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Harriet W. Meek

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Decisions about location of services sometimes appear to be made more on the basis of agency preference than assessment of need. Today the profession has enough experience with service locations that it is possible to develop more clear guidelines for the decision about where work with clients should take place, in the client's home or nearby community or in the practitioner's office. This study was conducted with two purposes; 1) to identify at a higher level of evidence the various reasons for seeing clients in their own homes and nearby community setting; and 2) to demonstrate how readily available information can be used to gradually increase the level of evidence by which practice decisions are made.

This review serves two purposes. It helps clarify the optimal location for social work services. It also demonstrates a way of increasing the strength of our evidence base using data that is readily available.

The human services serve a wide range of clients in different situations. One way the field has coped with its breadth is to divide itself into areas of specialization; medical, school, child welfare, clinical, etc. In recent years a new area of specialization has emerged, home-based practice, cutting across the usual lines between fields. Family preservation is one form of home-based service; other less specialized formats also exist within the domains of child welfare, mental health, juvenile delinquency, services to people with handicaps, the elderly and others who have difficulty getting to the office. Many of these services provide intensive, flexible supports and a form of family therapy that takes place in the family home. The several varieties of home-based services often operate in situations of crisis, usually when there is danger of a family member being removed to foster care, hospitalization, etc. It is unusual for a single agency, or agency program to provide services both in client homes and the office.

The social work code of ethics (NASW, 1999) emphasizes respect for the dignity and worth of the person and suggests decisions about the location of care should be made on the basis of a careful assessment of individual and family needs. Assessments are made in both home- and office-based services, but it appears that once a client family has arrived at a particular agency, an assumption tends to be made that the *location* of service will be whatever is usual for that agency. Thus, client families who are first seen by an agency organized around family preservation or another form of home-based service are quite unlikely to be seen in the office. Those who first come for help at office-based programs are likely to stay there, though a few may be referred to home-based programs.
It can be argued that families who need these services are the ones referred to the home-based agencies and for the most part this is probably true. However, our Code of Ethics (NASW, 1999) advocates making care decisions on the basis of a specific assessment of particular individuals and families which is not always done in relation to the optimal

location for care. We are now in a position to make a more informed and specific decision. A more formal study of this situation would be a useful project for further research and may be made more possible through the conceptualization provided by this review.

Methodology

This appraisal should be considered an intermediate step in the production of stronger evidence about practice. In research related to social work practice, the questions are often not sufficiently conceptualized to allow the design of studies that will produce high level evidence. Intermediate work is often needed, often substantial enough to be worth calling it *research* in its own right. Most research design tends to treat this part of the research process as if project conceptualization is a relatively simple matter, but often it is not. This analysis serves as a demonstration of this mid-level of conceptualization.

The paper uses three sources of data to examine decision making in regard to whether a client or family should be seen in their home or in the office. Underlying the methodology is an assumption that the question under study has not yet been conceptualized sufficiently to design a more definitive study. The data sources used in this study are: 1) a literature review; 2) ethnographic field notes from a practitioner's workshop; and 3) the author's examination of the situation from her role as expert practitioner. The results from examining these data offer further conceptualization of the question, "Should this client/family be seen at home or in the office?" and provide a roadmap, more detailed than existed previously, for further study.

Important to the thinking behind this study is the idea of a taxonomy of evidence, a concept not often discussed in social work practice circles. Practitioners often seem unaware there are *levels* of evidence, a hierarchy based on a classification of the *strength* of evidence available. Several schemes grade levels of evidence according to consistency, quantity and quality, requirements provided by the Agency for Healthcare Quality and Research (AHRQ) (Finklestein, 2005). One oft-cited scheme is the relatively elaborate one presented by Guyatt, et al. (2000). An abbreviated model used in medicine that seems useful for human service practice is the Strength of Recommendation Taxonomy (SORT) (Finklestein, 2005).

