GOODWILL SOCIAL WORK CENTRE, MADURAI, INDIA

INTENSIVE FAMILY PRESERVATION PROGRAM FOR CHILDREN IN DYSFUNCTIONAL FAMILIES, MADURAI, INDIA-THE INDIAN EXPERIENCE

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Introduction

According to the United Nations, the family is a basic unit of society and the natural environment for the growth and well being of all its members, particularly children and youth…. The World population plan of Action which emerged from the World population Conference (1994) recommended that a) family to be protected by appropriate legislation b) family ties to strengthened by giving recognition to the importance of love and mutual respect within the family units c) measures to be taken to protect the social and legal rights of spouse and children in the case of dissolution or termination of marriage by death or other reason.

There are a wide variety of families, which differ from place to place. Changes in family structure occur as the family passes through different stages in its life cycle, as family formation, family extension and family dissolution. The functions, role and relationships are often said to create a sense of society, belonging and purpose that create psychological and emotional strength in the family and are essential to its stability, cohesion and continuity. It is an undeniable fact that the family has the greatest personal investment in the welfare of the children by virtue of biological, emotional and social ties. It is the prime responsibility of the parents as 'adults' to protect the best interests of the child in the family. Article 18 of the United Nation Convention on the Rights of Child (1989) states "State parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basis concern."

Sad to say, many a family become disbanded, disintegrated or distressed owing to myriad social-cultural, economic, psychological or emotional barriers. The term 'dysfunctional family' is defined as one which develops a sense of powerlessness (Mishe and Mishe, 1977) that pervades the lives of the members in the family and which is unable to cope with adversities of life effectively and accomplish the life tasks. A dysfunctional family is incapable of a) giving attention to the family need b)

ameliorating or preventing negative effects on the family and c) bringing about changes in family's environment through the provision of opportunities for improving the standard of living.

Unfortunately, children in dysfunctional families experience crises and are being considered at risk of abuse and neglect. There are a number of factors correlated with family dysfunctions that force the children at risk. It is evident that children in dysfunctional families lead a life devoid of the rights to childhood. The problems of these children are multi-faceted which call for preventive family support services which range from available services (primary prevention services), through early intervention services to assist families of children as 'at risk', to intensive crisis intervention services. Research on the functioning of 'intact' families and delinquency in the United States has been more than matched by studies of "broken" families (defined as the absence of at least one biological parent through deaths, divorce or separation, (Rankin 1983, Wells & Rankin 1991). In an American study of 197 'intact' families. Quinn, Stephen and Gale (1994:12) examined family functioning in terms of adaptability, partnership, growth, affection and resolve. The absence or presence of these factors was seen as critical to the behavioural outcomes of children. Crime and delinquency were considered to result if family functioning was 'inadequate'.

The Australian studies (Thomas & Helm 1993a: 2) into the relationship between "family factors" and youth offending have revealed the fact that offending in "dysfunctional families" (offending families are seen to indulge in more "fights", "arguments", "conflicts" as well as "drunkenness" and "aggressiveness") were considered to result from a number of socio-economic factors namely discordant family relations, poor management of the child's behaviour, criminality in the parent, large sibship, below average IQ, language delay, aggressive oppositional, and destructive behaviour,hyperactivity, Institutionalization, including hospitalisation and foster care.

In point of fact, the need for family strengthening is being greatly realised in the context of child development in developed and developing countries. The role of the family as primary carer/s is to accept responsibility for or directly meet the physical, individual guidance, educational, spiritual and developmental needs of the child. The way this role is fulfilled is shaped by the family's cultural context. Failure to fulfil this role leads to the vulnerability of the child in the family. "If a family is unable to meet the needs of the child, the family unit per se is vulnerable in terms of physical survival, within its own relationship and within the community in which it lives. The vulnerability of the child then reflects the vulnerability of the family". Since the child becomes disadvantaged due to varied causes of family dysfunctions, there is a need for organising 'intensive family preservation program' for sustaining the families from being dysfunctional and rebuilding such dysfunctional families through a spectrum of family support services.

Family support services have a special contribution to make in meeting the needs of families and the children. They prove to be highly beneficial to the families and the children in as much as they are a. comprehensive b. Integrated c. flexible d. combine practical assistance and therapeutic counselling e. involved with the family long enough to ensure change is sustained f. grass roots organisations g. based on a model that recognises and builds on strengths and h. preventive.

