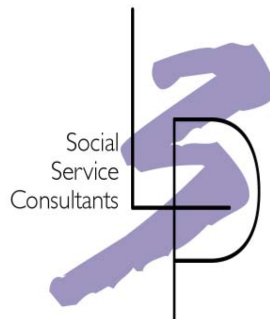
POSITION PAPER:

FAMILY CENTERED ASSESSMENT IN CHILD WELFARE PRACTICE



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POSITION PAPER ON
FAMILY CENTERED ASSESSMENTS

By
Lorrie L. Lutz, MPP

Introduction

Doing child welfare well is the most demanding and difficult of social enterprises. Child welfare professionals must do four things right: We must get children out of harm's way; we must decide how to get them safely back home as soon as possible or, if that can't work, get them into a caring permanent new family and do it quickly, and finally, we've got to make sure that children are safely, supportively, stably cared for while we're getting them to a safe, permanent arrangement. While the nature of child protection has always been time sensitive, the passage of the Adoption and Safe Families Act (ASFA) has heightened the tension surrounding practice. The time frames outlined in ASFA and the need to make decisions quickly to ensure permanence in the life of the child require that social workers make **rapid decisions** about the ability of the child's family to provide long term care and support to their child. Giving safety and permanence the day in, day out priority it deserves requires several things. It requires that leadership of the system clearly affirms that safety, permanency and child well being are the core of sound child welfare practice. It also requires that the system hold itself accountable -- in measured and rewarded ways -- for achieving safety and permanency benchmarks including avoiding unnecessary delays, reducing moves, shortening lengths of stay, achieving prompt reunification at the earliest safe moment, and expediting adoptions.
The purpose of this position paper is four-fold:

1) To describe specifically how a family-centered assessment should be conducted.
2) To describe how a family-centered assessment meets the requirements of the Adoption and Safe Families Act of 1997.
3) To discuss the best practices emerging in the area of family centered assessments.
4) To contemplate the barriers and controversies surrounding family centered assessments in child welfare.
5) To discuss ways in which the National Resource Center for Family Centered practice can support public child welfare agencies in implementing family centered assessments in daily practice.

SECTION I FAMILY-CENTERED ASSESSMENT IN CHILD WELFARE

In current child welfare practice in many states, the initial stages of the case require that the social worker focus on gathering data–examining and searching for facts concerning an alleged incident based on a report of abuse or neglect. This information gathering rarely serves to develop a relationship with the family; in fact, most often alienates the family from the system. Because the relationship with the family is considered by many experts to be crucial to the ultimate goal of child safety, permanence and well-being, there must be a change in the focus from one that emphasizes information gathering, to one that emphasizes the building of a relationship, gathering of information and laying the groundwork for any necessary ongoing work with the family system. This focus should include assessing the family in relationship to the allegations (their ability to keep their child (ren) safe, their needs and their capacities. This kind of focus is described in this document as a family-centered assessment.

A family centered assessment describes a comprehensive process for identifying, considering and weighing factors that affect child safety and well being through engaging the family and extended family in a focused dialogue. While assessment includes both the safety and risk concerns, it goes beyond the determining safety and level of risk to explore connections, community resources and permanency considerations. In a Family Centered Assessment workers learn about and engage the family in identifying their needs, strengths, and current resources to achieve and maintain the well-being, family connections and permanency for the child. A family-centered assessment links directly to case planning by contributing to key decisions regarding steps to be taken, resources to be used and outcomes achieved.

How do we conduct an assessment that really teaches us about the family and the most effective means of successfully intervening to ensure child safety and permanence? In *Ours to Keep, A Guide for Building Community Assessment Strategy for child Protection,*[1] the following comparisons are made about the current approach to child protection assessment, and the approach reflected under a family centered model. These distinctions are outlined in the table below and serve as the background for this paper.

Current Approach To Assessment In Many Child Protection Jurisdictions	**A Family Centered Approach to Assessment in Child Protection.**
Focus on gathering information, often to the exclusion of building relationships.	Gathering information in a way that fosters a relationship with the child/family.
Focus on the substantiation of whether or not maltreatment has occurred.	Determining how to support the family and how to remedy any harm that may have already occurred.

[1] Day, Pamela, Robison, Sheila, and Sheikh, Lisa Our to Keep: A Guide to Building a Community Assessment Strategy for Child Protection CWLA Press 1998

Current Approach To Assessment In Many Child Protection Jurisdictions	A Family Centered Approach to Assessment in Child Protection.
Collecting a body of evidence around the alleged abuse.	Identification of child and family needs, strengths, resources and goals.
Identifying deficits, risks, and needs.	Conducting a holistic assessment, including the identification of strengths, resources and capacities as well as risks and needs.
Tools and methods often create distance between the worker and the family.	Using tools and methods that enhance the workers ability to engage the child/family and support them in achieving their goals.
Insular decision-making, with CP staff making decisions independently of families and others who have a stake in what is going on.	Emphasis on collaboration with families, their existing support networks and other community based providers.
A routine approach to child protection that consists of essentially the same methods and often results in the same set of service options.	Assessment process provides the flexibility to address individual family needs and respond to each family's varied backgrounds and experiences.
Episodic CPS practice where workers conduct assessments only when there is a crisis. This results in a series of snapshots of the family, which do not provide a full picture of overall family's functioning.	Ongoing and frequent assessment of safety and well-being and of the family's progress as well as most effective methods of helping the family achieve their goals. Teaching the family to self assess.

From this comparison it becomes clear that while a risk assessment/investigation is valuable for the sole purpose of gathering information, a family centered assessment is imperative if we expect to build a relationship with the family and successfully engage them in addressing the issues that brought the family to the attention of the system.

A) The Philosophy and Values of a Family Centered Assessment

A family centered assessment is based on the following core values of all family centered practice:

1) Ensuring the safety of children and other family members.
2) Working as partners with families.
3) Recognizing and building on families' strengths, capacities and resources—using those as the basis for mobilizing change.
4) Creating a climate where families are free to make decisions and develop skills that contribute to their families' safety and well-being.
5) Respecting and being sensitive to cultural differences and supporting diversity.

Underlying all family centered practice is the assumption that human beings can be best understood and helped within their significant environments and that the family is the most intimate environment of all. In a family-centered assessment, the process is

directed as much as possible at learning about the strengths and capacities of the family as a source of help in family problem resolution. The family's own environment is employed as the arena in which social workers help strengthen tangible resources such as food or housing and intangible resources such as community support system, communication between parents and siblings, parenting skills, etc.

1) Child Safety

First and foremost, the work of the child welfare system is to ensure that the child must is safe. This is part of every child welfare legislation in the country and emphasized by the 1997 Adoption and Safe Families Act. If an assessment is to meet the requirements of ASFA it must assess if the child is safe and if not, must guide the social worker to immediate intervention. The challenge for many social workers is to conduct a family centered assessment, where family's strengths, capacities and resources are highlighted, and yet never minimize the seriousness of the alleged abuse or neglect to the child. A comprehensive and well-done family centered assessment teaches us more about child safety than an investigation or interrogation. A good family centered assessment, increases the likelihood that the family will disclose their need for help, the child will tell his/her story and that the family will experience a non-judgmental, but very clear message, "*your child must be safe and must have permanence. Our goal is to strive with you as partners to ensure that this occurs."*

In reviewing the assessments in the attachments to this paper, it is clear that states have devised very specific strategies and processes for assessing child safety. Those states that are able to integrate a family centered assessment approach with the child safety assessment, such as New Hampshire, Colorado, North Dakota, Missouri, go a long way to increase the probability that that the child can remain or return safely to their biological family. If that is not possible, a strong family centered assessment can serve to engage the family in voluntary relinquishment of parental rights if in fact that is in the best interest of the child.

2) Working As Partners with Families

In her book *Strengthening High-Risk Families,* Lisa Kaplan suggested that the most critical part of the assessment is the **establishment of the relationship**. She goes on to emphasize that workers must show genuine respect for families as full partners in the process and join families where they are; not where the worker wants them to be. The more involved the family in verbalizing and prioritizing their needs, the greater the likelihood that they will be committed to change.[2] Sometimes parents may expect the worker to be the expert and want to turn over all decision-making to them; workers who acquiesce and set goals for the family will in the end, fail in reaching their goal. The initial assessment involves the whole family and if possible the extended family and others key to the day-to-day life of the family.

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[2] Kaplan, Lisa and Girard, Judith Strengthening High Risk Families 1994 Lexington Books

Adopting a family centered approach necessitates re-evaluating and re-thinking the way we fundamentally intervene with families. Becoming a family centered practitioner involves having an unwavering conviction that families can change. If an individual does not believe this, then they have minimal ability to impart this needed hope and conviction to the families they serve.

The process of finding new ways of thinking about the relationship between family members and professionals grows from the realization that the way we have traditionally practiced did not serve us well. Although we have come a long way from the days of “blame and shame” we are still not to the point where we are seeing the family as real partners in the process of change. We must demonstrate that it values families by radically altering the premise on which social services are based, moving from “replacing families” to supporting and strengthening them. We must look beyond exemplary or pilot programs scattered her and there, to a place where family centered values infuse all aspects of the system.