> The randomized controlled trial (RCT) is the most rigorous study design. According to SORT, RCTs that deal with patient-oriented outcomes and include concealment, double-blinding, intention-to-treat analysis, and complete follow-up (and meta-analyses or systematic reviews of such randomized trials) provide a level of evidence (LOE) of 1. Observational studies, such as cohort and case-control studies (and systematic reviews that include them), are less rigorous in their design, and they are given an LOE of 2. Level 3 evidence, the lowest level, is assigned to consensus guidelines, expert opinion, usual practice, etc, or to studies that look at intermediate or disease-oriented outcomes.
>
> Finklestein (2005, 1032)

In present human service practice, most evidence is likely to be at Level 2 or 3, rarely at Level 1. Workers are often dealing with questions that are difficult to conceptualize and

direct practice decisions are most often made on a case by case basis. The human service practitioner's main question is likely to be "What will be best for this family? or "What will help Mrs. Jones?" rather than decisions on behalf of *groups* of clients.

Our conceptualization of the client's situation may not be adequate for the design of a randomized controlled trial (RCT), but our careful observations, thorough assessments and, over time, developing expertise in working with people dealing with similar situations can still contribute to the profession's evidence base. Practitioners can help collect evidence by writing about their experiences and compiling these accounts. Later it will be possible to gather together accounts of similar experiences and contrast and compare them, developing a clearer conceptualization of the issues and collecting evidence at a higher level on the taxonomy.

This discussion is concerned with evidence that is probably at Level 3 according to Finklestein's (2005) taxonomy. Although this is the least strong form of evidence, it *is* considered evidence and when combined with similar work, could be used to help in the conceptualization of an issue preparatory to the gathering of higher level evidence. These three sources of information also serve as an informal triangulation device used to shed more light on different situations that may indicate whether work in the home or office is most appropriate or suggest more evidence is needed before a clear decision can be made.

A Brief History of Home Based Services in the United States

Human service workers always function in a particular context and these contexts shift over time. This makes it useful to take a brief foray through the history of home-based services in order to understand how we have arrived at our current situation.

The human service professions in the USA have their roots services provided in client homes (Hamilton, 1940), though the practice of seeing clients primarily in the office became more common during the middle part of the 20th century. With the exception of child welfare, by the 1960s in the USA it would have been unusual for an entire course of intervention to be carried out in a client's home. The reasons for this shift are complex; they have to do in part with the incorporation during this time of psychoanalytic ideas into social work's knowledge base, resulting in a tendency to value therapeutic work more than problem solving, attempts to improve the environment and clarify the systems in which people live. This is another area that might warrant further, more formal, study.

Well before the 1960's it was clear some people were more difficult to help than others. These were often identified as individuals and families who seemed disorganized, found it a challenge to make use of in-office services and did not appear to respond well to the methods offered in the clinical settings of the time (Bandler, 1967; Pavenstedt, 1967). During the 1970s many of the agencies providing office-based services were mental health programs that later, because of funding demands, began to follow an increasingly medical model. Prior to about 1980 it was possible for these agencies to be more fluid in their decisions about the needs of individual clients and families and the location of care. One agency known to the author had traditionally seen most people in the office, but also reached out to clients in rural communities and geographic areas where it was understood it might be difficult for clients to come to the office. Home visits, sometimes repeated frequently, were actively encouraged on a programmatic level.

Social workers and psychotherapists carried the materials they needed for work with individuals and families in their cars and did much of their work in client homes across a large geographic area. As funding began to be more constrained, administrative limitations began to be placed on more expensive practices. Since on the surface it looked as though these outreach activities were more costly, they began to be prohibited. Later, it became clear that such things as failed office appointments also added to the expense of care in other ways, and home-based programs began to develop.

By the late 1970's, concern had also developed about the large numbers of children who were taken into foster care and never returned to their families. As a result, changes were made in public policy that encouraged an emphasis on keeping children with their own families and in their own homes, the 1980 Child Welfare Act. About the same time agencies began to be formed that reached out to clients who were not being served effectively by office-based services. Services aimed at providing intensive services for vulnerable families began to emerge (Hooper-Briar, 1995).

