training professionals.

Implications for Further Research

Two kinds of research are essential:

- o Research in curriculum development and field instruction in schools of social work.
- o Research that furthers prevention technology and strategies in social agencies.

While interrupting the intergenerational occurrence of a problem is the most innovative of the many conceptualizations of prevention discussed in this study, research is needed to further define and to develop a consensus about prevention in social work. It will be important to learn how agencies compare themselves with the "ideal types" above and whether these models are useful for prevention goal setting. Shifts in organizational dimensions need to be examined where changes in service mix are desired. A test of this taxonomy of prevention approaches when implementing other prevention programs may expand it and add to its usefulness. Jansson's study (1983) of the ecology of organizational factors related to prevention services and its taxonomy of agencies ranked by time and place of services suggests a quantitative methodology that, combined with the intensive case, ideal type analysis developed for this study, might shed additional light on defining and developing meaningful prevention activity in social work agencies.

It is certainly important to learn more about prevention services offered in social agencies and their relationship to treatment services and social change.

Research and its utilization is also necessary for sharing and encouraging effective preventive intervention by social workers. As with treatment services, when we do prevention, we spend too much time "reinventing the wheel." It should be noted also that the kind of research needed is qualitative as well as quantitative so that complex outcomes can be truly understood.

As we embark on further research, we will arrive at better, more complete answers to many of the typical questions that arise in any study of human services: What populations and problems are most likely to benefit from preventive intervention? What kinds of preventive interventions? What are the risk factors for a particular group that is not yet experiencing a particular problem? What are the strategies that address at risk populations without stigmatizing them? Are there cultural models for prevention services? And more specifically about particularly programs: Does it work? What are the benefits? How much is the cost? What does it save in the way of future costs? Prevention research will, undoubtedly, engender many of the same questions about effectiveness that plague treatment program evaluation and research in general. The payoff, however, may be learning how to break the cycle rather than attempting to heal the wound or merely to reduce the pain.

APPENDIX ALetter to Agencies

March 28, 1991

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 XXXXXXXXXXXXXXXXXXXXX

Dear XXX:

In a phone conversation we had in November, you kindly agreed to my making a return visit to XXXXXXXXXXXXXXXX to interview you and others about your experience with Discovering Normal. The purpose of this work is to develop knowledge about prevention program implementation through a comparative case study of the three agencies that piloted DN. This visit is in connection with my doctoral research at the Hunter College School of Social Work. While my findings may be useful to the Children of Alcoholics Foundation in their development of DN and other innovative programs, I will be visiting you with the Foundation's knowledge and endorsement, but on my own behalf.

Since the results of our interviews will be published as a dissertation and, possibly, in other forms, I want to assure you that both the name of your agency and DN will be disguised. Information or quotes from interviews will be reported anonymously.

At this point, I would like to arrange to spend two or three days at XXX so that I may speak with you, XXX, XXX and, perhaps, one or two others who may offer different perspectives on prevention and on the implementation of DN. If it is convenient for you and your staff, I would like to spend time at your agency between June X and June X or June XX and June XX. I would also appreciate it very much if you could have someone gather and send me the materials listed on the next page so that I may begin to identify the factors that contribute to your successful implementation of DN.

I will call you to find out whether it is convenient for you and your staff to each spend an hour or so with me on the dates suggested above. I look forward to speaking with you.

Sincerely,

Irene R. Bush, M.S.W.

REQUEST FOR AGENCY INFORMATION

If at all possible, please send me the following items. If there are other agency materials that shed light on your agency's experience with prevention programs, please feel free to include them.

Agency MISSION STATEMENT--Goals and objectives of the agency

A TABLE OF ORGANIZATION (Organization Chart) and any staff job descriptions, if available.

Descriptions of other prevention programs implemented by your agency.

Information about funding prevention programs; (titles or brief descriptions of funding proposals).

Recruiting material (brochures, flyers), public relations (press releases, newspaper and other coverage) used with Discovering Normal; letters, memoranda, meeting agendas, etc. that shed light on the process of implementing DN.

Anything else that you feel might be helpful that is connected with prevention and implementing DN.

SEND TO:

Irene R. Bush
(Address)

APPENDIX BInterview GuidePrevention/DN Implementation

Date:

Name: _____

Sex: / /F / /M

Agency: _____

Age: _____

Degrees/Years: _____

Other

credentials: _____

Professional organization

affiliations _____

Position (title &/or description):

Involvement with DN:-----

--2--

I'd like to find out how you conceptualize prevention and what it is about your organization that helps you implement a prevention program like Discovering Normal. Can you comment on this.

What is your agency's history with prevention programs?
How does DN fit with this history?

What did you need to think about before you decided to use DN?

Environmental factors Domain, Funding, Societal)

Organizational factors Structure. Leadership, Group
Environment, Tasks, Problems
Solving [Coping], Communication
Patterns)

Your own personal practice orientation

Needs Assessment Probes

o. What did you (What is your understanding of what your agency) hoped to accomplish by using DN?

- 1.1. How did you see it serving potential clients?
 - a. In what ways do you see it as prevention?
 - b. As treatment?
 - c. Something else?
- 1.2 Agency Mission

--3--

What went in to the planning and recruiting process?

Environmental factors

Organizational factors

Your own prevention goals

Planning and Recruitment Probes

- o What kinds of resources (supports) were needed to mount DN? (Outside agency? Inside agency?)
- o What kinds of participants (clients) did you want to attract?
- o Are there staffing issues to be considered when implementing a prevention program like DN? (reward structure, training)
- o How do your personal goals in using DN fit your agency's goals?

--4--

What can you tell me about the actual implementation of DN?

Environmental factors

Organizational factors

Your own orientation

Implementation Probes

- o What factors outside your agency affected your ability to implement DN?
- o. What agency factors shaped how you implemented DN?
 - 10.1 Which enhanced implementation?
 - 10.2 Which detracted? (rules, authority)
- o What about DN itself enhanced or limited your use of it as a prevention program?
- o How has implementing DN affected your agency?
 - 12.1 Structure (Staffing, Table of Org.)
 - 12.2 Operations? (Decision-making, domain)
 - 12.3 Evolving mission (innovation, change)

--5--

How do you evaluate your agency's experience with DN?

Environmental factors

Organizational factors

Your own orientation

Evaluation Probes

- o Can you describe whether DN affected how your agency is viewed in your larger community (environment)?
- o What did you learn about community needs in relation to the work of your agency?
- o How did it meet your expectations as a prevention program?
 - 15.1 What were its assets?
 - 15.2 What were its shortcomings?
- o How does your experience with DN affect future prevention program efforts with respect to:
 - 16.1 Recruitment and planning?
 - 16.2 Implementation?
 - 16.3 Evaluation?
- o How do accomplishments and learnings fit with your agency's mission?

--6--

General

- o Please define prevention in a way that's meaningful to practice in your agency?

- o How does DN fit your definition?

- o What should / /family / /child / /alcoholism treatment agencies be doing in the way of prevention?

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