PRIMER HANDS ON- CHILD WELFARE

HANDOUT # 6.1

Arizona Department of Health Services: A Comparison of Six Practice Models

Frank Rider, (2005) Arizona Department of Health Services

A Comparison of Six Practice Models

Compiled by Frank Rider, ADHS [May 2005]

Model (Describer) →	CPS Family Group Decision Making Tim Penrod/ Randy Grover	Wraparound Model John VanDenBerg PhD [and see National Wrap-Around Initiative 10/04]	Child Welfare Policy & Practice Group Paul Vincent	Person Centered Planning - DDD Joe Patterson PhD	Individual Family Service Plan [IFSP] Process Carol Wegley AZ-EIP	DDD Individual Support Plan Davida Moraga-Monts de Oca, DES-DDD
Meeting Length	6 - 8 hours	30 - 45 minutes	1 - 2 hours	1-2 hours	1-2 hours	1-2 hours
Meeting Frequency	Once (typically). Follow-up offered, but additional meetings seldom needed	Every 1–2 weeks initially, then meeting frequency tapers off as needed	Every 1-2 months initially, then meeting frequency tapers off as needed	Core Group meetings may occur every 1-2 weeks initially, then monthly	Every 6 months at a minimum, and any time a parent/guardian requests	ISP completed annually, and service reviews vary from quarterly to every 6 months, depending on service and program eligibility – more frequently as may be needed or requested.
Purpose of using the model ...	To involve the family in decision making regarding the safety of the children, often to avoid dependencies and/or resolve placement issues	When traditional services are not working well for the family	For every case entering the system in order to provide a better service team	To identify and engage Stakeholders and the Focus Person to solve problems and accomplish outcomes over time.	To facilitate partnership between the family and supporting professionals and to determine supports and services necessary to achieve family-identified, functional outcomes.	To facilitate communication between team members to determine outcomes, supports and services necessary to achieve the person's vision of the future.
Strengths Based	Yes	Yes	Yes	Yes	Yes	Yes
Plan derived directly from strengths?	Family views all listed strengths while creating plan. Family/team decide extent to which they can incorporate strengths into plan.	Yes	Yes	Yes	Yes	Yes
During the engagement / planning phase, strengths are gathered from ...	From everyone who will participate in the meeting	Primarily from the family, usually from all members of the team	From all team members – family, informal supports, professionals	From the Focus Person and all the participating Stakeholders.	From the family and other professional team members	From the individual, family, other team members (friends, and service providers) and other professional team members
Amount of time typically spent listing strengths during family team meeting	Several hours	A few minutes – however an extensive strengths discovery is done prior to the meeting and a copy is given to each team member before the meeting	Approximately 20 -30 minutes	Varies, a few minutes to a few hours. Identification of Capacities and Opportunities is an on-going process for the length of the Core Group's life.	Varies, intensive work is done before the meeting to identify the priorities and strengths of the family and the child.	Varies from team to team a few minutes to an hour. Average is 20-30 minutes.