Family preservation services are the most specialized of the home-based services. Family preservation services almost always take place in client homes or nearby in the local community. These programs are organized specifically to preserve the family via attention to the following principles (Hooper-Briar, et. al., 1995): an emphasis on the protection of all members of the family, especially children; the family *[rather than the individual]* as the focal point of services; services are available, culturally, psychologically and geographically; services are organized via a strengths perspective; developed along a continuum; and with planning that is inclusive of all groups (Williams, 1994). Thus, family preservation services are aimed specifically at the best interests of the family, generally try to keep the family together and functioning as effectively as possible (by the family's definition) and with the wellbeing of all the family's members in mind (Hooper-Briar, et. al., 1995). Family preservation services are primarily found in child welfare, usually offering flexible and often creative supportive services, frequently operating in situations of crisis, but sometimes also as a preventive measure.

During the 1980s agencies began to see people primarily at home; others continued to use the office as their main base. During this time, concern over the decision as to home or office appears to have been made more on the basis of the client's membership in a poorly defined group than their specific needs. This tendency has persisted. Now, after more than twenty years of serving some clients in their homes and communities and others in offices, it appears that we should be able to begin making decisions about venue of service on the basis of specific need rather than assumptions.

Client Home or Agency Office? Some Findings

The remainder of this paper identifies circumstances reported as having led to the decision to see an individual or family in their own home, along with other situations that appear to have led to a decision for work in the office. It suggests some conditions where clear enough indicators exist to allow more elaborate studies to be developed that could produce a higher level of evidence for or against their use. Other situations may indicate the need for further information at a more basic level.

Who is seen at home? Who is seen in the office?

By looking at the descriptions of clients seen in both settings and reported in the literature, it became possible to identify, in a general way, those for whom each service location was used. The evidence for home- vs. office-based care falls within the third level (least strong) of the Strength of Recommendation Taxonomy (SORT) (Finklestein, 2005). At the same time, it is clear some of the client situations identified by the literature and other sources are considerably stronger than others. These findings are grouped by strength of evidence.

A caveat: A limitation to the literature

The social services have developed in a branching way, rather like a deciduous tree. Areas of specialization have evolved, with sub-specialities forming out of the main trunk, eg. mental health, child welfare, medical, school, etc. Home-based services have developed, not from the branches, but from the main trunk with especially strong links to child welfare and mental health. This means early literature about home-based work tends to be found in general bibliographic sources, while later it moves to child welfare and mental health. The literature search was not at all straightforward; it was necessary to use synonyms and think carefully about related words in order to make use of the usual library databases. Also, since home-based work grew, in part, from family therapy and the family therapy literature had earlier emerged as a separate area of study out of individual mental health, this growth pattern was evident in the literature.

This literature review located papers on "home visits" until about 1980, mostly in child welfare and occasional mention in the mental health literature, until family therapy began to be prevalent. By that time, the question had shifted to whether clients were better seen as individuals or in a family format. Whether the intervention should take place in the client *home* had not yet appeared as a question. Material about home visits in the older sense seemed to disappear from the literature, though, certainly, some social workers continued to make regular home visits.

Some people were already experimenting with home-based work during the 1960s and 1970s. Pavenstedt, Sander, and Bernard conducted an important study in the Boston area of a group of clients who were then called "hard to reach" (Pavenstedt & Sander, 1965; Pavenstedt, 1967; Pavenstedt & Bernard, 1971). This was an ambitious study, interdisciplinary, with work in client homes and the hospital clinic. A senior social worker named Louise Bandler was on the study team and wrote movingly of her work with these families, especially in the book called "The Drifters" (Pavenstedt, 1967). In a class with Mrs. Bandler during the 1970's, the author remembers discussion about the social worker helping with the dishes or (literally) scrubbing the kitchen floor in client homes. Mrs. Bandler clearly thought that for some people it was necessary to work on this very practical level, on an issue of concern to the client, long before work of the sort we might call "therapeutic" could be done. It has been a long time since one has heard of a social worker getting on their hands and knees to help scrub a dirty floor!

With the 1980 Child Welfare Act, the idea of family preservation emerged in earnest and work in the client home became more common. Even so, in the literature there was a gap of nearly fifteen years with almost no apparent recognition of the question as to where clients are best seen. Hansen and Epstein (2006), speak of clinical data mining, an interesting way of exploring agency records that might be used to

demonstrate that actual decisions, not just assumptions, were made. This was not yet seen as a possibility when the current study was being conducted. Interestingly, the literature on family preservation did not show up in an explicit way while conducting the literature review for this study. Searching made use of terms such as in-home, home-based, home visit, etc. It is as if the people who did home-based work assumed the home was the proper venue and those who habitually saw clients in the office assumed the office was the best place for intervention. The exception seems to be those people who fit the most generally accepted definitions of suitability for home-based work, people who are disorganized and/or where a family member is at risk for out of home placement.

