Society For Psycho-Prevention

Society For Re-Socialisation

PROGRAMME ASSUMPTIONS PROCEDURES, MODELS, PROFESSIONAL STANDARDS

(DRAFT MATERIAL)

The second completed edition

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PRELIMINARY INFORMATION

The Society for Psycho–Prevention was founded in 1992 by the group of psychologists, pedagogues, educators, therapists and doctors who were working in the fields of psycho–prevention, psychotherapy, family therapy, addiction treatment, re-socialisation and psychiatric rehabilitation. The Society conducts and supports community psycho–prevention, therapeutic, re-socialisation and rehabilitation programmes, and it trains people, who work in these fields. The Society has five branches: in Białystok, Bielsko-Biała, Łódź, Puławy and Warsaw.

The Society for Re-socialisation was founded in 1998 by the employees of Children's Homes, Upbringing Institutions and Reformatories, Addiction Treatment Centres, Upbringing Centres, Therapeutic Club Rooms, Curator's Centres, Counselling Centres, Adoption Centres, and other community psycho–preventive programmes. Society for Re-Socialisation serves as a forum for discussion and exchange of experiences for people who are looking for alternatives for contemporary, very expensive and ineffectual system of institutionalised care and re-socialisation for children and youth.

Both Societies co–operate in training and preparing and spreading professional procedures and standards. Since 1998 the societies have organised 9 conferences on professional standards, their implementation, the modification of care system, social prevention and re-socialisation, and standards of training courses, co-operation the professional circle with local governments, standards of addictions treatment as well as problem of violence in family.

We believe that effective prevention of upbringing pathology, violence, crime, and addictions is possible, if dysfunctional families are offered support in their natural environment at the earliest possible stage. Such support should be accompanied by the work with a child in its natural community within peer corrective groups. If such support is not sufficient and it is necessary to take the child away from its natural family, the child should be placed in well–chosen and prepared foster family. We consider placing a child in a stationary institution as the last resort. It is acceptable, provided that the institution is small, and it has corrective character.

We’d like to introduce you the second completed edition of the brochure “ Programme Assumptions, Procedures, Models, Professional Standards”, which includes standards and professional procedures worked out by our circle. There were few hundreds of graduates from our training courses and conferences who took part in preparing this material. They reflect our way of thinking, our values and beliefs as well as our general experience that comes out of our work with children and youth. The proposals have preliminary and draft character. They serve rather as and invitation for discussion than its final outcome. We do however attempt to reach these standards and to comply to them to the maximum possible extend in our everyday work with children and youth.

PREVENTION – CARE- RESOCIALISATION
/the forms proposed/

1. **Work with a family** (at possibly early stage),
   - early diagnosis (e.g. pre–school psychologist),
   - psycho–educational programmes,
   - social work,
   - crisis interventions,
   - support groups for parents,
   - counselling on upbringing,
   - family, marriage therapy.

2. **Community psycho–prevention programmes** (at possibly early stage),
   - Upbringing Centres, Therapeutic clubrooms, clubs (open daily min. 4–6 hours),
   - curatorship centres of work with youth,
   - counselling centres and sites (e.g. at schools),
   - teams for crisis interventions, helplines, etc.
   - street workers,
   - individualised teaching,
   - centres for stimulation for vocational activity,

3. **Foster family care** (placing up to 13 years old)
   - family emergency,
   - supporting families (friendly ones),
   - foster families (non–relatives),
   - contract families (specially trained):
     a. therapeutic families,
     b. rehabilitation families,
     c. re-socialisation families,
   - Family Children's Homes.

4. **Small (10–30 children) care and resocialisation centres**
   - only for children above 13, significantly demoralised,
   - coeducational centres,
   - (possibly short) periodic stay in a centre,
   - centres of therapeutic (corrective) programs,
   - open centres, contacts with graduates,
   - corrective communities (partnership relations with children and youth),
   - involved and qualified staff

WORK WITH FAMILIES – ASSUMPTIONS

I. The goals of work with families

1. Providing help in solving everyday problems of a family.
2. An assistance in constructive problem solving and overcoming crises in families.
3. Supporting family integration, supporting emotional bonds within a family.
4. Neutralisation of pathogenic influence of a family on children.
5. Restoration of care and educational functions of a family.
6. Support for an integration of a family with its social environment.

