ing. Consequently, the recommended approach for a family that is struggling with meeting basic needs (food, safety, equality, etc.) is different from the approaches recommended for the family having problems around issues of unclear boundaries or a lack of intimacy in family relationships. (For additional information on work with families, see Items 11.2, 11.10, 12.8, and 13.14.)

SUGGESTED READINGS

THE FAMILY PRESERVATION MODEL
(OR HOME-BASED MODEL)

**Purpose.** To avoid having to place a child into foster care by focusing on those dysfunctions or circumstances that place the child at risk of placement.

**Application.** This approach is appropriate whenever a child is at risk of placement and when there is reason to believe that an intense and focused intervention and frequent monitoring will sufficiently reduce the chances that the child will be abused or neglected.

**Description.** There are several models of family-based or home-based services. All are designed to prevent out-of-home placements and all share a common set of beliefs about what works best with dysfunctional families in which children are at high risk of being removed and placed in foster care because of abuse, neglect, or the parent’s inability to deal with a rebellious adolescent. Most of these programs share the following characteristics:

- A primary worker or case manager establishes and maintains a supportive, nurturing relationship with the family.
- One or more associates serve as team members or provide backup with the primary worker.
- Workers (or their backup person) are available 24 hours a day for crisis calls or emergencies.
- The home is the primary setting for service delivery (i.e., heavy to exclusive use of in-home interviews).
- A wide variety of helping options are used (e.g., both concrete and clinical services).
- Emphasis is placed on identifying and building on family strengths.
- Caseloads are kept small (two to six families per worker).
- Employ maximum use of informal and natural helping resources, including the extended family, neighbors, churches, support groups, and so on.
- The parents remain in charge of and responsible for their family as primary caregivers.
The agency is willing to invest at least as much in a child’s own family as society is willing to pay for the foster care of that child.

Services are goal oriented and time limited, usually lasting from one to four months.

SUGGESTED READINGS

THE CLUBHOUSE MODEL

Purpose. To improve the social and vocational functioning of adults with serious mental illness by providing a supportive community based on mutual needs, interests, and shared work.

Application. Member and staff experiences in this model are structured and given meaning through work that benefits both the clubhouse and individual members of the community. Each member chooses the character and extent of his or her involvement in the activity of the clubhouse community. For many people with mental illness, the clubhouse model is considered an especially helpful, noncoercive source of continuing support for adaptive community living.

Description. At the heart of the clubhouse model is the recognition that people need to be valued and contributing members of a group. The participants in a clubhouse are viewed as members rather than as clients or patients. Their days are ordered by shared work and by a focus on work-related roles and tasks, rather than by a schedule of treatment or rehabilitation services or sessions with professionals. Three themes characterize social work practice in clubhouses.

First, respect and equality among members and staff are emphasized. Both members and staff are full participants in the daily operation of the clubhouse. Typically, members and staff cook and serve meals, write and produce a newsletter, clean and maintain the club, reach out to isolated members, and serve in other useful, contributing work roles. Members are involved in all aspects of program development, operation, and governance of the clubhouse. By design, member work is essential in the life of the club, yet is not coerced.

Second, attention is given to enhancing many aspects of each member’s life, including social relations, recreation, housing, transportation, medical care and medication management, and employment. The value of meaningful work and its regenerative potential is recognized in the “work-ordered day” of the clubhouse and in the array of competitive work opportunities developed by the clubhouse. Through competitive, *transitional employment* placements, members (as they become ready) choose real jobs, as opposed to the sheltered or “make-work” experiences often found in conventional rehabilitation programs.

Third, it is recognized that mental illness often produces complex, idiosyncratic, and disabling social and psychiatric symptoms and that most members uti-