Findings from the literature: Situations where home-based services are recommended

Welfare services for people who require protection are advocated by Fuller (2004), Napoli and Gonzalez-Santin (2001), Tracy and McDonell (1991), and Denby, Alford and Curtis (2003). Services involved with leaving and returning to family life were another area where home-based resources were often recommended, ranging from intervention in school phobia (DiGiuseppe & Wilner, 1980); adoption (op. cit) and reunification (Frankel, 1988). As might be expected, the transition points during which a family member moved toward or away from the family received particular emphasis.

Another expected home-based population involved people who were unable or unlikely to keep office appointments (Tracy & McDonell, 1991; Morris, 2003), including those who were incapacitated or homebound (Soreff, 1983), those with very young children (Napoli & Gonzalez-Santin, 2001; Tracy & McDonell, 1991), very mobile families and those who appeared to expect immediate gratification and magical solutions (Cortes, 2004).

Further expected populations for home-based services were people at risk of out of home placement, (Sheidow & Woodford 2003; Napoli & Gonzalez-Santin, 2001; Seelig, et al. 1992; Cortes, 2004; Frankel, 1988; Soreff, 1985). People who had experienced repeated hospitalizations without resolution (Fuller, 2004; Soreff, 1983; Friedman, 1962) and those with threatened hospitalization where family interaction appears to contribute were also thought to especially benefit from home-based work (Fuller, 2004; Soreff, 1983).

Friedman (1962) described somewhat related situations, including families where further estrangement was a danger or where it was important for family to maintain responsibility for the patient and their illness within the family. Friedman also spoke of situations where it was important for the family not to deny a "bad" part of itself by the hospitalization of one of its members, including also a history of disruptive alliances and splits (1962). Other writers advocated home-based services for families when a child had been assigned an inappropriate role by other family members, eg. the Infant King/Queen (DiGiuseppe & Wilner, 1980); where severe distress existed simultaneously with a strong wish for independence (Soreff, 1985) and family crises (divorce, illness, accident, death) (DiGiiuseppe & Wilner, 1980). Finally, in-home services were recommended for isolated individuals and families (Soreff, 1985).

Situations concerning difficult-to-engage clients constituted another main venue for home-based services. Fuller (2004) and Cortes (2004) wrote about clients who seem resistant, suspicious, shy about the office and involuntary clients. Morris (2003) spoke of clients who had difficulty recognizing the worker might be truly interested in their well-

being. Friedman (1962), Woods (1988) and Corets (2004) wrote about people whose resistances were expected to interfere with office-based therapy and where there was reason to think they might be overcome by work in the home.

Situations where it was thought home-based work might facilitate the professional intervention useful to heighten the "real" context; make use of the participant-observer role of the therapist, encourage more active involvement of family and possibility of immediate analysis of family behavior in situ or bring family behavior to quicker focus were advocated by Friedman (1962) and Woods (1988). Bury (2002) advocated home-based work with families who were in the midst of a potentially violent crisis under certain conditions, while Morris (2003) recommended work in the home for families who needed support, validation and the creation of a "sense of possibility." Cortes (2004) and Morris (2003) also drew attention to the use of home-based services in relation to a wide range of family members, especially those who would not come to the office.

In summary, services typically recommended for work in or near client homes include basic services for people needing protection, resources needed around the transitions of separation from families and the return to living with one's family, especially people at risk of out of home placement and those who have difficulty keeping appointments or who are difficult to engage in an intervention or treatment process. Less often mentioned were situations where it was thought the home venue might facilitate the therapeutic process. Although some of the specifics of these situations are perhaps rather obscure, the broad categories are mentioned often enough that a case could be made for their inclusion in Finklestein's (2005) Evidence Level Two. Certainly further study of these categories could now be made in order to provide additional evidence testing of these observations.