II. The assumptions underlying work with a family

1. The work with natural family is a first and most important form of preventing pathology of a child, and therefore it should be started as soon as possible (e.g. at pre–school).
2. For that reason an early diagnosis is required to prevent family and upbringing pathology (e.g. school psychologist).
3. Up to 7 one should concentrate on a work with families, the work with the child itself is less important and its effects are unstable.
4. At school age (age 7–15) the work with families is still fundamental but if the effects are not satisfactory it should be supported by the work with a child within peer corrective group (for example in Upbringing Centre).
5. At adolescence (age 15–20) the work with families has only supplementary meaning, as the personality of a young person is already shaped, and there are more often peers than parents who serve as a point of reference.
6. One should rather concentrate on improvement of general functioning of a family than merely on improvement of its relations with children.
7. While working with a family one should stay in regular contact with all members of the family, not only with these highly motivated.
8. It is essential to stay neutral towards all member of the family.
9. A therapist tries to understand the relations within the family as well as feelings and reasons of all its members, but at the same time tries to avoid judging from his own point of view.
10. Therapist's system of values can differ significantly from norms and values of the family that he intervenes in. It can make understanding difficult, if not impossible.
11. Teamwork with a family seems to be appropriate approach as it reduces the risk of perceiving the family through own subjective judgements, norms and unconscious traumas and prejudices.
12. Working with families to be effective has to be permanent, regular, intense and must deal with important problems.
13. Working with families to be effective has to deal exclusively with the problems the family is ready to deal with.
14. Because most of the "pathological families" is not motivated to any significant change (they do not know the changes are possible and can depend on them) one should actively look for contact with them.
15. It is better to contact families at heir homes than in counselling centres, as the family feels more safe and comfortable there.
16. It is a good idea to start working with unmotivated and suspicious family by helping its members in everyday troubles (e.g. of social nature) and to postpone all conversation about children till their situation becomes more stable and some trust appears.

17. While helping a family in their everyday difficulties it is good to avoid doing things for them, as is often causes unnecessary dependence and demands.
18. Even if what happens in families seems to be horrifying, the emotional bonds within the family are very strong. They are rather based on partnership, similar to ordinary bonds between siblings rather than between parents and their children. Braking these bonds may cause enormous tragedy and a loss of the sense in life.

III. The ways of working with families

1. preliminary diagnosis and qualification,
2. establishing contact (exchange of information),
3. social work (support in everyday routine problems),
4. crisis intervention(support and mediation in family crisis),
5. support group (parents, mothers, fathers, addicted persons, etc.),
6. educational counselling (increasing educational and upbringing skills),
7. family, marriage therapy (the process of emotional changes),
8. psycho–education programmes.

COMMUNITY PSYCHO–PREVENTION PROGRAMME – ASSUMPTIONS

I. The aims

1. Counteraction and prevention of family pathology, children upbringing pathology and various forms of social pathology (crime, violence, addictions, etc.).
2. Helping children and youth threatened by crime and addictions.
3. Creating groups and natural peer environment that act as an alternative to counterculture and crime bands.
4. Supporting family, school and local community in solving upbringing and educational problems with children and youth threatened by demoralisation and addictions.
5. Activation and integration of local community in preventing and counteracting social pathology.
6. Limiting the amount of children sent to stationary care and re-socialisation centres.

II. Community programme standards

1. It is preceded by a diagnosis of needs, problems and potential of the local community,
2. It is addressed to specific recipients,
3. It has a local nature,
4. It is permanent, continuous and long term by the nature,
5. It is based on stable professional staff,
6. It allows co–operation with volunteers,
7. It co–operates with local institutions, services and organisations,
8. It has an educational quality.

III. Recipients of the programme

1. Broken up, dysfunctional, educationally inefficient in temporary crisis.
2. Children and youth causing substantial educational troubles threatened by demoralisation, crime and addictions.
3. Schools, kindergartens, and other local centres and services.
4. Local community (inhabitants, firms, organisations).

IV. The staff

1. professional (trained),
2. involved,
3. open and authentic,
4. distinct (personality, values, interests),
5. ready to work upon oneself,
6. partnership relation with children,
7. accepted by children and youth and co–partners,
8. working in teams,
9. permanently raising skills and competencies.

V. The ways of community work

1. Upbringing Centres, Therapeutic Club Rooms, Community Clubs, etc., *(Opened daily, min. 4–6 hours per day, whole year),*
   a. helping in family, school, peer or personal crises,
   b. socio-therapeutic activities,
   c. individual correction programmes,
   d. corrective community (partnership, collective decision making),
   e. social and activity training, self–service,

f. helping on school lessons, re–education,
g. social assistance, supplying extra food because of malnutrition,
h. organising leisure time, awaking interests, plays, sports,
i. organising journeys, camps, winter and summer vacations,
j. permanent work upon parent at their homes,
k. permanent co–operation with school and other institutions (Social Care, courts).

2. Family Counselling Centres, Counselling Sites, family counsellors,
   a. crisis interventions in families,
   b. counselling on children and youth upbringing,
   c. family therapy,
   d. support groups, training groups,
   e. psycho–education programmes.
3. Crisis Intervention Centres.
   a. help line,
   b. crisis intervention team,
   c. crisis hotel,
   d. Family Emergency Centre.
4. Street work (street counsellors ,pedagogues, street workers).
5. Individual teaching.
6. Stimulating vocational activities of the youth.

VI. The work with local community

1. open nature of centres, participation of neighbours, other children, "open days", etc.,
2. organising meetings, activities, entertainment for inhabitants, other children’,
3. small investments for the benefit of the nearest neighbourhood (e.g. cleaning, trees planting),
4. co–operation with other services and local organisations,
5. appearance in local media.