When we take the time to really listen to families and what they tell us about their treatment by the “system”, we continue to hear deeply felt feelings of frustration, anger and pain. If we are to realize the potential inherent in relationships between family members and professionals, it is important to recognize that neither can accomplish their goal without the other. All players are a necessary part of the whole, with each bringing their own special set experiences, skills and knowledge to the process.

3) Strength-Focused Assessments —What We “See” Is Often What We Get

Often as we think about the process of assessment we make a significant distinction between assessment and treatment/intervention. However, the process of conducting an assessment is also a profound intervention. Consider Billy, a 14-year-old boy who has been hospitalized 12 times in the last 3 years, and is increasingly involved in the juvenile justice system. At his most recent court appearance, an intake worker is collecting his previous hospitalization history and involvement in the juvenile justice system. The worker also collects all of the interventions that have been tried with the family system. As the worker methodically obtains the details of precipitating factors, treatment course, and discharge plan for each intervention, he notices Billy and his family’s presence in the room increasingly shrinking. The intake worker is only collecting information, not "intervening," and yet is it any wonder that by the time Billy and his family describes his 11th unsuccessful hospitalization, his fifth court appearance and a string of services and interventions that their sense of sense of hope has shrunk to microscopic level? **The questions we ask in an assessment not only collect information but also generate experience**. The process of answering those questions shape client's experience of self and powerfully affect how subsequent work unfolds.

In his *Collaborative Therapy with Multi-Stressed Families: From Old Problems to New Futures*, Bill Madsen describes the Smith family’s interaction with two teams of social

workers from the state child welfare system.[3] The first team viewed the family as chronically dysfunctional, whereas the second team saw them as having tremendous coping skills and survivors of many family traumas, desperate for help but very suspicious due to a long history of previous negative experiences with helpers. As we reflect on the families' interactions with the two different teams, several important points emerge. *Different observers "see" different things in a situation. Perception is not a passive process of observation but an active drawing of distinctions*. The distinctions we draw as social workers are profoundly organized by our conceptual models, our own history, the institutional contexts in which we work, and broader cultural assumptions that shape our interpretation of the world. The different views of the Smith family and the problems in their life were shaped by the context of the perspective teams' interactions with the family and the clinical/value orientations within which those interactions were interpreted. The first team operated within a medically oriented model where the family felt very uncomfortable. Their work was organized by an assumption that treatment must begin with a thorough assessment of all of the family's problems and past issues. This assumption encouraged a particular set of questions and organized a particular relational stance with the family. The second team saw the family in her own home, and while they valued the importance of clearly understanding situations, they organized their work around an assumption that therapy must begin with a compassionate connection, focusing on learning about the family's strengths and successes in coping with crisis in the past. That different priority positioned them in a different relational stance with the family. In turn, the family interacted quite differently on her own turf than on professional turf and the different organizing assumptions encouraged the respective clinicians to draw quite different conclusions about those interactions.

Our distinctions promote selective attention to particular events and inattention to others. Those distinctions organize our experience of what we are observing. The respective stories about the family influenced the various responses to them. The first team anticipated the families "dysfunction" and described themselves as stiffening up in anticipation of the families "craziness." The second team, whose perspective emphasized the families' resilience and commitment to one another, had a different reaction. They admired their persistence in continuing to struggle to get their children back, and wanted to help her have a different experience in their interactions with her.

Our reactions to them are often communicated in subtle ways and, in turn, invite client reactions that develop into repetitive interactions. For example, the Smith family thought the first team of social workers were uneasy around them, and perceived them as critical, "uptight and judgmental." The family responded with suspiciousness and defensiveness, and an interaction developed that was characterized by mutual mistrust, blaming, and antagonism. As the interaction became more polarized, each party became more entrenched in their negative view of the other. In contrast, the family felt understood and validated by the second team and responded with "more appropriate"

[3] Madsen, William *Collaborative Therapy with Multi-Stressed Families: From Old Problems to New Futures* Guilford Press 1999

behavior. Although the family had the ability to argue and become defensive, a fiery temper and reacted strongly to perceived slights, she also recovered quicker and the interactions between the second team and the family were largely characterized by mutual appreciation. Their respective views of each other led to a more constructive interaction. Our formulations have strong effects on our views of clients, on clients' views of us, and on our developing relationships.

If we accept this premise, it makes sense that we need to be conscious about how we choose to view clients, understand problems, and organize our work. The questions we ask and the ways in which we organize the information we receive have a profound effect on our subsequent work. At the same time, it is important to not simply view this process in a strictly linear fashion. Clients' actions organize workers' views of them. Workers' views of clients organize what they attend to while relating to clients.

Some of the tools in that have been highlighted as being effective in identifying the strengths of families involved in the child welfare system include:

- Multi-Cultural Guidelines for Assessing Family Strengths and Risk Factors in Child Protective Services (National Center on Child Abuse and Neglect 1993)
- Step-By-Step Model for Working with Neglectful Families (Family Resource Center – St. Louis Missouri 1996)
- A Measure of MY Family's Well-Being (Institute for Family Support and Development of Mid-Iowa Community Action 1996)
- Families to Families Assessment (Anne Arundel County Department of Social Services-Maryland 1995)
- Family Assessment Cards (Kinney, Robinson and the Behavioral Sciences Institute 1995)
- New Mexico Family Centered Assessment (New Mexico Children, Youth and Families Department 1997)

4) Creating a Climate Where Families Are Free to Make Decisions and Develop Skills that contribute to Their Safety and Well-Being

A critical aspect of a family centered assessment process is the partnership between the families and the helping system in 1) identification of the issues the family is facing and 2) crafting of the solution. The assessment process is a means to an end—to learn what will be most effective in resolving the issues of child safety and helping to support permanence and well being in the life of the child.

Getting a child out of a dangerous situation is such a straightforward imperative, that it tends to overshadow the obligation we have to work rigorously to restore that child to a safe and permanent family setting. When we are fortunate enough to find an appropriate, safe and nurturing foster setting for a child, it's often hard to remember that this achievement is not really an end, but only a means to our true goal of restoring permanence. We have to make getting to permanence a more central, a more urgent,

and a more prominent priority than it has been. By creating an assessment climate where the family is as intimately involved and feels as urgent about safety and permanency as the worker, we can tap the family's expertise on what works and what doesn't in the family system. This supports the creation of a service plan that has optimal chance at success.

In order to get better at permanence we've got to *more quickly, more deeply and more meaningfully* engage with birth family networks than we are doing right now. At its heart this process involves learning about the family, what they believe …**it is about creating "relationship" with the family**. Achieving safety and permanence means making wise and difficult decisions about how and whether safety can be restored in the families from which children have been taken. ASFA, good practice, and the best interests of the child demand that we make those difficult decisions with all deliberate speed. However, you can't make them with all the facts and you can't make them fairly, unless you really know the family, understand its strengths and limitations, know its networks and context, understand its perspective and hopes, evaluate its response to help and treatment, and assess the nature of parent-child relations.

5) Honoring the Family's Culture and Background

Those who work in child welfare encounter families of diverse cultural and ethnic background. Because ethnicity is such an integral part of people's makeup and inextricably linked to who they are and how they live, social workers cannot afford to overlook or profess ignorance of their client's cultures. The first step in developing cultural awareness is to scrutinize our own feelings and beliefs about ethnic groups other than our own. Everyone who grows up in society has racial and ethnic stereotypes. They may be conscious or unconscious, subtle or obvious. What is important is recognizing and acknowledging these stereotypes and biases. **Lack of understanding of how these biases are impacting their social work practice can create barriers to service deliver and each barrier could represent a lost opportunity to help.**

The second critical aspect of working effective with families of diverse cultures is to understand the norms and mores of the culture. While generalities are dangerous, there may be some important learning of cultural mores that can occur. For example, ethnicity plays a critical role in determining how people seek assistance. Certain cultural norms discourage seeking outside help. Perhaps stigma, shame and discomfort are associated with this seeking help. Recent immigrants to the United States who come from countries characterized by widespread governmental corruption and oppression have a legitimate fear of government agencies based on their history.

Language is also critical in working with families from different countries. Of course it is helpful if the worker speaks the family's native language, but that is not the entire solution. If the worker does not speak the same dialect, or if the family speaks English but only minimally—some of the nuances of emotion and need may be lost.

Besides language there are more subtle differences in communication between some minority groups. One of the most common relates to eye contact. European-Americans consider eye contact a form of respect and a means of conveying honesty. Thus a client who fails to make eye contact may be viewed as disrespectful, dishonest and in avoidance. Yet many ethnic groups view eye intact as a sign of disrespect to authority.