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Strengths are in regards to ... / during the family meeting the strengths are gathered from ...	In regards to the entire extended family and informal support system / gathered from all team members	Strengths discovery prior to meeting is regarding the extended family / gathered primarily from immediate family / During the family meeting, each participant is asked what strength he or she brings to the meeting that day	In regards to the immediate family, especially the child(ren) of focus / gathered from the entire team during the meeting	"Strengths" in regards to the Focus Person, the Family, other Stakeholders, and the Community / gathered from review and discussion in the planning process	In regards to the individual child, and the capacities and resources of the immediate and extended family, informal support networks, and community resources/ by and with the family before team meetings, and from team members during meetings.	In regards to the individual and family.... Gathered from the entire team during the meeting.
Method used to present strengths during the meeting	An orderly process is followed that allows each participant to identify as many strengths as desired. The facilitator determines the order in which people speak, in a strategic manner.	All team members are given the write-up of the strengths discovery that was conducted prior to the meeting. These are used to build upon during the meeting.	An open process for discussion of strengths is used during the meeting. Any team member can offer strengths and observations in any order desired.	The Facilitator guides the Focus Person and other Stakeholders through an examination and discussion and assists the participants to discover Capacities and Opportunities for themselves.	Service Coordinator and/or Team Lead assist the family in providing team members with a summary of their priorities, concerns, and resources. Team members may offer additional insights based on their observations and professional judgment.	The facilitator guides team to openly discuss and any team member can offer strengths and observations in any order desired.
Openness of the model to the inclusion of issues that are extemporaneous to the topic being discussed by the team during the meeting	Open to any topic relating to the safety and care of the child. The meeting lasts as long as needed to address any issues the family desires to discuss.	Newly introduced issues are not discussed at length during the meeting if not related to the topic at hand – reserved for a future meeting	These issue(s) would be discussed briefly during the meeting. The team would decide how much time to spend on the issue(s).	Open to almost any issue. Participants identify personal goals and issues at the initiation of each meeting. The group prioritizes issues and sets time limits for discussion. They may decide to deal with some issues in another setting.	Open to any topics relating to supporting the child's development. Some topics may not be resolved in the IFSP meeting, but a team member may be assigned to for follow up.	Open to any topic relating to the individual. The meeting lasts as long as needed to address any issues or concerns the team desires to discuss.
Barriers or challenges to the family / child are called ...	"concerns"	"needs"	"needs"	"Barriers, obstacles, issues, concerns, fears, challenges"	"concerns"	Needs, concerns, recommendations

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Concerns / needs relate to ...	Open to any area that relates the safety and care of the child	Limited to the life domain area selected by the family to be discussed during that particular meeting	Any area that arises that relates to the safety and care of the child.	Topics for discussion, e.g. (current and future concerns, goals, barriers, needs)	The family's ability to facilitate and enhance their child's development.	Any area that relates to the safety, care or quality of life of the individual.
Needs are framed as ...	Concerns ... shared in a strength based manner	The "why" behind a goal being important to the family. Needs are strengths that have not been fully developed, or areas where the family has not been properly supported	Underlying areas of importance requiring resolution by the family/child for optimal development	Conditions and supports needed to accomplish a better life for the Focus Person (and Family).	Conditions or barriers that may be outside of the scope of early intervention (housing, employment, etc.), but that negatively impact the family's ability to foster their child's development.	Conditions, barriers and supports needed to accomplish a better life for the individual.
Possible solutions are called ...	"Options"	"Options"	"Offers"	"Visions of the future" "Next steps" "Opportunities"	"Strategies"	Vision of the future, Goals/Objectives
Solutions come from ...	A plan derived by the family during private family time (when no professionals are present)	Ideas from the family / team during the meeting that are directly related to the strengths	Ideas from the family / team during the meeting	The Focus Person, Family, and other Stakeholders in consensus decision-making.	Ideas from the family / team during the meeting related to the identified "desired outcomes."	The individual and their team.
Final product of the meeting is ...	A summary, which includes a plan developed entirely by the family during private time. The plan must be approved by CPS, and it contains family background info, strengths, concerns, a plan to meet the needs, and a backup plan	A brief plan developed by the team outlining the life domain, strengths, needs, goals, and plans	A plan developed by the team containing the family story, strengths, needs, offers, next steps, and a back up plan	A Person Centered Plan including: Personal Profile, Vision of the Future, Opportunities and Obstacles, Next Steps, and a Core Group	An IFSP, including: A summary of the child's development; priorities, resources and concerns, outcomes, strategies and resources, and activities for transition after age three	A plan (Individual Support Plan) developed by the team containing the current health, strengths, resources, needs, concerns, team recommendations, what works, what doesn't, vision of the future, outcomes, services, support information, rights, safeguards, provider selections, services, risk assessments and back-up plans.
Desired size of the family team	Unlimited -- average size of 15 participants	4-8 members	8-12 members	Unlimited	Variable	Variable