VII. Monitoring and evaluation

1. self–evaluation of the team (documentation, periodical valuation),
2. children's and parents’ evaluation,
3. co–operating institutions' evaluation,
4. an analysis of statistical data (attendance, progress at school, cases at criminal courts, etc.),
5. simple questionnaire surveys.

THE STAGES OF FORMULATING COMMUNITY PSYCHO–PREVENTION PROGRAMME

1. **Creating the team that formulates a program**
   a. forming an initiative group,
      - the group that has common interests, values, professional standards, etc.
      - the group that passed common training, support group,
      - the group that emerged out of another team,
   b. formulating a program of the group,
      - common goals and interests,
      - ready to work and bear the costs,
      - common plan for action,
      - dividing tasks.
2. **Diagnosis of the needs and problems in local community**
   a. gathering information, statistical data, opinions, expertise,
   b. describing the needs and problems of the local community,
   c. evaluating potential of the local community,
   d. characteristics of possible clients,
   e. diagnosis of mechanisms and the causes of existing problems.
3. **Description and evaluation of existing local offer**
   a. description and evaluation of the offer of local public services,
   b. description and evaluation of the offer of local non–government organisations (societies, foundations),
   c. evaluation of the actual possibilities of the clients and local community,
   d. an analysis of shortages and shortcomings of the offer,
   e. local sources of funds (money, premises, people, organisations, etc.),
   f. possible allies,
   g. possible opponents and concurrency,
4. **Formulating the goals of the programme**
   a. goals in relation to clients,
   b. goals in relation to whole local community,
   c. goals in relation to social services (public and non–government),
   d. goals in relation to local authorities,
   e. goals in relation to own team (e.g. prospects for development),
5. **Unfolding expected outcomes**
   a. in relation to clients,
   b. in relation to local community,
6. **Planning the forms of client's recruitment**
   a. characteristics of the clients,
   b. neighbourhood entertainment, street work, working with counterculture groups,
   c. social work with pathological families,
   d. counselling sites, crisis interventions,
   e. permanent co–operation with local services and organisations:
      - systematic "inspections" of first grades at school,
      - permanent co–operation with school counsellors and counselling centres,
      - permanent co–operation with employees of the social services, court curators and the police,
      - permanent contact with non–government organisations, churches, administration, etc.

7. **Formulating long term strategy**
   a. foresight of destination:
      – aims and assignments,
      – forms and methods of work,
      – predicted outcomes,
      – forms of teamwork,
   b. consecutive stages of realisation:
      – successively introducing the functions planned,
      – timetable of incorporating the programme,
   c. the plan of gaining the sources (money, premises, training, etc.):
      – allocations and instructions of self–government,
      – allocations and instructions of government (e.g. agendas and purpose funds),
      – allocations from international funds,
      – allocations from non–government organisations (polish and foreign),
      – donations from firms and inhabitants,
      – collections, picnics, auctions, paid services,
8. **Preparing the staff**
   a. basic training and workshops,
   b. apprenticeships in good teams,
   c. formulating basic standards and professional procedures of the team,
   d. formulating the rules of teamwork,
   e. programme of internal training:
      - clinical meetings,
      - supervisions
   f. junior staff members and volunteers (staff reserve).
9. **Acquiring external allies** (self–government authorities, local institutions, non–government organisations, firms
10. **Ensuring legal and organisational conditions.**

FOSTER FAMILY CARE (FFC)

I. Goals and tasks for FFC

1. Comprehensive care for a child that is lacking an elementary support in natural family (being in crisis, orphaned, deserted, etc.).
2. Providing a child an opportunity to realise emotional bonds in a correct family environment.
3. Focus on possibly quick return of a child to its natural family, and, if it is not possible, on providing permanent care in foster or adoption family.
4. Protecting children lacking care in natural families against institutional forms of care.

II. Components of FFC model

1. conducting in which a child is included
   a. gathering comprehensive information about a child,
   b. qualifying the child to an appropriate form of FFC,
   c. gradual introducing a child to foster family,
   d. carrying out personal (corrective) bring–up programme for a particular child,
   e. co–operation: a child – foster family – natural family – professionals,
   f. preparing a child for homecoming to natural family or

preparing a child to become independent 2. conducting in which the foster family is included

   a. recruitment and selection of candidates for FFC,
   b. training and preparing the candidates for FFC,
   c. fitting a child and a foster family (gradual, natural process),
   d. co–operation between foster and natural family facilitated by a professional,
   e. support groups for foster families, co–operation between foster families,
   f. professional assistance for foster families, individual care,

preparing foster family for leaving of a child3. conducting in which the natural family is included

   a. crisis intervention in a natural family,
   b. diagnosis and a proposal for an assistance (therapy) for natural family,
   c. preparing a natural family to let foster family have a child,
   d. possible clarifying legal situation of a child,
   e. realisation of an assistance (therapy) for natural family,

preparing a natural family for come back of a child 4. professional staff supporting FFC

   a. building up a team,
   b. training and supervising a team,
   c. qualifying committees for children and foster families,
   d. support for natural family
   e. supervision and support for foster families,
   f. co-operation with experts, legal services,
   g. monitoring and evaluation.