Findings from the literature: Situations where in-office services are recommended

When speaking of arranging for therapeutic and supportive services, home-based services still constitute the exception to the rule, which means it is rare for the literature to report on specific recommendations for in-office care. The situations named in this section should not be considered the only venues where office-based care is recommended.

The range of possibilities for outpatient psychotherapy has expanded greatly over recent years. Fonagy (2004), who has conducted extensive studies of multiple forms of psychotherapy, says we know ". . . precious little about who is likely to benefit from what type of therapy. . . " (p. 357). He says a range of approaches appear to be effective for many conditions, though they are often constructed from ". . . a collection of interventions of varying specificity. . ." (op cit.) which makes it very difficult to identify specific characteristics. Fonagy also warns against the propensity for both researchers and clinicians who have become accustomed to one or another method of treatment to develop preferences for some and to negate others.

Sheldon Roth (2000, pg. 97), writing about the difference between a psychotherapeutic and a psychiatric diagnosis, identifies qualities that "encourage" the use of psychotherapy. For Roth, motivation, insight and flexibility are internal qualities that bode well for psychotherapy. On an interactive level, he lists honesty, the ability to tolerate frustration, the capacity to bear affect and a sense of humor. On an interpersonal level he identifies warmth, responsiveness, dyadic resonance and the pressure to

communicate. Holding Fonagy's (2004) cautions and Roth's (2000) recommendations in mind when reviewing the literature on individual psychotherapy, it seems possible to extrapolate some further recommendations for location of care. Outpatient mental health services in an office setting appear to be offered primarily to relatively well-organized clients who can keep scheduled appointments. People who identify their difficulties as "internal", between parts of their own personalities rather than between themselves and others or the environment, are likely to be well-suited for in-office work.

Other situations where in-office intervention are recommended are crises involving the need for protection or social control that cannot be maintained in the client's home, (Fuller, 2004) and situations involving children who are no longer living in the home (DiGuiseppe & Wilner, 1980). DiGuiseppe & Wilner (1980) go further to recommend in-office treatment for specific symptoms such as stuttering, enuresis, encopresis, tics, trichotillomania, thumb sucking and learning disabilities. They also say some violent families are better seen in the office, specifically where it seems better to "divide and conquer" rather than try to fight overwhelming odds. The same authors identified situations where there is a preoccupation with sexual difficulties as being more appropriate to couples work, not involving the whole family. DiGuiseppe and Wilner (1980) go farther, saying that families with a particularly vulnerable and overcontrolling parent respond more positively in the office situation. Finally, they identify divorced families, depending to some extent on their degree of continued bitterness, as benefiting from in-office work, saying it may be useful to work toward developing the capacity in each individual to handle conjoint work later on. One further situation was involved with those families whose goals are rather different from those of the agency and the worker. Muller (1986) suggested the use of a neutral setting, neither the home or the office, under these circumstances.

A practitioner's workshop looks at the question

About ten years ago, members of a small supervision group led by the author realized they were repeatedly asking, "How do we decide where to see the client?" In this organization services had traditionally been provided in client homes, but after funding sources began requiring more medical-model assessment and planning, staff were encouraged to see some people in the office as a money-saving device. This decision was left to staff. Over time the group began to realize their ongoing supervisory meeting functioned like the practitioner's workshops described by Rustin (1997), supporting practitioners working with difficult client groups. Following Rustin's model, this practitioner's workshop began keeping notes about their discussions, usually beginning with case material, exploring what was taking place with clients and with particular attention to the relationship between client and worker. The following represents some of the more coherent field notes made at that time.

- circumstances appear to exist in which the *worker's* need (and ability to function therapeutically) must be taken into account; this might sometimes have to do with a decision toward either home- or office-based care.
- it is important to face the reality of the situation and provide a service which has the best *manageable* (for both family and worker) chance of providing a helpful ntervention.

The group was surprised to discover they were identifying situations in which they thought care *in the office* might be indicated. These included:

- families living in multigenerational, overcrowded circumstances where there was difficulty providing a semblance of privacy, especially when it seemed helpful for only part of the extended family group to be included,
- marital treatment or other interventions when family members were seriously impulsive and unable to refrain from outbursts of temper and threatened/actual violence,
- situations where there was actual, and considerable, danger to the worker in the family home, and
- situations where the house was infested with filth (e.g. excrement) or insects Some families best *seen at home* were also identified by the practitioner group.