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Team members chosen by the family?	Yes, but the family must allow CPS participate in the meeting	Yes, but when child is in state custody the worker must be on the team	Yes, entirely. If family does not want the state worker, they are not a part of the team	Yes with assistance and collaboration by other Stakeholders.	Yes, but Federal regulations specify the minimum IFSP team requirements (e.g., parents, Service Coordinators, and at least one other professional member representing evaluation or service provision.	Yes, but Medicaid regulations specify the minimum ISP team requirements (e.g., individual/responsible person and Support Coordinator. If the individual is receiving services, then their service providers are also considered team members.
Types of team members the family is encouraged to select	Everyone associated with the family -- all immediate and extended family members, informal supports, professionals. Even if the family does not get along with some individuals, they are encouraged to allow these people to attend in order to hear them express their concerns, as they may be valuable insights that only these individuals are willing to voice. These issues are processed during engagement and during the meeting.	4-8 people, most of whom are informal supports, who would be the most likely to help the family. Family members at odds with the parents/child typically are not involved as they are not seen as most likely to help them progress.	8-12 people, at least half of whom are informal supports. This model offers some ability to help team members who are at odds work together. However, the family would primarily choose team members they view as supportive and on their side	Anyone who is a real "stakeholder" in the Focus Person and Family's life. Stakeholders may be defined as "emotional stakeholders" who are typically family and friends. "Professional stakeholders" are those persons who will be able to provide assistance and information. Stakeholder identification and recruitment is an ongoing and entirely individualized process that varies from situation to situation.	The family is encouraged to include all individuals who have a central role in the growth and development of their child. Representatives of other programs serving the child and family are also encouraged to attend and collaborate in the planning, to avoid duplication of services.	The individual/ responsible person is encouraged to include all individuals whom they wish, and are encouraged to invite those individuals who know the person well. DDD Service Providers or representatives of other programs serving the individual are also encouraged to attend and collaborate in the planning, to avoid duplication of services.
Back-up plan developed during meeting?	Yes	No -- a new plan would be created at the next meeting if the first one did not work	Yes -- Team determines "what could go wrong" and makes a plan accordingly	Yes. In some situations, a Crisis Response Plan will be developed to prevent a serious crisis if something does not work. Alternative support strategies may be developed in some	No – The IFSP would need to be revised or a new one developed	Yes, in certain situation if the person would be at risk should a service provider not showing up, a backup plan must be developed to address the need. Risk Assessments are also

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				situations.		required for some individuals that assist the team in what to do should the risk present it self or how to prevent the risk behavior.
Parent mentors typically used?	No – but uses family members assigned as "monitors"	Yes	Yes	In some instances, if a Parent Mentor is identified as a resource available and the family wants to use that approach.	No – but some families may have accessed mentors through the community, such as Raising Special Kids and the ASDB Deaf Mentors.	No – but some families may have accessed mentors through the community, such as Raising Special Kids and the ASDB Deaf Mentors.
Are team members typically brought in from out of state for meetings?	Yes – often	Not typically	Sometimes	Sometimes	No - not at the expense of AzEIP	No - not at the expense of the Division.
Theoretical elements	**Family systems** – family, group interaction produces change **Cognitive** – value in processing **Emotive/affective** – hearing the family story/feelings behind actions has value **Reality** – Plan for best case scenario with detailed backup plan	**Behavioral** – value in actions/outcomes **Cognitive** – reframing struggles as strengths **Humanistic** – value in human's ability to improve under the right conditions **Ecosystemic** – all levels of society influence the family	**Cognitive** – reframing struggles as needs **Behavioral** – developing an action plan **Emotive/affective** – hearing the family story/ feelings behind it has value **Humanistic** – value in human's ability to improve under the right conditions	**Values Clarification Group Process** - addresses Quality of Life issues **Cognitive Behavioral** - helps reframe conflict and struggle for consensus building and problem solving **Functional Behavior Analysis** - helps Stakeholders develop and implement scientifically proven strategies for support efforts. **Participatory Action Research** - engages the Family and other Stakeholders in an ongoing learning process **Systems / Community Building** - links the Core Group to the larger	**Family-centered Supports and Services** – based on the priorities, resources, concerns, and interests of the family, in order to be meaningful to the child family **Routines Based** – young children learn, grow and develop in the context of their daily interactions and activities **Natural Environments** – children should receive early intervention in natural settings to support and enhance their interactions with family and other significant caregivers **Ecological** – the child's development is	**Individual/Family Centered Approach (Person Centered Planning):** Emphasize in-home, family-oriented services and supports provided either in the natural home or in a home-like setting. This individualized and flexible approach seeks to strengthen intact families, prevent out-of-home placements, and promote the return home of individuals to families desiring to reunite. The family support approach encourages the continuation of family relationships in natural and substitute families.