The Goodwill social work centre to explore the main issues, which were found to be correlated with family dysfunctions endangering children in dysfunctional families to be at imminent risk, conducted a survey on dysfunctional families in Madurai city, India (1997-1998). The study was an outcome evaluation of the 'Intensive family preservation program which was implemented by the Goodwill social work centre under the aegis of OZ Child-Children Australia Inc, Victoria, Australia. It surveyed 361 families of various types covered under the project during the period 1991-1997.

This paper sets out the context in which family support services were operating, the particular strengths of family support services and the contribution of such services, which were aimed at strengthening and preserving families of children, methods and techniques used, strategic process and interventions in the program. It further presents the personal and demographic characteristics of children and their families covered under the program and an overview of the family support services offered by the centre. The program was launched with a holistic care approach, keeping in view the following core principles:

- All children have the right to survival, protection, development and Participation
- Growing up in their own family enhances their opportunity for their wholesome development
- A family which is socially and economically stable is a strong family
- Helping the family is helping the child
- When the family is vulnerable, the child is vulnerable
- When a family is dysfunctional, a support to assist it to address the difficulties and build on its strengths reduces the vulnerability, and therefore of the child

About the GOODWILL

Goodwill Social Work Centre, a professional social work organization deeply committed to the development of children, youth and women was founded in November 1981 in the temple city of Madurai, India by a professionally trained Social The Worker with the prime objective of performing a wide spectrum of roles in the development of children, youth and women and undertaking a comprehensive action through professional approach with a preventive, curative and rehabilitative perspective. It aims at utilizing positively the scientific methods of Social Work for problem identification, problem solving and problem prevention for the multifaceted development of children, youth and women who are at a disadvantage. It is a Non-governmental organization registered under the Tamil Nadu Societies Registration Act 27 of 1975 and Foreign Contributions (Regulations) Act 1976. The centre is an

Associate Member (Corporate) of the International Forum for Child Welfare (IFCW), CRIN (U.K) and ENCSW, Belgium.

The centre aims to promote the overall development of children, youth and women in rural and urban areas in India, who are socially and economically deprived; to provide family centered home based intensive services to children, youth and women in dysfunctional families in slums and backward areas in India; to sensitize rural and urban children and women on various environmental issues and concerns through education, training and communication; to create public awareness on the rights of the child and women and to work for the promotion, protection and defence of children's and women's rights. It focuses education sponsorship; home based care and school placement for children in dysfunctional families; referral services to children for problem children; family counseling; environmental education for children and children and women rights education. It is operational in service provision, training, and advocacy, research information.

The aims of the program
The program had the following aims:

- To work with families of children in their homes at the point of crisis and to offer preventive family support services.

- To provide support to parents to develop their coping skills and competence to provide an adequate child-rearing environment through family resource programs.

- To empower dysfunctional families (female headed) through income generation activities for gainful self-employment of women.

- To create a contact centre for children in dysfunctional families for providing opportunities for them to fulfil their life sustaining, enriching and development needs.

- To network with local resources systems in making services and benefits available to children and their families on a short term and long term basis.

Indicators followed to work with families
The initial phase of the project, the centre had followed a few indicators for selecting dysfunctional families that are outlined below:

1. Identifying dysfunctional families
2. Focus is on the family, not the problem area
3. Family has to be supported as a ‘whole’ and strengthened
4. Time limited home based family centered support services
5. Children to grow within their own family
6. Family’s willingness for child placement in homes

7. Identifying internal and external stresses in the family and responding to crises to resolve
8. Discussion with family on new opportunities for the growth and development of the family
9. Family members to make decisions-family's participation in decision making
10. Terminate relationship and support once family gets strengthened

The centre had identified 361 dysfunctional families that could fit into the indicators outlined for the purpose of the program.

Case management process

The case management approach adopted by the centre involved six components namely 1.Case identification 2.Assessment and Planning 3. Co-ordination 4. Implementation of services 5. Monitoring, evaluation and reassessment and 6. Termination. (based on Karen Orloff Kaplan model, USA, 1990). The activities carried on by the family support workers at each level in the case management process are enumerated below:

1.Case identification: Field visits to project areas by Family support Workers for conducting base line surveys- Identifying families which fall within the indicators outlined by the funding agency- Home visiting by family support workers to the families identified-Selecting families referred by local NGOs, religious and educational institutions, local formal and informal leaders etc.