III. Programme of spreading up FFC

1. **Goals of FFC organizators**
   a. training professionals, creating new centres and agencies of FFC,

b. recruiting candidates for FFC,
c. recruiting children to FFC ,
   - from dysfunctional natural families,
   - from care and re-socialisation institutions,

2. Institutions and individual people supporting FFC,
   a. programmes and community centres working with children and families,
   b. care and upbringing institutions,
   c. non–government institutions, religious communities, local communities,

3. Public opinion and lobbying
   a. media,
   b. materials and promotion programmes for professional circles and decision–makers,
   c. evaluation surveys,
   d. legal and economic lobbying.

TYPES OF FOSTER FAMILY CARE

1. **Friendly families –** the form of supporting a child that lives in dysfunctional natural family or in care/upbringing institution. It does not require special legal regulations, it does require however consent of a natural family or the care/upbringing institution. Very flexible way, it allows for the full contact with natural family, recommended as preliminary form of foster family.
2. **Family emergency-** the form of immediate, temporary care in foster family needed in case of crisis in natural family, a necessity for specialised care, time needed to find foster of adoptive family when it is not possible to return to natural family
3. **Foster families (non–relative)** – the form of providing care in new, well functioning family. It is often accompanied with restrictions of natural parents' authority, however this is not essential. Foster family receives 40% of average income benefit.

4. **Contractual families -** the form of specialised foster family, permanent or temporary, for children of different age, requiring specialised corrective (therapeutic, rehabilitating, re-socialising, etc.) treatment. This form requires professional training for parents and appraisal of specialised commissions or centres. The allowance is higher and equals 100% of average income or the parents are paid additionally for their professional work. This form involves professional support and supervision of specialised authority. The types of contractual families:
   a. **therapeutic families,**
   b. **rehabilitating families,**
   c. **re–socialising families, etc,**

5. **Family Children's Homes** – the form of foster family for a group of 6–12 children. The children live together within one foster family. The foster parents are concerned with care, upbringing, correction and giving the children independence. Family Children's Homes provide care for numerous siblings. The children of different age live there growing, helping each other and gradually becoming independent. This form is fully financed (costs of living, salaries). Family children's homes require appropriate accommodation (house, large apartment).

6. FAMILY EMERGENCY
/model proposed/

1. **Diagnostic-qualifying team,**
2. **Crisis intervention team**
   - helpline,
   - crisis intervention team,
   - crisis hotel.
3. **Foster Family Centre**
   - family emergency,
   - supporting (friendly) families,
   - foster families (non–relatives),
   - contractual families,:
     a. therapeutic,
     b. rehabilitation,
     c. re-socialisation,
   - family children’s homes,
4. **Upbringing Centre**
   - day groups,
   - night groups,
   - all day groups (Mon.–Fri.).
5. **Family Counselling Centre**
   - crisis interventions,
   - support groups,
   - counselling on upbringing,
   - family, marriage therapy,
   - psycho–education, training,
6. **School** – individualised teaching,
7. **Stimulating vocational activity center.**

CARE AND RESOCIALISATION CENTRES – ASSUMPTIONS

A. The clients

1. exclusively for children above 13,
2. exclusively for children significantly disturbed and demoralised,

B. The goals

1. care,
2. development, education,
3. therapy, re-socialisation:
   a. therapy of emotional problems,
   b. social adaptation,
   c. independence in real everyday life,
   d. preparation to undertake vocational activity,
   e. preparation to live within a family,
4. temporary stay in a centre,
   a. staying in contact with natural family,
   b. seeking foster family,.
5. gradual gaining of independence:
   a. boarding–schools,
   b. groups of gaining independence
   c. hostels,
   d. re–adaptive flats,

C. Organisation of the Centre

1. possibility of choosing a centre by a child,
2. co-educational centres,
3. small centres for 10–30 children,

D. The staff

1. professional (trained),
2. involved,
3. distinct (personality, values, interests),
4. open and authentic,
5. ready to work upon oneself,
6. ready for partnership relation with children,
7. accepted by the centre’s community (the staff and children),
8. ready for teamwork,
9. permanently raising skills and competencies.