Every culture has its own family values concerning child rearing. There are vast differences among cultures in parental expectations and attitudes regarding child development. The European-American culture for example has delineated specific developmental milestones to which many parents rigidly adhere. Other cultures have a more casual attitude and are less concerned about the attainment of developmental milestones— they are more accepting to their child's individualism. What may be considered positive child rearing behavior in one culture may not be in another. Discipline practices vary from culture to culture—with some cultures appearing more strict and confrontive of child behaviors than other cultures.

Terry Cross, in his book *Services to Minority Populations; A Cultural Competence Continuum*[4]*,* provides the following guidelines for all social workers to follow in providing family centered, culturally competent work:

Social workers who are Culturally Competent:

1) Respect the unique culturally defined needs of various clients' populations.
2) Acknowledge culture as a predominant force in shaping behaviors and values.
3) View natural systems (family, community, faith groups, healers, etc.) as mechanisms of support for minority populations.
4) Start with the family, as defined by each culture, as the primary and referred point of intervention.
5) Acknowledge and accepts that cultural differences exist and have an impact on service delivery.
6) Recognizes that minority populations have to be at least bicultural, and this status creates a unique set of mental health issues to which the system must be equipped to respond.
7) Recognizes that concepts like family and community have different meanings for different cultures and even for subgroups within the cultures.
8) Believes that diversity within cultures is as important as diversity between cultures.
9) Functions with the awareness that the dignity of the person is not guaranteed unless the dignity of his or her people is preserved. For this reason, the system must incorporate cultural knowledge into practice—and into policy making.
10) Understands that minority clients are usually best served by persons who are part of or in tune with their culture.
11) Treats clients in the context of their minority status, which creates unique stressors related to self-esteem, identify, isolation, and role assumption.

[4] Cross, Terry Services to Minority Populations: Cultural Competence Continuum CWLA 1988

12) Advocates for effective services on the basis, that the absence of cultural competence anywhere is a threat to competent services everywhere.
13) Respects the family as indispensable to understanding the individual, because the family provides the context within which the person functions and is the primary support network for its members.
14) Understands when the values of minority groups conflict with the dominant values of this society.

Sexual Orientation

Like individuals of different cultures, gays and lesbians have a history of institutional oppression. Institutional heterosexism, for example, is a supposition by those who run institutions, (including social service agencies) that heterosexuality is in all ways better than homosexuality. It can be as blatant as refusing to provide service to gay and lesbian clients or as subset as assuming that all clients are heterosexual.[5] However the facts are that there are three to twelve million gay and lesbian parents in the United State raising six to fourteen million children.[6] Gay and lesbian parents are inventing a new model of relationship, developing their own rules and roles for their family. Same-sex parents are creating a culture of their own and evolving new definitions of family relationships. Children of gay and lesbian parents face their own set of difficulties and transitional issues.

The role of the family centered social worker is not to learn what these developing styles and cultures are and to weave them into the fabric of their work with the family. As in dealing with any minority culture, the workers familiarity with resources in the gay community is critical.

B) Who Should Be Involved in The Assessment

One of the major struggles of many line social workers is determining who should be involved in the assessment of a family involved in the child welfare system. Rather than using a standard list of individuals or organizations that participate in every assessment, it is important to consider whose involvement is appropriate for each family assessment. Both the essential team members and collateral partners will depend on the family and their relationship to the outside worlds. The family should have a strong voice in determining who participates in their assessment. Some of the following questions should be kept in mind as the worker determines who to involve in the family-centered assessment:

- Who lives with the child?
- Who has contact with the child and family? What is the frequency of this contact?
- What is the degree of involvement and connection with extended family members?

[5] Faria, Geraldine Educating Students of Family Based Practice With Lesbian Families NAFBS Select Papers 1992
[6] Markowitz, Laura M. "Homosexuality: Are We Still in the Dark? Family Therapy Networker July 1998

- Who dies the family identify as important to them?
- What informal support networks are available, including those currently utilized by the family as support?
- What neighborhood factors may impact child safety, such as crime, drugs, housing, neighborhood participation and improvement projects?

While the family may not be able to identify professionals or specialists, they know who matters to them in the day-to-day life. They also know whose participation may threaten the safety of a family member.

C) Content Of The Assessment

Many brilliant clinicians and authors including Lisa Kaplan, Lizbeth Schorr, Sally Palmer, Harry Aponte, Insoo Kim Berg, Barbara Pine, Robin Warsh and Tony Maluccio have written volumes about the key components of family-centered assessments in child welfare. This section of the paper draws from their work.

At a minimum, the critical information to be gathered during an assessment process includes:

- Risk assessment—ensuring above all that the child is safe.
- Description of the family's view of the problem and what brought them to the attention of the system.
- Assessment of the strengths and the resources of the family, including previous successes, accomplishments, problem-solving skills and coping skills.
- Determination of concrete needs.
- Recognition of health, medical and dental needs.
- Recognition of the child's educational needs/status.
- Identification of family struggles.
- Previous attempts at alleviating the problem (not just a list of services previously received) and how they have helped or not helped.
- An intergenerational family history.
- Information about the family's culture.
- Discussion of internal family dynamics and interactional patterns.
- Identification of formal and informal supports.
- Determination of the service goals of family members.
- Screenings for domestic violence, mental health issues, substance abuse, sexual abuse as indicated. (See Below)

D) Using Of Screening Instruments in Conducting a Family Centered Assessment in Child Welfare

Screening instruments are necessary components of a comprehensive assessment. Effective use of these tools help ensure that issues critical to each family are considered, that timely decisions are made, and that each child and family receive the

most appropriate and effective response. While it may not be possible for every worker to have expertise in every family issue, they can be trained to effective utilize screening tools and then, based on the results, refer to professionals skilled in dealing with the family issues identified. Screening is accomplished with strategies such as observation of symptoms, posing a brief list of questions, and/or using instruments/tools that are completed by the worker and/or by the clients themselves.

The following are some of the issues related to the screening process:

- No single screening question or instrument satisfies all screening demands for any one of the barriers discussed (e.g., substance abuse, mental illness, etc.). Importantly, most forms and procedures for screening relate to deficits; very few gather information about successful interactions between the individuals and their environment, or about assets and resources

- Some individuals within the family system may not realize they have the “problem” (for example, that they are substance abusers, or victims of abuse) or they may be too afraid or embarrassed to respond to the questions. Their answers may not constitute a valid screening.

- Families’ situations and resources change constantly and many needs reveal themselves only over time. Therefore, it is unwise to lean too heavily on information that individuals provide during the “intake” (the first meeting) and then expect these individuals to keep them posted on any relevant changes. *Collecting information and screening are ongoing processes.*

- Many families, especially those from minorities and low-income populations often have very little trust of the “system.” Before disclosing personal information that would be needed to conduct a screening, these families must be made aware (and believe) that the purpose of the screening is to support and inform decision-making for their best interest and is not just another attempt to “get them.” Before any screening can be conducted, there must be a relationship of trust between the family and the person conducting the screening.

- The screening must be respectful and culturally appropriate. The way the worker treats the family, the kinds of questions asked and how they are asked, as well as the way the information gathered is handled, all send powerful messages about the kind of “help” that the family might get from the expert or the agency.

- Observations, questions, and instruments are only as effective as their users. Therefore, it is critical that individuals who are responsible for screening are knowledgeable about the issue being screened and skilled in interviewing, observing, and posing questions. These individuals must be trained on using and interpreting the screening questions or tools and on what to do with the information.

Some general recommendations for screens are highlighted below:

Child Sexual abuse screening: While specific protocols are typically used for sexual abuse reports, a specialized screening tool can help identify sexual abuse that might otherwise go undetected. For example, if a family is reported for child neglect, sexual abuse may be revealed without the worker being attentive to the behavioral indicators that are summarized in a good screening tool.

Domestic Violence Screening: Domestic violence goes by many names: wife abuse, marital assault, spouse abuse, wife beating, battering, and intimate partner violence. In addition to different terms or labels, there are varying definitions of domestic violence. A clinical or behavioral definition of the problem is different (and more comprehensive) from a legal definition. Intimate partner violence refers to a wide variety of behaviors used by individuals, mostly men, to exert power and control over their intimate partners or former partners. Domestic violence includes physical and sexual assault, behaviors which are criminal and can be reported to the police and prosecuted by the courts.

Because of the prevalence of domestic violence in families experiencing child abuse, its impact on child safety, and the implications of undetected domestic violence on the social workers ability to intervene in child abuse situations, workers need to routinely screen for domestic violence. If the initial screen indicates the dynamics of a family stressed by domestic violence, then a more specific and comprehensive safety assessment should be offered to the abused adult and child.

- Workers must be aware of the need to protect the safety of the alleged victim. The following are suggestions on how to protect the victim:
- Always speak to the alleged victim of domestic violence *alone and away from the alleged offender*.
- Perform a records check to determine if the police, child protective services or other agencies have received previous reports of domestic violence at the same address or involving the same victim of the children. Ask if there is a temporary restraining order in place.
- Obtain case specific authorizations for the release of information (e.g., medical records, court records).
- When domestic violence is revealed, a safety plan must be created immediately.
- Tell the woman about her confidentiality rights.