2.Assessment and Planning: It involved collecting and gathering information about the families identified by the family support workers, Social and psychological assessment tool- Social investigation of the clients' needs and problems, and threats-Direct observation of the family at their homes and workplaces-Developing a Case plan-assessing the extent of involvement and participation of clients in the program-Designing a plan of action in consultation with the clients.

3.Coordination and Referral: Identifying direct and indirect practice actions to be taken for the client population- development of strategies, resources, nature of support available locally to help and the client and his/her family-Offering information and referral to link families to specific services to meet particular needs-Representing the needs of families to other local agencies so as to enable families to gain access to services-raising awareness and advocating for better and more appropriate services to meet family needs. Networking with Governmental and Non-governmental organizations.

4.Implementation of services: Planning of services to be provided (Centre as well as community based)-provision of therapeutic services and social support services to the client and her/his family-determining continuity of care and maximal functioning of

client/family-Preparing daily/weekly/monthly reports on the family-Preparing and updating of case plan for each family.

5.Monitoring, evaluation and reassessment: Regular home visiting by family support workers to assess the improvement of clients and their families after the intervention by the centre-holding monthly 'Family Fellowship meetings' at the centre as well as at the project areas-Conducting personal interviews/discussions with the client population to assess the utilization of services and resources provided by the centre-modifying 'intervention strategies' based on client's response and the improvement shown-assessing the need for continual service-establishing a plan of action to determine the anticipated time for termination of helping relationship.

6.Termination: Disengagement from the relationship with successful client/family after a review by the Family Support workers-Providing guidelines to clients on problem management-"Information sharing" with successful clients about the activities of the Goodwill social work centre-Formation of 'Self help groups' among the clients/families at the community level who have received family support-Disengagement of clients showing continual non-responsive behaviour over a period of interaction.

Table 1 Types of dysfunctional families (N 361)

• **Stressed families (both parents alive)**	**89 (24.65%)**
• **Female headed families**	**129(34.90%)**
• **Disintegrated families**	**23(6.37%)**
• **Offending families indulging in 'fights' arguments' 'drunkenness' 'aggressiveness'**	**41(11.36%)**
• **Families likely to disintegrate**	**20(5.54%)**
• **Families of street children, working Children,HIV affected and disabled children**	**62(17.18%)**

Table 1 shows that a sizeable section (34.90%) of the families fell under the type 'female headed families', whereas a lower proportion of them (5.54%) were classified

as 'families likely to disintegrate'. Families of street children and working children accounted for 17.18%. It was found that 24.95% of the 'stressed families' had both father and mother alive. Sadly enough, 6.37% of the families got disintegrated owing to marital discord. In point of fact, the causes of family dysfunctions in the client population are manifold. **An analysis of the causes has revealed the fact that lack of means of livelihood, marital disagreement, financial difficulties, death of spouse, problem of ill health of spouse (husband), alcoholic behaviour of husband, domestic violence (wife/husband battering), lack of understanding of family values, shirking of family responsibility by the husband, and neurotic/psychotic behaviour of spouse have resulted in families becoming 'dysfunctional'**.

Characteristics of the client population

General characteristics of the client population have shown that of 361 clients, a large proportion of them (57.34%) were married; 18.83% were widow/widower; 14.68% were single and 9.15% were separated. As to the gender of the client population, a high proportion (69.25%) were females while the remainder (30.75%) were males. The dominant religion among the client population was 'Hinduism' which accounted for 70.08%. A small percentage (6.93%) were 'Muslims" whereas the remainder (22.99%) were Christians. It is noticed that 18.84% of the client population have not had received any formal education whereas a high proportion (55.12%) of them have had primary education.19.39% of them have had formal education up to secondary school while only a smaller percentage (6.65%) have had collegiate education. When asked their caste affiliation, a high majority (72.58%) of the client population identified themselves as 'socially backward community' while a negligible section (1.94-%) belonged to 'Forward community'. A sizeable portion of them (24.09%) identified themselves as Schedule caste (socially oppressed community). Only 1.39% belonged to socially 'Most backward community.' Overall, the client population belonged to various socio-cultural backgrounds.