E. The ways of corrective and upbringing work

1. individual correction programmes,
2. emotional bond with counsellor,
3. therapy, psychological training,
4. working on functioning in sexual relations,
5. therapeutic community,
6. training of self–service (lack of “technical” support staff),
7. individualised teaching,
8. development of interests,
9. work with natural family,
10. permanent numerous contacts with local community,
11. gaining independence:
    a. playing a role of patrons for younger children,
    b. boarding-school, college hostel,
    c. hostels, re–adaptive flats,
    d. assistance in getting a job, social apartment,
    e. friendly families, grants,
    f. organisations of graduates,,

F. Monitoring and evaluation

1. periodical self evaluation of a team,
2. evaluation of children and youth,
3. evaluation of local community,
4. graduates screenplay (scripts),
5. analysis of statistical data,
6. simple evaluative surveys,

G. Teamwork

1. examining children and youth,
2. examining the groups,
3. own training of the staff,
4. support groups – openness,
5. supervisions,
6. teamwork,
7. participation in training courses,
8. clear professional identification (ideology, standards, ethics),
9. junior staff members and volunteers,

ASSUMPTIONS FOR EVOLUTION PROCESS OF CARE AND RESOCIALISATION CENTRES

1. **Creating a team that will realise a programme of changes:**
   a. founding an initiative group,
   b. formulating programme of the group:
      - common goals and interests,
      - readiness for work,
      - common plan of work
      - dividing tasks,
   c. forming the rest of the team,:
      - programme in relation to sympathisers,
      - programme in relation to undecided,
      - programme in relation to opponents.
2. **Diagnosis of the needs and problems of children currently under care:**
   a. caused by the stay in the centre,
   b. caused by the life history,
   c. caused by the age and developmental stage,
   d. caused by current life situation ,
   e. caused by the prospects for future,.
3. **Evaluation of current the programme of the centre in relation to the needs and problems of children currently under care:**
   a. scale of meeting the needs and problems of the children,
   b. quality of relation between the children and youth and the centre (satisfaction, identification, co–operation, second life, violence).
   c. the relation and attitude of the staff towards children and youth,
   d. relation within the team, co–operation, motivation to development and change,
   e. an analysis of causes
4. **Adapting programme to the needs and problems of children and youth currently under care:**
   a. changes in attitude and relation with children and youth,
   b. changes of the programme and methodology of work,
   c. changes in the rules of work and co–operation in a team
5. **Diagnosis of the needs of local community:**
   a. local needs and social problems,
   b. the level and the ways of solving problems,
   c. local sources of founds (money, premises, people, organisations, etc.),
   d. possible allies,
   e. possible concurrence,
6. **Formulating long term programme for the centre**
   a. foresight of destination:
      - characteristics of the clients,
      - aims and assignments,
      - forms and methods of work,
      - predicted outcomes,
      - forms of teamwork,.
   b. consecutive stages of realisation::
      - graduate reduction of the functions that are closing down,
      - successively introducing the functions planned,
      - timetable of incorporating the programme,
   c. the plan of gaining the sources (gaining money, adopting premises, training people, etc.),

7. **Preparing the staff:**
   a. basic training and workshops,
   b. apprenticeships in good teams,
   c. formulating basic standards and professional procedures of the team,
   d. teamwork,
   e. internal training:
      - clinical meetings,
      - supervisions,
   f. junior staff members and volunteers (staff reserve).

8. **Acquiring external allies** (self–government authorities, local institutions, non–government organisations, firms)

9. **Ensuring legal and organisational conditions.**

10. **Realisation of a long term programme**

ORGANISATION OF THE WORK OF UPBRINGING TEAM

I. Goals:

1. Increase of work effectiveness,
2. Lowering the costs of work,
3. Development of the programme and the methods applied,
4. Co–operation within the team,
5. Professional growth of team members,
6. Formulating and maintaining professional standards,
7. Support in case of problems and difficulties,
8. Building good atmosphere in a team,
9. Building an external prestige of the firm,

II. The ways of recruitment of new staff members

1. presentation of own methods of work, standards, values, theoretical assumptions in professional circle, at the universities, etc.
2. Clear expectations from the candidates
3. process of gradual entering into the team::
   a. volunteers,
   b. trial tasks,
   c. trial periods,
   d. preliminary training,.
4. Evaluation of a candidate's usefulness should take into consideration:
   a. evaluation of his qualifications and professional experience,
   b. evaluation of his motivation,
   c. evaluation of his emotional dispositions,
   d. potential for development,
   e. evaluation of his readiness to work upon himself,
   f. evaluation of his willingness for teamwork,
5. What may be helpful:
   a. candidate's offer,
   b. recommendations,
   c. interview,
   d. team's evaluation (after trial period),
   e. client's evaluation (e.g. within the frame of corrective community),
6. Conditions of taking leave of candidate, giving up collaboration with him:
   a. feedback information,
   b. indicating limitations and the ways of going beyond them,
   c. proposals of future collaboration (training, work on volunteer basis, other work),

III. Essential goals of preliminary training for new staff members:

1. own training,
2. ability to explore in a safe way,
3. ability to learn on one's mistakes,
4. ability to use feedback,
5. ability to work in a team,
6. knowledge of the basic rules of the work and professional procedures,
7. ability to establish contact and to draw up a contract,
8. ability to diagnose a person, a family, a group,
9. ability to formulae corrective programme,
10. knowledge of the specifics, tradition and theoretical assumptions of the team,