These included:

- situations where there was severe discord between parent and child,
- situations where the worker did not sufficiently understand the situation underlying the stated problems,
- situations where the worker suspects the family was not disclosing a full or accurate enough picture to allow help to occur, and
- families who were so disorganized that they could not manage to keep appointments.

Home-based services tend to be directed toward clients identified as disorganized and unlikely to keep regular appointments; whose households are described as chaotic, and where workers complain that clients do not follow through on agreed-upon tasks. Children in these families often do not do well in school; they are also more likely to be in trouble with the police and the legal system. Conversely, *office-based services* are more likely to be offered to people who can keep regular appointments, and perhaps individuals and families without children. Some people with specific symptom pictures may be more likely to be referred to office-based care; the details vary considerably (Meek & Ware, 1996). It may sometimes be assumed that certain groups of people are organized enough to make use of the office, eg. single adults without children, more value judgments ("they ought to…") than evidence has demonstrated.

The effect of the service setting on client and worker: Comments from an expert practitioner

Both worker and client have reactions to the service setting. *Workers* can face a considerable emotional onslaught when they enter client homes. This may range from simple discomfort with different customs, ways of arranging furniture and greeting guests, to frank confusion and disorientation due to unfamiliar ways of being and relating. Sheer numbers of people and different ways of dealing with emotions may also cause confusion. A worker may experience distaste, even horror, at having to sit in a place where it looks as though a child or animal may have urinated or where cockroaches

are visible. All of these conditions affect the worker's ability to think clearly and respond appropriately (Meek & Ware, 1996).

The fact of such events taking place *must* be acknowledged by agency administrators and appropriate supports provided for staff. This is not always the case; there is a large tendency to turn a 'blind eye' as if these events almost never happen and can be ignored. In addition, workers who have experiences like these are not often encouraged to reflect on their reactions. Instead, they are encouraged to catch their breath, recover as soon as possible and not spend much time thinking about it (Meek & Ware, 1996).

The home-based situation allows the worker to gain a more accurate view of the client and family in their home environment. It allows reluctant clients to be seen in their own homes, where they may be more comfortable. They may also feel more valued by the worker taking the trouble to come to them, along with many other possible benefits of the home-setting for particular individuals (Kadushin & Kadushin, 1997). The office, however, allows the worker to make these observations against the backdrop of many repeated observations of different families and individuals in the same office situation, which can allow subtle differences to emerge (Winnicott, 1941). It also allows workers to feel more safe, less likely to be confused or harried and thus, more able to think clearly about the family and their situation and in the short run, is programmatically less expensive. There are advantages and disadvantages to both practice situations.

With today's emphasis on collaborative work, it seems important to weigh these observations in a direction that favors the family rather than the worker. In order to establish a truly collaborative relationship with a family, maybe it is important for a worker to experience a sense of the confusion and disorganization the family lives with every day. Or, perhaps, it only seems disorganized to the worker? If it is true that it is useful for the worker to experience the conditions faced by the family (and we think it probably is), then it becomes especially important that workers receive special help in recognizing and work with their previously unacknowledged reactions to clients, families and their situations. All too often social workers, counselors and others in similar positions are told that they must be self-aware but are given few suggestions about how self-awareness might be developed. *The result often appears to be a fending off or denial of the awareness of any negative feelings or behaviors in relation to clients until the situation has escalated to an unmanageable level* (Meek & Ware, 1996). At the same time, there is a point at which the worker may be so overwhelmed by the home situation that it becomes impossible to think. Therefore it is suggested that for every worker and every client, an equilibrium must be found -- between client needs and worker needs – that is part of the decision about location of services.

Toward More Evidence Based Practice

The triangulation of three sources of information used for this study points out several situations in which it appears clients should be seen at home and one situation which suggests these clients might better be seen in the office. These are: 1) families at risk for a member's out of home placement and families where a member is returning home or being added to the family; 2) disorganized clients or others who cannot come to the office; and 3) people with multiple psychiatric hospitalizations when family dynamics

seem to be at issue. Families where violence or uncontrolled anger was a problem were thought to do better in the office (eg. marital problems) or at least a neutral setting out of the home. Each of these situations was supported at the third evidence level (Finklestein, 2005) via several literature citations, the practitioner workshop and the author's experience. These situations may be ready for further, more stringent investigation that holds the promise of obtaining a stronger level of evidence.