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				Community and the Human Services Systems	influenced by their surrounding environments of family, community, and culture.	**Ecosystems Perspective:** the interaction/influence between people and their environments. **Social Work Perspective:** assist individual/family with all supports not just those services provided by the Division.
How long does the family team continue?	The team usually meets only once, but the family monitors itself after the meeting to see that the plan/backup plan is carried out	Team continues as long as needed by the family	Team continues as long as needed by the family, even if the CPS/Parole/Probation case closes	Indefinitely. In some cases, the Core Group will disband within a few months. In others, they will become a Self-Directed Core Group that may continue to meet for years.	The IFSP team will function with the family as long as the child is eligible for AzEIP services, although membership may change as service providers change	The ISP team will function with the individual/family as long as the person is eligible for the Division, although membership may change as service providers change
Preparation / engagement time required for initial meeting	1 -2 months, approximately 20 – 30 hours	1 - 2 weeks, approximately 5 –10 hours	2 - 4 weeks; approximately 10 – 20 hours	1-2 weeks, approximately 4 - 6 hours	A maximum of 45 calendar days from the date of the initial referral	1-2 weeks; approximately 3 - 5 hours
Agency case managers typically used as the team facilitator?	Never	Often. However, in more complicated cases, a facilitator who is not the case manager needs to be appointed. Family members can even be facilitators	Some states use the case manager exclusively as the facilitator, while others hire independent facilitators	Any person with the prerequisite values, knowledge, and skills may be the Facilitator. However, when complex situations require greater capacities, a well-developed Core Group will build facilitation capacities among its members, including family members.	Usually. The Service/Support Coordinator holds the ultimate responsibility to facilitate the IFSP meetings.	Usually. The Support Coordinator holds the ultimate responsibility to facilitate the ISP meetings but the individual/responsible person may choose someone else to facilitate.
Family culture is part of the meeting / process?	Yes. The family participates in a family ritual to begin and end	Yes. A family culture discovery is conducted in order to capture the	Yes, however not as explicitly as in the other models. Culture in this	Yes and is clarified through the Values Clarification process and	Yes. The IFSP team process depends on following the family's	Yes. The persons culture is captured during the assessment

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	the meeting (ex: family song, prayer, story, etc.)	subtleties of the family culture. A plan is built with this culture in mind.	model is captured during the engagement process and the meeting and goals should be adapted to match the family culture	is expressed in the Vision of the Future.	priorities (including Cultural competence is achieved by following family's lead in identifying outcomes that are important to their cultural and family systems.	process and the persons "vision of the future and outcomes" should be adapted to match the individual's family culture
Lower case load needed for agency case managers when they have a case involved in this model?	No -- having a case in Family Group Decision Making should not be a burden on the case manager at all	Yes, especially if the case manager is the facilitator. Even if not the facilitator, significant time is needed for frequent initial meetings and follow-up. But in the end it should save the case manager time	Yes, especially if the case manager is the facilitator. Even if not the facilitator, extra time may be needed for follow-up arrangements. However, in the end it should save the case manager time	Not typically, however, lower case loads improve the case manager's opportunities to do a good job.	Lower case loads for early intervention service coordinators are imperative. Currently, the Arizona average caseloads far exceed the national averages of 15-20 families.	Not usually. A general child/adult caseload may be lowered only if a particular case is very involved and time consuming. Foster care caseloads are lower due to case complexity.
Food is a part of the meetings?	Yes – a big part. Meals/snacks are provided as determined by the length of the meeting.	Yes -- strongly recommended to have a snack	Yes -- strongly recommended to have at least a snack	Varies from group to group.	Sometimes, if the family arranges it.	Sometimes, if the family arranges it.
Multiagency involvement common?	Yes	Yes	Yes	Yes	Yes	Yes
Typically addresses the coordination of services from multiple agencies?	No, while representatives from agencies may be involved, focus is on family developing its own plan, not on coordinating agencies' efforts	Yes	Yes	Yes, as a part of Team Building and accessing community resources.	Yes	Yes
Ground Rules	Established by facilitator, called "foundation for success"	Facilitator presents the ground rules at the beginning of the team meeting. These are rules that were agreed upon by the family during the engagement phase.	Ground rules are drawn out of the group during the meeting and discussed with each team member prior to the meeting	The Facilitator models respectful group process and helps the group follow a set of implicit "ground rules." The facilitator may assist the group to develop their own set of explicit "ground rules."	These would be established by each individual facilitator/group.	There is no requirement for teams to establish ground rules.