IV. Conditions of team's integration:

1. Honesty and openness in mutual relations,
2. Mutual respect and tolerance,
3. Giving feedback without delay,
4. Partnership relations within a team,
5. Natural hierarchy in a team (based on natural authority),
6. Teamwork, clear procedures of co–operation,
7. Essential decisions made collectively,
8. Structured forms of current analysis of the work and co–operation,
9. Identification with values and standards of the team,
10. Clear distribution of competencies and responsibility,
11. Clear expectations from a leader,
12. Clear relations between an individual and the team,
13. Clear distinction between work and privacy,
14. Appreciation for variety and complementary,
15. Contract for discipline

V. Constant "internal" forms of professional improvement:

1. Supervisions
2. Clinical meetings (discussing clients)
3. Apprenticeship (collaboration with more experienced members of the staff)
4. Summaries, gatherings on programme, evaluation matters, etc.
5. Documentation of ones own work
6. Teaching others.

VI. "External" training courses:

studies,seminars, etcApprenticeship in good teamsMethodical and specialised trainingsExtended own training

CORRECTIVE COMUNITY

A. Partnership is an effective way of working with street children because:

1. they have nothing to loose but their freedom and they will not give it up,
2. one can temporary “buy” them or intimidate them, but can not change them against their will,
3. they do not obey the rules and authorities, instead they are rather led by their feelings and life pragmatism,
4. they respect the rules and reality if they achieved them by themselves,
5. they change significantly their behaviour only if they identify with the place, the group or the patron,
6. they are suspicious because they have been so often disappointed by intentions, declarations and responsibility of adults,
7. they are masters of destruction and sabotage of authoritative and arbitrary decisions of adults,
8. they do not receive real support from adults, so they quickly have to became independent and responsible,
9. partnership with these children neutralises pressure and enables their engagement in the process of change,
10. partnership allows for autonomy without violating autonomy of others.

B. The rules of corrective community:

1. The corrective community is constituted by all children and youth under care, all staff members – patrons and all technical support team members.
2. The aim of corrective community is mutual help and supporting development and therapy of its members.
3. The membership in corrective community is exclusively voluntary and requires acceptance of its rules.
4. The community can function well provided full openness, honesty and responsibility of its members.
5. The community undertakes all decisions regarding communal life as well as development and therapy of its members.
6. All decisions regarding common matters are made by majority of votes.
7. All members of corrective community have rights to speak freely on all common mattes.
8. All members of corrective community have rights to convene its members and present a problem to be solved.
9. The community sets all its rules and principles by itself.
10. The rules apply to all members of corrective community – children and youth under care, the staff and members of technical support team.
11. The community can set the rules that are always valid and can not be withdrawn.
12. The community periodically discusses and judges functioning of its members.
13. The community may set the stages of therapy or re-socialisation and judge its progress.
14. The community may formulate and approve the tasks for its members on particular stages.
15. The community decides upon ending the process of therapy or re-socialisation.
16. The community may suspend its rules and rights temporary.

C. The conditions for building up corrective community:

1. The absolutely necessary condition for corrective functioning of the community is **unquestionably voluntary** participation of children and youth and the staff.
2. The corrective community **must be built slowly**, progressively introducing the rules and gradually increasing independence and responsibility of the group,
3. Full partnership and responsibility is possible when majority of the children and youth **identifies themselves with the goals and rules** of corrective community, has solved many of their problems, and has given up destruction, violence and addictions as a way of copying with their lives.
4. The absolutely necessary condition for corrective functioning of the community is exclusion **of violence and second life** and mutual trust and feeling of safety among all the members of the community.
5. The requirement of upbringing or therapeutic work through corrective community is willingness of the staff for open, authentic, partner relationships with children and youth. The partnership **excludes the possibility of functioning in a role** (of parent, patron, therapist, etc.)
6. In the form of corrective community the possibility of constructive influence of the staff is based only on their wider life experience, real professional competencies, engagement, goodwill, tolerance, and emerging from above **natural authority**.

CRISIS INTERVENTION

Crisis intervention-it is a form of work with person or family undertaking in crisis situation, in which person or family has difficulties in satysfying his/her own elementary needs or in fulfilling his/her basic rules.