Substance Abuse Screening: Substance abuse has been defined as being dependent on alcohol and drunk at least once a week, *or* being dependent upon an illicit drug other than marijuana and having used an illicit drug at least monthly or used heroin at least once in the past year.[i] The overlap between child abuse and neglect and substance abuse is documented in multiple studies to be as high as 70%. Because

substance abuse often poses particular risks to child safety, is frequently accompanied by many other family problems and is often difficult to treat, substance-abusing families require a specialized response.

Screening for Special Health Care Needs: Families experiencing special health car needs, including HIV infection, often benefit from specialized forms of assistance. The children entering the child welfare system often present complex medical and emotional conditions that are taxing the capacity and the ability of the child welfare system. Characteristics of children in Foster Care include:

- *They have been maltreated* - 53% neglected, 26% physically abused, 15% sexually abused, 5% emotionally abused, 3% medically abused (US Department of Health and Human Services, Center on Abuse and Neglect (1998).
- *They are young* -infants and young children with medical complications and physical and mental limitations constitute the fastest growing groups of children residing in care (George et al 1994).
- *They have severe disabilities* -children entering out of home care are presenting more serious and complex problems including post traumatic stress from past physical, emotional or sexual abuse, alcohol or drug exposure, HIV infection, poverty and homelessness (Halfon et al, 1993).
- Almost one half were shown to have at least one chronic health problem.
- Over one-third have *"marked to severe" levels of psychiatric impairment.*[7]

According to the data from the Administration on Children Youth and Families there are an estimated 600,000 children residing in foster care in our country. Each of these children enters foster care with a background of abuse or neglect sufficient to warrant being removed from their families.

Given the gravity of the circumstances from which children in the child welfare system originate, the severity of their presenting medical and psychological problems it seems logical that these children would be afforded access to timely and comprehensive medical, social developmental and psychological evaluation and treatment. However the research and anecdotal stories reflect a very different picture of the health care information provided to foster parents and the health care services provided to children in care. According to (Battistelli 1996, Klee and Halfron 1978) health care delivery to children in out of home care frequently suffers from lack of adequate record keeping, poor communication among providers of services to children in out of home care, lack of adequate reimbursement for services, lack of adequate health care supervision including comprehensive physical and mental health screening, referral and follow up. Although most states mandate an initial health examination between 72 hours to 5 days after placement, surveys and conversations with state child welfare agency representatives indicates that this rarely occurs.[8] The literature is in agreement that due to multiple moves, changing of primary care physicians and social workers and pressure to attend to the immediate safety issues rather than the overall well-being of children in

[7] Tatara, Toshio (October 1998) Characteristics of Children in Substitute and Adoptive Care

[8] Batistelli, Ellen Making Managed Health Care Work For Kids in Foster Care CWLA Press 1996

care, the medical care children in foster care receive is often inconsistent and without focus. States representatives indicated that generally only 15-20% of the case files of children in foster care actually include comprehensive health information. They describe problems associated with the health passport being misplaced, that there are significant problems updating the information in a timely and efficient manner, that the data included in the health passport is not user friendly (written in medical language) and that the information is not available in aggregate form to monitor the overall health status of children on the caseloads.

This lack of medical care and subsequent lack of transferable medical records is not due in most cases to a lack of health care coverage. The coverage Medicaid affords children in care through the Early, Periodic, Screening Diagnosis and Treatment (EPSDT) provisions of the Medicaid law is by most standards considered to be a generous benefit package. This child serving legislation allows states to provide an array of services for children, which may not otherwise have been covered. (Horvath 1997)

The lack of quality medical care and inconsistent documentation of services received has not gone unnoticed. Over the past 15 years researchers, advocates and policy makers have made both major and minor recommendations in health care policies for children residing in out of home care (Schor 1981; White et al 1987; Halfon and Klee 1987). In 1988 the Child Welfare League of America in collaboration with the American Academy of Pediatrics, took this collection of recommendations added others and developed a comprehensive health care policy for children in out of home care. **One of the key opportunities for social workers to improve the consistency and quality of medical care for children in the child welfare system is the use of a "medical passport" to document the health care problems and medical services delivered to children.[9]** A medical passport is just as it sounds; a medical record that is designed to accompany the child as they work their way through the child welfare system and on to permanence. Medical passports contain the following information:

- Name of the child
- Name of the child's Primary Care Physician
- Immunization Record
- Date last seen by physician
- Primary medical concerns
- Secondary medical concerns
- Any known allergies
- Serious accidents or injuries, surgeries, hospitalizations or seizures
- Any Medications the child is on (dose, when administered)—or has taken within the past 12 months and why the child is taking the medication.

While some of their needs may be obvious, others may not be as easily detectable. A standard screening instrument for medical need, used for every child and family

[9] Lutz, Lorrie and Horvath, Jane Health Care of Children in Foster Care: Who's Keeping Track?

entering the system, can help ensure that medical needs of children in the system are being met.

Screening for Learning Disabilities and Educational Needs

The Adoption and Safe Families Act reiterates the emphasis that was made on assessment the educational needs of the child involved in the child welfare system as part of a comprehensive assessment. Children involved in the child welfare system have often experienced multiple moves, including transitions between schools. Much is lost in the transition from one educational environment to another. Testing and tracking of school performance is lost if educational records do not accompany the child. A child's school records are as critical as the child's medial records in ensuring continuity of the child's learning and educational experience. Equally important is the assessment of any specific needs of the child as they relate to the learning process. There is a significant correlation between children involved in the child welfare system and the prevalence of learning disabilities due to the child's experience of neglect or abuse.[10]

L*earning disabilities* is a generic term that refers to a heterogeneous group of problems manifested by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning, or mathematical abilities or social skills (for example, attention deficit disorder with or without hyperactivity, communication disorders, dyslexia, and motor skills disorders). Learning Disabilities (LD) is defined as a *disorder in one or more of the basic cognitive psychological processes involved in understanding or using language, spoken or written, which may manifest itself in an imperfect ability or listen, think, speak, read, write, spell or do mathematical calculations and can impair socialization skills.* Individuals with a learning disability are generally (but not necessarily) of average or above average intelligence, but the disability creates a gap between ability and performance.

As with all disabilities, the level of severity and the impact on the individual can vary greatly. While there is no typical profile of the learning disabled adult, most exhibit a discrepancy between their apparent ability to perform in one or more areas and the actual level of performance. These problems are presumed to be due to central nervous system dysfunction.

Experts in the field suggest that the following four criteria be included for an LD to exist:

- A significant discrepancy between overall inherent cognitive ability and actual achievement.
- The ability to process information is impaired in some way.
- The processing deficits must be shown to be directly contributing to underachievement.

[10] National Committee on the Prevention of Child Abuse 1997

- The underachievement cannot be primary due to factors other than a processing deficit.

SECTION II ASFA and Its IMPACT ON FAMILY-CENTERED ASSESSMENTS

A) Impact of Adoption and Safe Families Act

Children need stable families and supportive communities especially in the early years of life in order to form secure attachments so vital to positive self-esteem, meaningful relationships, positive school achievement and success in the adult world of family and work. Sadly, child welfare systems across the country have had an uneven history of meeting children's developmental needs for stability and continuity in their family relationships.[11]

In a recent study of the well-being of children 2-4 years after leaving foster care the data was not promising:

Within 2-4 years of leaving foster care:

- Only half the youth have completed high school
- Fewer than half are employed.
- One-fourth have been homeless at least for one night.
- 39% of homeless adults spent time in foster care while growing up.
- 30% have no access to needed medical care.
- 60% of girls give birth.
- Less than 20% are self supporting.[12]

In November of 1997, in response to this reality, Congress passed and President Clinton signed into law the Adoption and Safe Families Act (ASFA). This law radically changes the child welfare environment, requiring states to act within tighter timeframes to establish and achieve permanent placements for children in care. The themes found in ASFA include:

- Safety as paramount throughout the life of a case.
- Foster care as a temporary service requiring timely decisions about permanency for children.
- Services are needed to support birth, foster and adoptive families.
- Accountability by moving from a focus on process to outcomes.
- Innovation to achieve more timely and positive outcomes.

Congress passed this legislation because of several widely head beliefs by both Democrats and Republicans including:

[11] "Tools for Permanency: Concurrent Permanency Planning." National Resource Center for Permanency Planning at the Hunter College School of Social Work of the City University of New York. 1998.