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Family story / history presented during the meeting?	Yes – brief general background presented by facilitator at the beginning of the meeting.	No	Yes – the family presents a summary of their story to the group. Facilitator helps the family tell the story	Yes in an initial frame titled "History/Background"	No. The family story may be recapped at the IFSP meeting, but families are not required to retell their story.	No, it is up to the support coordinator to review file. Some involved cases may have "History/Background" already written up. Families can tell their story if they choose, but it is not required.
Documents used / created	Summary of the meeting, which includes the family plan	*Wraparound plan *Crisis plan *Safety plan *Outcome forms *Strengths and culture assessment	Write-up from the family team meeting	Wall charts are initially used to display Stakeholder input in color-coded sections within the Frames. The wall charts are then transcribed in 8.5 x 11 typed sheets distributed to the focus person and all stakeholders. These eventually form the Person Centered Plan with parts noted in the Final Products section described above.	An IFSP which includes: ◦ A Integrated summary of the child's development; ◦ Family-identified Priorities, Resources and Concerns ◦ Child and Family Outcomes ◦ Strategies and Resources to achieve the outcomes (e.g. frequency, intensity, etc.) ◦ Activities to address transition to services after age three years old	An ISP including: ISP Cover Sheet; Annual Review and Update; Summary of Professional Evaluations (required for individuals who are 21 yrs older); Team Assessment Summary; Preferences and Vision of the Future; Action Plan I and II, ISP Support Information; ISP Spending Plan (for individuals in licensed settings or for individuals whom DDD is rep payee; Rights Health and Safeguards (required for individuals in licensed settings); Attributes Checklist, Risk Assessments (as needed-required for licensed and for independently designed living situations (IDLAS).
How inappropriate comments / suggestions are handled (reword "inappropriate")	Put in the "parking lot" to save comments/suggestions for later use	Redirected to the topic at hand	Re-framed and shaped toward the topic at hand or redirected	Listened to with an attempt to understand the function of the comment. The function will be addressed in	Varies by IFSP team. The team process would promote the reframing of the comment to become relevant and	attempt to understand the issue. The issue may be reframed and

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				some cases. The comment may be re-framed. A "parking lot" procedure may be used. A separate discussion may be planned.	constructive to the topic of discussion.	addressed during the meeting; or a "parking lot" procedure may be used if there is not enough time to discuss at that time and a separate discussion may be planned.
Potential to encompass multi-agency case plan?	No	Yes	Yes	Yes	Yes	Yes, but a combined effort should not be too costly in terms of time commitment for teams
Team members get buy-in through ...	Engagement, meeting process and interaction	Action / outcomes	Engagement, meeting process, outcomes, interaction	Engagement, meeting process, interaction	Team composition is determined to align with and support family's resources, priorities and concerns. Buy-in starts from the framework of family-identified outcomes, and grows through engagement, the team meeting process and member interactions.	...the lead of the individual/and family. The team works together through the meeting process to best meet the needs of the person based on the person's priorities, strengths, needs, and resources.
Process may seem overwhelming to already busy staff?	No	Yes	Yes	Yes. This systems issue must be addressed for the process to be successful.	Yes, a challenge to coordinate schedules with staff from multiple agencies.	Yes, a challenge to coordinate schedules with staff from multiple agencies and meet the "requirements" from all agencies in just one meeting.
Does the whole team have to meet for each family meeting?	Yes -- vital that all members be there in person, by phone, or through written contribution	Vital that each member be at the initial meeting. After that the busier members may only attend occasionally, depending on topic to be discussed	Important that as many of the team members as possible be at all meetings, however, sub-teams may be developed for specific meetings (school team, mental health team, etc)	Important that as many of the team members as possible be at all meetings, however, sub-teams may be developed for specific activities. The operating principle is Inclusion.	A professional team member may provide a written summary or participate by phone, if they cannot attend the IFSP meeting.	The individual must be part of the meeting unless otherwise specified by the guardian. Guardians may meet via conference or review the ISP prior to implementation. A professional team