1. The essence of crisis present:
   a. Subjective experiences of own situation as a very difficult and impossible to accept, in which so far ways of dealing with situation disappoint;
   b. Experiencing this situation in extremely dramatic, hardly realistic way, which can lead to inadequate and often destructive or self-destructive solutions;
   c. Subjective feeling of lack of understanding and support;
   d. Limitation of time in opportunity of aid, causing from treatment with hard, and often irreversible results of destruction or confrontation..
2. Crisis intervention is focused on:
   a. Providing basic support and safety,
   b. Preventing destructive solutions and minimising costs of crisis;
   c. Explaining reasons and essence of crisis;
   d. Finding solution possible to accept by everyone;
3. Crisis intervention is only the first stage of aid:
   a. Frequently doesn’t include target solution of the problem ;
   b. Intervention finishes when person or family gain basic balance, understanding reasons and negotiation the direction of solving problem which evoked crisis;
   c. Frequently only after its finalisation undertaking long-term activities, which can lead to solving problem and removing reasons of crisis is possible.
4. The crisis could be evoked by natural developmental problems connected with adolescence:
   a. Breaking out school career,
   b. Difficulties in contact with peers,
   c. Failures in first emotional experiences,
   d. Conflicts with parents result from searching for own identity,
   e. Changing the community (flat, school, peers),
   f. Necessity of undertaking new social roles (e.g. unplanned parenthood),
   g. Necessity of increasing self dependence and responsibility for own life,
   h. Living the family home (e.g. studies, marriage),
   i. Encountering images with real life,
   j. Crises of parting (e.g. death or divorce of parents)
5. Crises of adolescence result from upbringing pathology:
   a. Wrong satisfied emotional needs,
   b. Pathology of emotional bonds – lack of acceptance or excessive attachment,
   c. Isolation from peers,
   d. Inadequate expectations parents toward child (unreal ambitions),
   e. Disordered relations and roles in family,

f. Internal contradiction of passing on normalised system in family.

6. Features which make dealing with crises difficult:
   a. Inadequate expectations towards people and own person,
   b. Emotional immaturity, dependence on opinion,
   c. Disordered feeling of own value, identity and autonomy,
   d. Inhibitions, lack of openness, mistrust,
   e. Lack of social skills, social isolation,
   f. Low task dexterity,
   g. Lack of own shaped system of values and norms

7. Hypothetical manifestations of crisis:
   a. Escapes from homes,
   b. Identifications with destructive counterculture groups,
   c. Behaviour inconsistent with law ,
   d. Excessive erotic behaviour and prostitution,
   e. Abusing or experimenting with psycho-active agents,
   f. Aggression , violence, destructive behaviour,
   g. Self-injuries,
   h. Sudden deterioration of marks in school, dropping out of school,
   i. Isolation from contact with other people,
   j. Suicide attempts,
   k. Escaping in illness,
   l. Disturbances appetite.

8. The Crisis Intervention should be:
   a. Completely accepted by whole system, in which the crisis has appeared,
   b. system- including whole system (e.g. family, peer group),
   c. quick and easy to reach,
   d. adequate,
   e. impartial,
   f. carried on directly but not arbitrary,
   g. it should respect clients' cultural norms,
   h. it should be carried on by a team (at least 2 person).

9. The most frequent mistakes of crisis intervention are:
   a. Basing on unilateral information and opinions,
   b. Making intervention focused on symptoms instead of reasons,
   c. Undertaking a crisis intervention in social surroundings interest not in client interest,
   d. Offering solutions before gaining mutual understanding the reasons of the crisis,
   e. Guiding by prejudices and cultural norms,
   f. Supporting one side of conflict against other,
   g. Pressing own solutions.

10. Competitions of people carrying on crisis intervention:
   a. High efficiency and professionalism,
   b. High abilities of work with family and group,
   c. Significant life and professional experience,
   d. Awareness of possessed values, limitations and prejudices,
   e. Not judging on, impartiality, tolerance,
   f. kindness, empathy and ability of following the client,

g. being at client disposal and involvement,

ASSUMPTIONS OF OUT-PATIENTS' CENTRE OF ADDICTIONS TREATMENT

A. Patients:

1. Chronic,
2. Addicted,
3. Patients who experiment on drugs,
4. People at risk of becoming addicted (difficult adolescent phase of development, addicted family),
5. People after treatment,
6. Patients' families,

B. Recruitment:

1. Applying by themselves,
2. Street-work in community,
3. Consulting points, substance abuse rehabilitation consulting centres ,
4. Treatment centres,
5. Crisis intervention teams, helpline ,
6. Schools,
7. Social aid, health service, court guardians, police,
8. Brochures, the Mass Media,

C. Functions of out-patients' centre:

1. Initial diagnosis and qualifying proceedings,
2. Transmission of information and referring to other institutions,
3. Motivating to treatment,
4. Aid in crisis situation (individual, family),
5. Reduction of threat,
6. Damages reduction,
7. Substitute programs,
8. Breaking a heavy drug addict and detoxification,
9. Ability of maintaining abstinence,
10. Aid in social problems,
11. Aid in health problems,
12. Gaining support in community,
13. Making expectations towards oneself and world more adequate,
14. Making aware and solving emotional problems,
15. Increase in psychological skills,
16. Increase in social dextrity,
17. Increase in task skills,
18. Increase in self-service skills,
19. Aid in becoming self-dependent,
20. Aid in getting a place of living,
21. Help in graduating from school,
22. Aid in gaining professional qualifications and finding job,
23. Forming support groups after treatment,
24. Supporting and integration of neophytes' circle,
25. Support and aid for patients' families,
26. Addictions prevention,
27. Psycho-education and promotion of healthy style of life,