[12] National Resource Center For Foster Care and Permanency Planning 1997

- The existing system has lost its focus on children and become too biased in the direction of keeping children with their biological parents regardless of how harmful such environments are to the children involved.
- Some children are returned to unsafe families or have been shuttled back and forth between their natural families and or multiple foster homes for extended periods of time, rather than achieving permanent care arrangements.
- The child's health and safety must be paramount.
- Foster care must be temporary and of short duration.
- Quicker permanent placements are necessary; increasing the number of children who are adopted is desirable, provided that is the appropriate plan.[13]

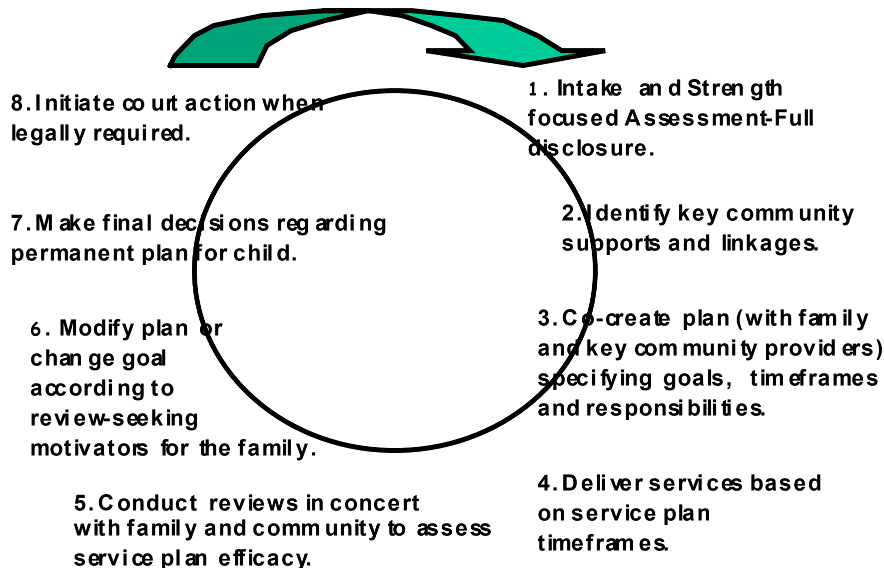
These reasons for passage of this legislation were troublesome to many who saw the legislation as being juxtaposed to the efforts over the past decade at integrating family preservation and support activities into the heart of child welfare practice. Yet, in a peculiar way ASFA offers the most compelling reason to date to integrate family-centered practice into child welfare practice. If we don't conduct a comprehensive assessment, and thereby learn about the family's needs strengths and capacities, we will not be able to meet the ASFA requirements of providing necessary services to support the reunification process, prior to seeking alternative permanency options. However, the Center needs to be prepared that there will be arguments posed that suggest that ASFA once and for all eliminated family-centered focus from child welfare.

B) Child Permanency –Need for Ongoing Assessment

The most significant point made in the Adoption and Safe Families Act is that children need and deserve permanency. There are multiple ways to define permanency—but the fundamental requirement is that every child has one or more adults who commit to being there for them throughout their childhood and into early adulthood. Options for permanency may include:

- Children remain safely with the families.
- Children are reunified safely with their parents or extended families.
- Children are adopted by relatives or other community families.
- Children are placed with legal guardians - relatives or other families.
- Children are placed in alternative planned living arrangements with relatives, community families or in group care settings.

[13] Testimony from the Committee Hearings in the summer of 1997



If we are to achieve permanency in the lives of children involved in the child welfare system, we must conduct a comprehensive family centered assessment that gives us maximum information about the stressors, risk factors and strengths on which to build a plan for success in the family. ASFA simply does not provide the time to conduct only investigative assessments that do not provide us with guidance as to what will work to improve the family's parenting capacities. Once this comprehensive assessment is complete—we build the plan based on the information gathered. But we are not done…ASFA **beacons the fact that assessment is not a one-time process but an ongoing process, necessitating continual reevaluation and requiring a system understand of family functioning**. The chart above depicts an ongoing assessment process. The importance of this ongoing assessment model is that it allows those who participated in the Family Centered Assessment to revisit the case planning decisions and to provide "real time" modifications in the plan if the services are not working as anticipated. While the Adoption and Safe Families Act also requires that there be a judicial permanency hearing 12 months after a child enters foster care, if we wait until the 12 months have gone by to assess the efficacy of the plan, it will be to late to make modifications and we may have lost a precious opportunity to reunite a child and their family. An ongoing assessment process assures that the worker, family and other individuals involved in the family, meet regularly to assess if the status of the situation that brought the child to the attention of the child welfare systems has changed, if the services being provided to the family are achieving their desired outcomes and if not, how the plan can be modified to better impact the family system.

C) Ensuring Child Well Being

ASFA not only requires safety, and permanency but it also requires that social workers emphasize the importance of child well-being. There are many tools that can be used to assess the well-being of children involved in the child welfare system. One such scale is the North Carolina /Family Assessment Scale developed at the University of North Carolina Chapel Hill. This tool is organized around five broad domains of family functioning: environment, social support, family/caregiver, family interactions and child well-being. Feedback from family preservation and support social workers around the country using the tool continues to be positive. Internal consistency and construct validity have been well established. The most recent version of the tool was published in April of 1998.

The Child Well Being Scales are also considered to be among the most comprehensive in the filed and have been employed in multiple research projects on family based services in the child welfare field. The Child Well Being Scales measure one or more physical, psychological or social needs that all families and children possess. The scales measure such areas as physical health care, nutrition/diet, clothing, personal hygiene, household furnishings, overcrowding, supervision of younger children, supervision of teenage children, money management, etc.

Whatever process or tool is chosen to assess child well-being, ASFA makes it clear that safety and permanency factors must be coupled with child well being assessment, if we are really to impact the quality of life of children involved in the child welfare system.

D) Concerns Regarding the ASFA Timelines

This document would not be complete if we did not reference the controversy surrounding the Adoption and Safe Families Act and family-centered practice. There may be a real dilemma in the time frames when families are facing substance abuse and mental health issues, or when the child is older and has very little possibility of being adopted. It is very frustrating to conduct a family centered assessment, finally engage the family in the process and in the end, have to face the reality that the family will not achieve the desired outcomes in the timeframes allowable under ASFA. This is where some of the best practice strategies outlined in section IV of this paper may serve the social worker well. Children need permanence in a timeframe that has meaning to them and where they are in the developmental stages. Families need to provide that permanence. If the length of time involved in the families change process conflict with the child's need for permanence and the ASFA timelines, it can create real tension for the line social worker invested in family centered practice. This area will need to be watched as ASFA unfolds over the course of the next five years.

SECTION III THE PUBLIC CONTEXT

The concept of a family-centered assessment was first introduced in 1980 as part of Public Law 96-272. Under this legislation, social workers were required to look at the family system when determining the best interest of the child and make reasonable efforts to keep the child and their biological family intact. The idea of a family-centered assessment was supported under OBRA 93-The Family Preservation and Support Legislation where the law stipulated that a comprehensive assessment be provided to the child's family to determine if the child could remain with their biological family and what services and supports were required.

ASFA further supports the expectation for family centered assessments and as indicated speeds up the timeframes for when the states must assess family needs, provide services to meet identified needs and evaluate the efficacy of those services in achieving child safety, permanence and well-being. If these services are not effective in allotted timeframes, aggressively pursue alternate permanency options.

Not only do states have a legislative basis for requiring that the families of all children in the child welfare system participate in a family centered assessment, there is also federal financial support. Because the family centered assessment is considered to be a critical aspect of social work practice, it is covered under the administration portion of Title IVE of the Social Security Act. Under this federal funding stream the Administration for Children and Families, Children's Bureau pays a portion of the cost for every administrative activity provided to Title IVE eligible children.

Additionally, if the state has amended their state Medicaid plan and included Rehabilitation and Support Services as eligible Medicaid services, then the Health Care Financing Administration through Medicaid, will reimburse a portion of the cost of the assessment as it falls within the definition of assessing medical need.

SECTION IV. BEST PRACTICE MODELS

The longer that states experiment with family centered assessments as a cornerstone of child welfare practice, the more “best practice” strategies are emerging. This paper explores four examples of emerging or existing best practice in family centered assessments. These include:

1) **Concurrent Planning**
2) **Family Group Decision Making**
3) **Differential Assessments**
4) **Brief Solution Focused Assessment and Service Planning**

This section also explores 'state of the art' assessment tools that are being used across the country.

A) Four Models of Best Practice

1) Concurrent Planning

There are many tools to support permanence in the lives of children. Concurrent Planning is one tool. Concurrent planning has been gaining increasing visibility and support as states are struggling with achieving permanence within ASFA’s reduced timeframes while at the same time, making reasonable efforts to support birth families’ efforts to change.

Traditional Permanency Planning as outlined in the Adoption Assistance and Child Welfare Act of 1980 (PL 96:272) worked toward accomplishing these goals through:

- Striving to provide children with stable, safe and permanent families in which to grow up.
- Ensuring family and community-centered practice in least restrictive placement settings.
- Ensuring culturally responsive practice.
- Facilitating an open and inclusive case planning process.
- Providing goal-focused and time-limited services.
- Conducting frequent and regular case reviews of children's status and family progress toward reaching safety, permanency and well-being goals.
- Encouraging frequent parent-child visits to increase likelihood of early reunification.
- Using non-adversarial problem solving strategies: family conferencing and mediation.