Figure 1. Families for whom services in client homes are recommended, along with a few situations where for an office or neutral setting is recommended.

Home-based services are recommended for:

- Situations when a family member is at risk of out of home placement
- Situations when a family member is returning home or being added to family
- Families where a member cannot/will not come to the office
- Families where there are physical limitations and/or transportation problems
- Families with several young children
- Families with a large degree of disorganization
- Families with multiple psychiatric hospitalizations and/or where family dynamics seem to be an issue
- Isolated individuals
- Clients and families who are difficult to engage
- Enmeshed families
- Clients who define their problems as being outside themselves
- Families with idealized or demonized children

Office-based or neutral setting is recommended for:

- Clients who define their problems as being inside themselves, eg. internal conflict,
- Families where violence or uncontrolled anger is a problem (eg. severe marital difficulty)
- Single parent families where the therapist is the opposite sex and the client has a strong tendency to sexualize relationships

\It should be noted that the identification of people for whom office-based services are recommended was not the purpose of this study. By no means does this list suggest thees are the only situations for which office-based services are recommended.

A number of situations suggesting home-based services were also supported at Level Three with fewer citations than the above but also with substantial support. These included: 1) enmeshed families; 2) clients who define their problems as being outside themselves; 3) families with idealized or demonized children; 4) families where it may be

useful to include family members who would not come to the office. These situations may also be ready for trials at higher levels of evidence strength.

Many situations were suggested by the literature, the practitioner's workshop or the author that were idiosyncratic, very specific and mentioned by only one or two sources. These included 1) clients who are resistant, shy, suspicious, overcontrolling or extremely vulnerable; 2) clients who have difficulty transferring gains made in therapy to the home; 3) families who need a great deal of support and validation; 4) situations where distress exists along with a strong wish for independence; 5) families where medical and psychiatric difficulties were combined; 6) family crises; 7) extremely mobile families; 8) families expecting immediate gratification and magical solutions; 9) isolated individuals and families 10) situations where it seems helpful to bring behavior into quicker focus. Because these items were mentioned by only one source, it is thought further investigation should be conducted on these situations before higher level investigation is attempted.

Finally, there seem to be a few situations that suggest care in the office is indicated, though this was not the primary intent of this assessment and should by no means be taken to mean these are the only circumstances in which in-office care is recommended. One such situation, supported at a relatively strong level, is the situation mentioned above regarding violent or very angry family members. People who are extremely angry with each other seem to do better if seen in a neutral setting or the office. This is because most people are likely to behave themselves in public and may need a little distance from the immediacy of the home in order to hear the other person and/or involve themselves in problem solving. Another group who appear to do well in the office are those people who define their difficulties as internal conflict, eg. "one part of me says -----; another part says -----." These people are quite clear that their difficulty is inside themselves; their work is internal, not *inter*personal. They tend to be relatively well organized and seem to need a different sort of care, a service that offers the space to look within themselves, hear themselves think (Meek & Ware 1996). They are not the typical home-based client, but occasionally are caught up in home-based services, which may not be the best resource for them. Further information is needed about this group of clients.

Conclusions

This review has explored the question, "How do we decide where to see our clients?" via literature review, the findings of a practitioner's workshop and the author's practice experience. One goal of the assessment was to begin the development of an evidence base for decision-making about location of services in individual cases by examining existing data and beginning the process of conceptualizing the issues. A second goal was to demonstrate how practitioners can help in the development of a stronger evidence base for practice. A brief history of services to clients in their own homes was presented, along with suggestions about possible reasons for the shift from home- to office-based services within the last century. Several client situations are identified as being ready for testing at a higher level of evidence strength. Others are identified as needing further observation and data collection at a lower level of evidence strength and a few situations are given that seem to indicate the need for office-based

work. It is hoped that this discussion can serve as a base for further studies aimed at identifying stronger evidence and that human service workers can use it as a model from which they can increase their participation in the development of an evidence base for practice.

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