D. Personnel

1. Skilled (education, specialised training courses),
2. Involved, open, authentic,
3. Ready to work on themselves (own training, supervision, feedback),
4. Ready to teamwork,
5. Ready to work in community,
6. Ready to work with family,
7. Ready to work with patients who are not motivated to change,
8. Constantly improving their qualifications,
   a. current programming and discussing the work,
   b. clinic meetings,
   c. supervision activities,
   d. apprenticeship in good teams,
   e. specialist training courses,

9. Co-operating with volunteers,

E. Forms of aid and therapy

1. Initial diagnosis, qualification proceedings and referring to proper forms of aid and therapy,
2. Street-work,
3. Crisis intervention,
4. Detoxification,
5. Substitute programs,
6. Short-term medical aid,
7. Social aid,
8. Homelike shelters and hostels for homeless,
9. Hospices,
10. Consultations and guidance,
11. Psychotherapy,
    a. individual,
    b. group,
    c. family,
12. Supporting groups,
13. Patients' club – out-patients' centre community,
14. Self-aid groups, neophytes' organisations (AA, AN),
15. Re-adaptive flats,
16. Individualised education (e.g. „SOS" schools),
17. Sheltered workshops, professional courses,
18. Preventive and psycho-education programs,
19. Co-operation with other services and organisations,

F. Monitoring and evaluation

1. Team's own periodical opinion,
2. Patients and their families' assessment,
3. Graduates' scripts,
4. Co-operating institutions opinion,
5. Analysis of statistics,
6. Simple evaluation researches

ASSUMPTION OF STATIONARY CENTRE OF ADDICTIONS TREATMENT

A. Patients
   1. Conditions of admission,
      a. regular contact with drugs,
      b. serious emotional problems,
      c. motivation to undertaking treatment, readiness to work on oneself,
      d. willingness of treatment, opportunity of choosing institution,
      e. patient after detoxification,
      f. patient is ready to maintain abstinence,
      g. qualification proceedings (preliminary diagnosis, session, admission session).
   2. Contraindications of admission
      a. mental disorders,
      b. taking medicines changing consciousness regularly.

B. Goals of therapy
   1. Gaining self-consciousness
   2. Making expectations more realistic
   3. Solving basic emotional problems
   4. Unblocking developmental potential
   5. Increase in psychological abilities
   6. Increase in social dextrity
   7. Increase in task skills
   8. Gaining ability of self-service
   9. Becoming self-dependent, re-adaptation
   10. Ability of maintaining abstinence

C. The center’s structure
   1. Time of staying – 6-12 month
   2. Number of patients – maximum 30
   3. Coeducation
   4. Dividing into centers for youth (under the age of 21) and adults
   5. Number of therapeutic personnel – minimum 1 therapist for 4 patients
   6. Duties:
      a. not rare than once a week,
      b. not longer than 36 hours,
      c. on duty during the day - minimum 2 persons of personnel
         during the night - minimum 1 person of personnel
   7. The center provides:
      a. medical consultations,
      b. social aid,
      c. contacts with family.
   8. Auxiliary personnel:
      a. minimum of management staff,
      b. lack of employees of technical support.
   9. Location and district activity of center provides:
      a. co-operation with local out-patients’ institutions,
      b. contacts with family (especially centers for youth),
      c. becoming self-dependent in local towns (re-adaptive flats, school, job),
      d. relative isolation from addicted people circle.
   10. Specified formal and legal status of center

D. Personnel

1. skilled (education, specialized training courses)
2. engaged, open, authentic
3. ready to work on themselves (own training, supervision, feedback)
4. ready to team work
5. ready to partnership relations with patients
6. periodically verified by community
7. constantly improving their qualifications
   a. work in pairs and discussing activities,
   b. clinic meetings,
   c. Supervision activities,
   d. apprenticeship in good teams,
   e. specialist training courses.

E. Forms of aid and therapy

1. Psychotherapy
   a. Individual
      - each patient has got permanent therapist,
      - has permanent, regular individual contacts,
      - has periodically verified individual problem diagnosis,
      - has periodically verified individual therapeutic program.
   b. Group
      - carried out by pair of therapists,
      - addressed, programmed and currently verified,
      - included group process and individual therapeutic work on the ground of group,
      - included emotional problems, relationships, social relations of patients.
   c. Family (permanent, regular family or individual sessions with family members)
2. Support groups (analysis of current problems in functioning in the center)
3. Psycho-education groups (transfer of knowledge and training of abilities)
4. Therapeutic community
   a. Every-day co-operation and co-existence in the center
      - creating bonds,
      - social training courses,
      - training course of self-service.
   b. Meetings of community
      - evaluation of progress in therapy,
      - establishing norms and principles of proceedings,
      - training course of partnership, openness, sincerity,
      - molding attitudes and values,
      - co-determining and co-responsibility,
      - conflicts settling,
      - discussing interpersonal relations,
      - feedback.
   c. Fulfilled functions and works realized in community
      - social training,
      - task training.
5. Individual plans of development
6. Crisis intervention
7. Social work
8. Medical aid
9. School education, apprenticeship
10 Hostel, group of becoming self-dependent
11. Re-adaptive flats