Concurrent planning is a form of evolved tool of “best practice” in assessment and service planning in that it supports, intensifies and expedites efforts to achieve

permanence in a child's life within one year – a timeframe that reflects a child's sense of the passage of time. It offers caseworkers a more structured approach to moving children more quickly from the uncertainty of foster care to the stability and security of a permanency family. It is consistent with a family-centered and community-based service orientation because it is rooted in the belief that children need stable families and supportive communities for their healthy growth and development.[14] Concurrent Planning holds promise for expediting timely decision-making for children because of its dual focus on family reunification, as well as alternative permanency options. Concurrent Planning works to respectfully involve parents and family members early in the planning process, as well as its identification of "red flags" that might serve as barriers to timely reunification or another permanency outcome.[15]

Effective Implementation of Concurrent Planning requires that the assessment process include:

- Full disclosure of information to birth families early in the planning process regarding the importance of their regular involvement in planning for the return of the child, their rights and responsibilities, and the legal consequences if they are unable to safely make the changes necessary for their child's return.
- Aggressively search for absent fathers, non-custodial parents, and relatives within the first thee months of placement.
- Provision of an early, differential assessment of families' strengths, needs and current/past problems that assists the social worker in determining the risk of foster care drift and the need to place the child with a "permanency planning resource family" - families who can actively engage in supporting family reunification efforts, and also commit to serve as a permanent home for the child if reunification is not possible.
- Offer support and clarity of roles, responsibilities and structure with birth families, resource families, agency workers, and courts.
- Appropriate use of family case conferencing, targeted case review and mediation services to support early involvement of families in case planning and decision making.
- An atmosphere were staff can be comfortable working in the "gray" – the plan is not set until it is clear which plan is needed, but considerations of options for contingency plans are established early on.[16]

Full Disclosure—A key Component of Concurrent Planning

If families are to be real partners in the process of change, then the worker must make a concerted effort to treat them as such. Given this, workers need to be open and forthright about their observations, concerns and perspectives. Much of the distaste that families and community members have about the child welfare systems is the

[14] "Tools for Permanency: Concurrent Permanency Planning." National Resource Center for Permanency Planning at the Hunter College School of Social Work of the City University of New York. 1998.
[15] Lutz, Lorrie L. Concurrent Planning: Tool for Permanency Survey Of Selected Sites 2000
[16] Adapted from Concurrent Permanency Planning Handouts. National Resource Center for Permanency Planning at the Hunter College School of Social Work of the City University of New York.

secretive nature of the work and the believe that the “state is out to get families”. Full disclosure suggests that workers emphasize to the birth families, at the moment of first contact, the importance of permanence in the lives of children, the various options for permanency planning, and the consequences of their actions or inactions. It suggests that the worker provide feedback throughout the life of the case on the progress or the need to confront planning ambivalence. Families are not helped by soft-pedaling the truth or avoid a necessary conversation about how lack of parental follow through is impacting the chance for the child returned home.

In a recent survey conducted by the National Resource Center for Foster Care and Permanence Planning the State of Texas described a unique best practice approach to the process of full disclosure. They have developed what is called Success Quest-a parent orientation provided by staff for all birth parents who have had their children removed within the past two weeks. In a sensitive, non-threatening manner, Success Quest lets parents know exactly what is happening to their family. Social workers walk parents through the law, describe in detail what will happen in court, tell parents exactly when court hearings will be held and thoroughly inform parents of their rights and responsibilities. Social workers walk parents through a generic service plan to show them what they look like and what will be submitted to the court. Additionally, a judge who is very committed to kids and families, created a video to be played for parents during the Success Quest orientation. The video that is about 20 minutes long and further answers families’ questions about the law and the judicial process. Success Quest is a key element of full disclosure and is considered part of the family centered assessment process.

2) Family Group Decision Making

Many states in the nation are implementing a model called Family Conferencing or Family Group Decision Making. In this model family members, extended family members, involved neighbors and community members are invited to a structured meeting where issues and strengths of the family are identified collectively and the plan is crafted jointly. Some states go as far as paying for the airfare for extended family members to attend the decision-making conference.

In this plan the roles and responsibilities of all participants are described. The goal of this model is to “wrap” extended family support around the family system and the child—striving to achieve safety, and ultimate permanence for the child. The primary strength of the Family Group Decision Making model is that it places the onus on the family system to craft a solution for the issues of child safety, permanence and well-being. During the explanation of the process to family members and concerned participants there is a profound emphasis placed in the importance of ensuring that the child has a consistent caring adult.

Additionally, this model is being used effective yin some states such as Colorado and New Jersey to help identify relatives who may serve as caregivers and even potential adoptive parents.

3) Differential Assessments

A Differential Assessment is a practice tenet where the worker considers the family's strengths, resources, permanency planning "red flags" and case history to develop a tentative, reasoned hypothesis about the potential of the family to access/use resources and make required changes within one year. This process requires looking at each family individually and assessing their capacity to become nurturing and safe caregivers of their children. Many differential assessments consider strengths in the family as contrasted with poor prognosis indicators as a means to clarify the potential for change, reunification and foster care drift.

These include conditions such as:

- Parent has killed or seriously harmed another child through abuse or neglect and has not significantly changed since the incident occurred.
- Parent has repeatedly and with premeditation harmed or tortured a child.
- Parents' only visible support system and only apparent connections are to the drug culture with no significant effort to change over time.
- Parent has significant, protracted and untreated mental health issues with no progress over time.
- Parents' rights to another child have been involuntarily terminated with no significant change in the interim.

In most cases, these indicators coincide with Aggravated Circumstances identified in ASFA.

Samples of a differential assessment from the state of Colorado are included in the attachments.

4) Brief Solution-Focused Work

Solution focused work has its roots in the child welfare arena with Insoo Kim Berg and her ground breaking book on family preservation and solution focused interventions. Solution focused therapy based on respect for and collaboration with the client concentrates on successes and solutions. Social workers develop goals with the clients and continually evaluate the efficacy of those interventions. Building on the work of Insoo Kim Berg, Scott Miller and Bill O'Hanlon, solution-focused practice emphasized the following[17]:

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[17] Berg, Insoo Kim Family Preservation Norton Press 1992

- Ensuring all **goals set are important to the client** and the client must view the achievement of that goal as personally beneficial.
- **Goals must be small enough so that they can be achieved**. Most of the clients in the child welfare system have very little hope that things can change and that their life circumstances can ever improve. Consumers of services are much more likely to be successful when the goals are small.
- The **goals for intervention are concrete, specific and behavioral-**stated in precise terms and thus it is clear when success is achieved. The advantage of setting goals is in precise terms is that it becomes easier for the social worker and the consumer to evaluate exactly what progress is being made, as well as to determine what else remains to be accomplished.
- The **presence rather than the absence of something-**this is an especially helpful approach in child welfare because so much of the focus is on what needs to stop. When the goals and treatment intervention are on what needs to occur immediately there is a new energy and new focus—doing rather than not doing.
- Goals **must describe a beginning, not an end**. This is very powerful for people who are perceived to have failed on numerous occasions. Rather than trying to focus on the end of the journey—which is fraught with fear, the journey focuses on the first and second steps.
- The goals set must be **realistic and achievable** within the context of the consumer's life. In child welfare while there are some non-negotiable goals such as child safety and permanence—the ways to get to those goals must be something that the client can envision being able to accomplish. While they may not be able to envision a time when they don't get stressed out with their child, they may be able to imagine that during the next visit they play checkers with the child without getting angry.
- The solution-focused intervention **must be perceived as involving hard work.** This final attribute of solution focused work supports and validates the family centered principle of respect and honoring the client. Stating at the outset of the intervention that the client's goals will involve hard work serves to protect the consumer's sense of dignity in the event that he/she is unable to reach the goal and may have to consider relinquishment of parental rights.

B) Assessment Tools

There are many wonderful assessment tools designed to encourage family participation that are non-threatening and provide an engaging means by which to gather information.

The **genogram** is an interactive way of involving the family as they talk through the complexity of family roles, patterns of interaction and relationships that have evolved over generations. It gives both the worker and the family members an understanding of the family's history and often reveals important information to family members. The goal of using a genogram is to determine what generational theses are present and how they impact the family today. (See attachment)

The **ecomap** helps families conceptualize their relationships to other systems, indicating sources of supports and stress. Constructing an ecomap helps to determine how the interplay between the family and the environment affects the family. Families often find the process of drawing an ecomap useful because it is visual and concrete. Using this tool may alleviate a family's anxiety because it takes the focus off the internal family problems, acknowledging and emphasizing their overlap between the family and their environment. (See Attachment)

The **timeline** is also an excellent tool for helping families to visualize their patterns and family events along a vertical line. The family's identification of key events and their dates and brief descriptions enable the worker and the family members to see what life events they consider to be most important. A timeline is a self-assessment vehicle that demonstrates to the family how they have responded to the positive and negative events in their lives. It clarifies areas in which family members possess strengths and reveals areas where they need improvement. It helps provide hope to family in that they have survived crisis and have developed strengths to get through complicated circumstances. (See Attachment)

The **behavior sequence** chart offers a circular, rather than linear interpretation of behavior. Linear thinking considers only the cause and effect; circular thinking examines the contest of the behavior, how everyone is involved in the problem, consequences of the behavior, why the behavior is maintained and how it is reinforced.[18] Once a behavior sequence is diagramed, the worker can consider with the family, various points of intervention.