A high proportion of client population (82.27%) earned a monthly income ranging from Indian Rupees 100-500,whereas a smaller percentage (11.91%) of them earned an income that ranged from Indian Rupees 500-1000 per month. Only a relatively small proportion (5.81%) earned a monthly income of above 1000 Rupees The types of occupation of client populations are shown in Table 2.Table 2:

Types of occupation of client population

Types	Number	%
1. Fruits, Vegetable & flower Vending	87	24.10
2. Artisans (handicrafts)	27	7.48

3. Auto/cycle rickshaw driving	11	3.05
4. Home based small business	105	29.09
5. Stone quarrying work	30	8.31
6. Garment cleaning	30	8.31
7. Tailoring	16	4.43
8. Machine repairing	14	3.87
9. Handloom weaving work	07	1.94
10.Housemaid servants	11	3.05
11.Secretarial work in private Office	23	6.37

As evident from Table 2, a high proportion of the client population (29.09%) was in Involved in home-based small business while a relatively smaller percentage (24.10%) was 'Fruit, Vegetable and Flower venders'. Others were employed to do odd jobs mostly in unorganized sectors. While assessing the economic characteristics of the client population, it was found that a significant majority of them (81.71%) have had financial debts while the remainder (18.29%) did not have any debts.67.59% have had earned daily/weekly/monthly earnings from employment whereas 7.20% earned income from home based business. Only 3.60% have had earned from agricultural lands.21.61% did not have any sources of family income. A sizeable percentage (45.15%) of the client population had been living in small hutments, whereas a slight majority of them (49.03%) had been living in tiled houses. Only a small proportion (5.82%) have had reinforced low cost houses either rented to them or owned by them. It is appalling to note that 58.72% of the client population has had 'one room' in their houses (huts); 38.24% had been living in 'two room' houses; 2.49% have had 'three rooms' in their houses. Only a miniscule percentage (0.55%) of the families had been living in 'more than three room 'houses. Overall, high proportions of the client population live in households classified as low socio-economic status (SES) while a relatively smaller proportion live in middle socio-economic households. Only a negligible section lives in an upper socio-economic household.

Fig 1 and Fig 2 highlight the stress factors within and outside the family, which were found to be responsible for causing 'dysfunctional' among the client population. The stress factors within the family included a) not being able to ensure basic necessities of life (97.2%) b) not being able to ensure marital relationship (86.7%) c) not being able to endure education for children (97.2%) d) not being able to ensure adequate

medical care (65.6%) and e) not able to ensure a job (89.5%). The external stress factors which affected the family functioning were a) exploitation by money lenders (86.1%) b) difficulties caused by neighbours/friends (58.4%) c) not able to ensure adequate housing (86.1%) d) caste and religious discrimination in the community (62.6%) and e) not able to avail of services and opportunities from local support systems (75%).

Table 3:An overview of family support services received by the Client population

Family Support services	No of families (N 361)
1. Educational assistance	294
2. Home & School placement	150
3. Family life education	336
4. Family fellowship programs	275
5. Financial aid to children	**160**
5. Family counselling	225
6. Vocational guidance &training	53
7. Health & medical care	311
8. Job search & placement	128
9. Referral services for children	50
10. Micro-financial aid	150
11. Material assistance to families	279
12. Development training for youth	90
13. Self managed savings schemes	64
14. Children's enrichment programs	41

Table 3 presents an overview of the family support services provided to the client population. Most family support services offered both one-to-one work with individual families and group activities. It is evident that a high proportion of the clients had availed of services namely educational assistance and home and school placement for their children, health and medical care, development training for the parents on family life management, parenting skills, understanding family values, inter-personal relationship, conflict management, child rearing practices, home based micro –enterprise skills etc. The family support workers used a range of therapeutic skills to work with families on their personal and relationship issues. As evident from the table, 225 clients were offered counselling by the family support workers. The Centre had helped in job search and placement for 128 clients and their family members both in organised and unorganised sectors. Interestingly enough, child focussed services provided to children in dysfunctional families were mostly preventive in the sense that they were protected from child abuse and neglect.

In the final analysis, the program implemented by the Goodwill social work centre had been more successful as it had a blending of the material interventions with

therapeutic services, which were used for placement prevention of children at imminent risk, early intervention services to assist families identified as 'at risk' and crisis intervention services. The centre to support families and to prevent child abuse and neglect offered a variety of family support services. The Centre very much realised that the benevolence and initiative of Oz Child-Children Australia Inc had thrown a ray of light on all the disadvantaged families especially the children and women and enabled them to smile again. In point of point of fact, there is a great need for the expansion of this innovative program to cover more number of 'dysfunctional families' in the larger community at Madurai city, India where the population is growing thick and fast and problems of coping behaviour continue to affect the functional ability of many a family.

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