[18] Kaplan, Lisa and Girard, Judith Strengthening High Risk Families 1994 Lexington Books

SECTION V. CONTROVERSY AND BARRIERS

A) Barriers

A frequent barrier to sound family centered assessments is the lack of supervision and support for the process that exists in the public child welfare agency. In order to be able to successfully implement a family centered approach to the child welfare assessment process, workers need the following three major supports:

1) **Commitment to family centered casework from the top.-**translating into advocacy for this model with the judicial and child advocacy community.
2) **Regular and quality supervision** and peer consultation to support and challenge the complex work of partnerships with families and to help keep values in line.
3) **Training** to continually sharpen the family centered skills and practice patterns.

1) Commitment From the Top

While child welfare agencies around the country are increasingly moving beyond the notion that they either work with the child **or** the family, there continues to be conflicting community pressures on the line social worker as he/she strive to meet the safety and permanency needs of children. Often some of the most vocal critics of family-centered practice are child advocates who are opposed to equal partnership with family in the service delivery process. The thinking behind this opposition stems from the belief that if people hurt their children they need to be punished and that if the "system" doesn't defend and champion the rights of children, no one will. The family-centered movement has been challenged by child advocates such as Richard Gelles who believe that in the name of family centered practice children have been sent home repeatedly to be revictimized.[19] There are others such as Murray Straus from the Family Violence Center at the University of New Hampshire who echo Gelles' concerns. These outspoken critics of family-centered practice in child welfare systems have caught the ear of many judges and CASA (Court Appointed Special Advocates) around the country.

The reality is that some children have been sent home and have been revictimized and some of these devastating decisions have been made by poorly trained social workers who thought they were doing what the agency expected. However, the ecological perspective of seeing the child in the context of family, and family in the context of community should in fact make this tension between serving the child or the family obsolete. While we may be child focused in our practice—ensuring that the child is safe—we must be family-centered in our approach. The welfare and the dignity of children cannot be considered separately from the families of which they are part.

[19] Gelles, Richard An Assessment of A Decade Of Family Centered Child Welfare University of Rhode Island 1996

Those who are advocates of a family-centered orientation to child welfare services empathize that:

- Best practice in family centered work takes into account the safety concerns of the child, and initiates immediate steps to ensure that the child is out of harms way.
- Best practice in family centered work ensures that the worker engages the family in assessing and planning for child safety and well-being.
- Best family centered work is aggressive in working with the family early in the process—so that if this effort is unsuccessful, the plan can shift to another form of permanency for the child.

It is up to the leaders of child welfare agencies employing family centered practice models to spearhead the education efforts with the judges, CASA workers, child attorneys, child advocacy groups, educational system, etc. so that the culture of the community is prepared to accept a more family friendly way of doing child welfare. While many of those in the field deplore the historical shame based, hostile to families system of child welfare, there are others who found no fault with the system—again believing that parents needed to be punished for their actions. Child Welfare commissioners and Directors must champion a family centered approach in order for line staff to be able to successfully implement this model.

2) Consistent and Quality Supervision

We all come from backgrounds and cultural influencers that create for us "presumed truths" that are part of the fabric of our everyday life and become almost invisible. They are difficult to question, they shape our identity, and influence our attitudes and behaviors. In our lives, we are subjected to multiple and often conflicting cultural influencers. However, over time, certain influencers become dominant and take up more space in our personal culture. These influencers are often prescriptive, and include specifications about how people “should be.” They reflect the prevailing social and political structures and tend to support them. Through this process, these influencers shape our sense of who we are and who we "should" be. When cultural influencers become a framework for making sense of our lives, those experiences that do not fit become invisible. This process has marginalizing effects on some individuals and families. Their *own* knowledge is obscured and their life is interpreted through the lens of dominant cultural influencers. When this occurs, the family’s perceptions, experience and expertise is ignored or seen as “less than.” In conducting an assessment these “presumed truths” play an all-important role in guiding the discourse between the client worker and the family and our challenge ability/willingness to accept new and different perspectives. The challenge of conducting a family centered assessment is to lay down these “truths” and to hear the family from their own set of cultural influencers. The role of consistent and quality supervision cannot be overstated as a means of managing these cultural influencers. If the line social is not provided a means in which to reflect upon and correct the way in which these influencers are impacting the work with families, they will most likely fail to validate that which is

different from their experiences. The potential is great that families' strengths and expertise will be ignored and invalidated—leading to a lack of buy-in and trust in the process.

Building the skills of the supervisors of the child welfare agency is paramount enacting a strong family-centered assessment model. As with any good clinical practice, supervision is critical to sustaining the quality of planning for service delivery and ongoing decision-making. Supervision provides an opportunity for quiet and thoughtful reflection of case progress. The ability to provide quality supervision is a well developed and honed skill, requiring the willingness to challenge staff about their assumptions values and decisions. It also requires time and consistency—moving from crisis-centered supervision, where only the "hot issues" receive the attention of the supervisor, to an approach where staff members are expected to enter into a weekly supervisory session prepared to discuss the progress families are making in goal achievement. The goal of supervision is twofold 1) to develop the social work skills of the supervisee and 2) to ensure that the makeup of the assessment and implementation of the service plan provide optimal chance for success in goal achievement for every family served.

3) Ongoing Training

There are several reasons why ongoing training is necessary to the development of a skilled social worker—competent in conducting a thoughtful and meaningful family centered assessment. First of all family centered practice principles are often not what the social worker was taught in social work classes. Strength- focused, family-centered social work is not the norm in every school of social work in this country. As such, social workers may come to the job with a pathology or deficit-focused orientation to assessment. Workers need to build upon what they have learned in their course work, by being exposed to other models of assessment. Second, even if workers have been trained in conducting a family centered assessment, it is the doing that creates the climate of learning. Once a social worker has conducted five to ten assessments the questions and the complexities of the work reveal themselves. Trainings need to be spaced so that the social worker can practice the art of assessment, become familiar with tools utilized and then come back to training prepared to sharpen skills, have questions answered, and develop new techniques for families who present special challenges.

We believe that a training curriculum should be constructed that begins where a social work starts—at their own value base and should then walk them systemically and regularly through a process of skill development.

The training curriculum might evolve to reflect the following sequence:

- Values work—making certain our own cultural influencers are not getting in the way.
- Safety assessment—what to look for.

- Engaging the family: the art of exploring, validating and discovering possibilities.
- Use of assessment tools—ecomaps, genograms, timelines, etc.
- Strength focused assessment—finding and building on the family's strengths and capacities.
- Solution focused assessment—working toward outcomes.
- Concurrent planning—including full disclosure and differential assessment.
- Combating "resistance"—seeing it for what it is and working through it.
- Building a "doable" plan from the assessment.
- Ongoing assessment—is what we are doing working?

B) CONTROVERSIES

The role of family centered practice in the child welfare system has long been regarded as one of the most contentious issues facing the field. Often during this debate, family centered practice is characterized as being synonymous with family preservation or child reunification. Rather than family centered practice defining a *process* that where families are seen as partners, where gathering information relies on mutual trust and respect and where developing service plans is based on the best thinking and expertise of the family and the social worker, it is mistakenly defined as the outcome—children returned to or left with their biological families. Therefore, if a child dies or is re-abused—"family centered practice" is blamed. Some of the questions that generate the controversy include:

- Does our assessment and the focus of our intervention belong with the family or with the child?
- Does family centered practice and family focused assessments compromise safety of the child?
- Can one do family centered assessments while at the same time ensuring that the needs of the child are met?
- If the emphasis is on family centered practice, there is some concern that the worker is under pressure to reunify or preserve the family. How does a social worker know when to "make the call"— to provide family preservation services or to remove the child, to return the child home or to move forward with the termination of parental rights?

These are very complicated issues and while there has been growing support for family centered practice—in the filed of child welfare, there is an artistry involved in being able to balance the rigor with which we must strive to keep children safe and connected to permanent caring adults, with family focused intervention. The success in achieving this balance ultimately depends upon the quality of the assessment. It is by gathering as much data as possible from the family in a way that causes them to see us as partners, and by co-crafting a plan that they help create and that has meaning for them, thus generating maximum buy-in, that we have the optimal chance at child safety **and** reunification.

SECTION VI. Emerging Influencers that May Impact the Resource Center's Approach to This Issue

Some of the emerging practices we can expect to see within the next five to ten years include:

- Under ASFA, the implications for "loose" social work practice, where services provided are menu driven, and where goals are nebulous and unclear—is that families will lose their children-permanently. Increased pressure for outcome based service planning, where the goals are concrete and measurable.

- Increased use of data as a basis for social work decision-making. As states are moving into new kinds of contracting arrangements with the community based provider, the need for data regarding what services are most effective with certain kinds of presenting issues will increase. Child welfare practice, which has not historically been a researched based process, may increasingly see research and data driven practice.

- Increased integration of assessment requirements, as a result of the integration of TANF, child welfare and primary care funding streams. Assessments will become more holistic and comprehensive—resulting in the creation of a single service plan as opposed to multiple and often-conflicting service plans. For example, in the District of Columbia, the Child Welfare Agency let an RFP requiring an integration of foster care and primary care services. In El Paso county Colorado, there has been an integration of the child welfare and TANF assessment. In the state of Missouri, under a pilot for children with seriously emotional disturbances, called the Missouri Alliance, special education, TANF, child welfare, juvenile justice and children's mental health and Medicaid dollars for health care have been pooled to create an integrated system of care. It is the expectation that the assessment will cover every area of the child's life.

- Increased expectation for family centered assessments under risk-based, performance based contracts between the state child welfare system and the community-based providers. As states continue to "privatize" the assessment role and partner more closely with the community based provider, the expectation for family

As these shifts in practice evolve, the National Resource Center for Family Centered Practice may want to develop product lines that could include one or more of the following:

- Provide Family-centered Assessment training for the Community-based provider.

- Design sample contract language that can assist states in defining contractual expectations for family centered assessments,
- Create ‘state of the art’ models of an integrated family-centered assessment approach, where special education, TANF, child and family metal health issues, medical needs are incorporated into a single assessment process. (WE may want to pull together a “think tank” of people from the various professions to address this issue.

Section VII Resource Center Implementation

Based on this analysis of the field, this section is focused on the following key conclusions:

A) The summation of the core components of a family-centered assessment.
B) Model Of Development
C) The Products that the Resource Center Could Develop.

A) Summation of Core Elements of a Family Centered Assessment

Based on this research and interviews with key state personnel, the National Resource Center emphasizes that the essential components of a family centered assessment include:

A value base that includes:

- Ensuring the safety of children and other family members.
- Working as partners with families.
- Valuing the importance of family and community to each child's well-being.
- Respecting and being sensitive to cultural differences and supporting diversity.
- Creating a climate where families are free to make decisions and develop skills that contribute to their families' safety and well-being.
- Recognizing and building on families' strengths, capacities and resources—using those as the basis for mobilizing change.

Each family centered assessment should contain the following:

- Risk assessment—ensuring above all that the child is safe.
- Description of the family's view of the problem and what brought them to the attention of the system.
- Assessment of the strengths and the resources of the family, including previous successes, accomplishments, problem-solving skills and coping skills.
- Determination of concrete needs.
- Recognition of health, medical and dental needs.
- Recognition of the child's educational needs/status.
- Identification of family struggles.
- Previous attempts at alleviating the problem (not just a list of services previously received) and how they have helped or not helped.
- An intergenerational family history.
- Information about the family's culture.
- Discussion of internal family dynamics and interactional patterns.

- ♦ Identification of formal and informal supports.
- ♦ Determination of the service goals of family members.
- ♦ Screenings for domestic violence, mental health issues, substance abuse, sexual abuse as indicated.

The individuals involved in the family-centered assessment should differ from family to family based on the particular needs of the family and their relationship to the outside world.

The family-centered assessment should be considered an ongoing process, where the progress of the family and the efficacy of services in meeting established goals are evaluated frequently and the plan modified as required. Under ASFA timeframes, these times of evaluation should occur at least monthly—ensuring that the family and the child have the optimal chance for living together successfully.

B) Model Of Development

It seems that ASFA clearly provides the vehicle to introduce or reemphasize the importance and criticality of family-centered assessment in child welfare. The central theme of ASFA is faster decisions resulting in increased permanency. How is a social worker or the court for that matter going to be able to make well-informed decisions in a faster timeframe unless the family assessment is comprehensive? How can the social worker and the courts move ahead with termination of parental rights, without knowing if all of the services that the family needed were actually provided? How can the worker know the services needed, unless they took the time to carefully assess family need? It seems tat the focus of the Center should be on the increased pressure for timely decision-making and how a comprehensive well-crafted family-centered assessment is the foundation of good decision making. This model of development does not harshly criticize past practices, but infuses new energy and importance on getting families engaged early—otherwise they stand to lose their children for good.

C) Products We Can Offer

1) Leadership/Supervisor Development

If the premise that conducting sound family-centered assessments requires ongoing quality supervision is true, we may want to design a focused approach to leadership development where supervisors in the organization are exposed to leadership training that encompasses at a minimum:

- ♦ Creating a culture of learning in the agency.
- ♦ Using data as a tool for best practice.
- ♦ Teaching how to conduct a strength-focused, family centered assessment.
- ♦ Heightening awareness of cultural issues in the family—helping your staff become culturally competent.

- ♦ Creating mutual responsibility for the success of the supervisory process.
- ♦ Primary focus of the supervision process.
- ♦ Understanding how to assess and redirect workers caught in their cultural influencers.
- ♦ Creating effective peer consultation and support models.
- ♦ Building strong community perception of the agency.
- ♦ Creating effective partners with community-based providers.

2) Training on Conducting an Ongoing Family-centered Assessment

The concept of ongoing assessment is new to the child welfare arena. Moving workers form the idea that assessment is a point in time event, to a process will take multiple training sessions and must be communicated learning every possible adult learning medium. The Center should develop a curriculum encompassing, reading, hands on activities, interactive training and teleconference calls that support the learning process behind an Ongoing Family-centered Assessment.

3) Focused Training on Conducting a Cultural Competent Family Centered Assessments for Specific Ethnic Groups

While much has been written about cultural competence as a key aspect of family centered practice, it maybe a novel thought to consider some of the newest cultures and ethnic background entering our country—specifically Bosnian and Kosovarian refugees, and Laotian immigrants and craft a specific training around conducting a family centered assessment with these unfamiliar ethnic groups.

4) Create a template for a Holistic Family-Centered Assessment

While this area is an emerging issue in child welfare services, it might be very wise for the Resource Center to lead the way in thinking about how one would integrate health, employment, education, mental health, child welfare issues into an assessment instrument that does not become so intrusive it scares the family. Additionally, it may be a challenge to secure agreement form the various disciplines about the important information to gather. As states are pooling funding streams this area will become more central to forward movement. The Resource Center could carve a niche in helping states understand best practice in this integration of assessment functions. It also provides the Center with the opportunity to influence the family centeredness of these emerging assessment processes.

Section VIII. Resources and Key Consultants Available to Develop the Center's Products

Based on the specific products identified in this paper, there are several recommendations:

There are leadership institutes around the country that have been developed for the for-profit corporate managers and for the not for profit leaders that could be modified to meet the needs of the child welfare supervisor. Some of the most exciting things on leadership today are being written by Margaret Wheatley[20] Steven Covey[21], Nicholas Tichy[22], and Peter Senge[23]. These writing have been synthesized by *L3P Associates* into an Outcome Based Leadership Curriculum for the Not for Profit Sector[24].

In the area of developing curriculum for training on Ongoing Assessment, Bill O'Hanlon provides excellent training on Solution-Focused Intervention that has as its core, ongoing assessment. His book Do One Thing Different[25] highlights the process of Ongoing Assessment as part of the assessment, service planning and intervention process. Mr. O'Hanlon is an excellent trainer and can bring a wealth of examples and hands on experiences to this topic. Insoo Kim Berg, who assisted the state of Michigan in introducing strength solution focused practice into child welfare, might also serve as an excellent support for this curriculum development. The state of Michigan ahs devised an entire training approach for this model based on their work with Insoo.

There is very little information on conducting a holistic and fully comprehensive assessment. Therefore the best strategy may be to begin at the beginning and gather experts together to really talk through what is needed in a comprehensive, multifaceted assessment. From this think-tank a draft product could be developed and disseminated to state leaders. Some of the experts in the filed that could be called to a "think tank" include:

- Ellen Battistelli Child Welfare League of America. (Medical issues)
- Pam Day Child Welfare League of America (child welfare issues)
- Representation from the American Academy of Pediatrics. (Medical issues)
- Representatives from APHSA regarding the assessment needs for the TANF population. (TANF issues)
- Representatives from the Association on Higher Education and Disability (educational issues)
- Representatives from SAMSHA (behavioral health issues)
- Jan McCarthy Technical Resource Center for Children's Mental Health

[20] Wheatley, Margaret, The Berkana Institute 1999 Bringing Life to Organizational Change
[21] Covey, Steven Principle Centered Leadership Covey Press 1997
[22] Tichy, Nicholas the Leadership Engine Harper Business 1997
[23] Senge, Peter The Fifth Disciple Doubleday 1990
[24] Lutz, Lorrie Outcome Based Leadership Institute L3 P Associates, LLC 1999
[25] O'Hanlon Bill Do One Thing Different Morrow Publishing 1999

- Representatives from Federation for Families (family perspectives)
- Representatives from The Center for Health Care Strategies (medical and Medicaid issues)
- Representatives from the Annie E. Casey Foundation (child welfare—neighborhood and community assessment issues)