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						member may provide a written summary or participate by phone, if they cannot attend the ISP meeting.

PRIMER HANDS ON- CHILD WELFARE

HANDOUT 6.2

Kansas Department of Social and Rehabilitation Services Family Centered Practice

www.srskansas.org/CFS/FCSOC/whatissoc.htm

Family Centered Systems of Care

FCSOC | Six Principles | Grant Information | Resources | Pilot Communities | About Us

What is Family Centered Systems of Care?
What is Family Centered Practice?

Family Centered Systems of Care (FCSOC) is not just a program, it is a concept, a process. FCSOC provides collaboration between agencies, service clubs, the faith community,tribal organizations, etc., to develop common values and visions that are family focused and family driven. As a result of the collaboration barriers break down, communications improve, and we all work together so that our community serves children and families together and in their best interest. At the family level this can be done by using family meetings and or wraparound process.

In a system of care, mental health, education, child welfare, juvenile justice, and other agencies work together to ensure that children and their families have access to the services and supports they need to succeed. A true system of care is about partnership - a partnership made up of service providers, families, teachers, and others who care for a child. The partnership assist in developing an individualized service plan that builds on the unique strengths of each child and each family. This customized plan is always implemented in a way that is consistent with the family's culture and language. The primary goal is for the family to get the services they need in or near their home and community.

Teams find and build upon the strengths of a child and his or her family, rather than focusing solely on their problems. Teams work with individual families including the children-and with other caregivers as partners when developing a plan for the child and when making decisions affecting his or her care.

Family Centered Practice (FCP)

A family centered perspective is a conceptual approach-a shift in the way we think about what is helpful for children and families in the child welfare system. It is not only a set of specific strategies or models (for example, family group decision making, wraparound, or family preservation) to use with families. Instead, it is a framework based on the belief that the best way to protect children in the long run is to strengthen and support their families, whether it be nuclear, extended, foster care, or adoptive. It requires specialized knowledge and skills to build family capital-resources for strength and resilience-by providing services

to the family, extended family, and kinship group, as well as by mobilizing informal resource in the community.

Family-Centered Systems of Care Practice and Child Welfare

The idea of involving the family as a part of valid intervention in child welfare is still relatively new when compared to other, well-established modes of practice. Traditionally, child welfare efforts were child focused. They were intended to protect, provide care for, and plan for children who were separated from their parents because of abandonment or abuse and who were living in some form of out-of-home care. Children were seen as victims of bad or incompetent parents and the solution to the maltreatment problem was to separate the children from their parents, placing them in the hands of foster care providers. The intent was to force parents to learn to become better parents. Parents were given conditions that had to be met before being reunited with their children. These conditions might include getting a job, cleaning up their apartments, learning better parenting skills, or engaging in counseling to solve the underlying problems that were thought to cause them to be abusive and neglectful. Many of the parents became labeled as "unmotivated," "resistant," and "in denial" or refusing to "assume responsibility" of their problems.

As a result of this approach, an increasing number of children were found to be drifting in foster care, often subjected to repeated re-placement, ultimately losing the affectional ties, but not the legal bonds, that linked them to their families. These children had no hope of either going home again or gaining permanency through adoption. Still others, largely because of race or ethnicity-mainly African Americans, Hispanics, and Native Americans-became over represented because of child welfare's historic misunderstanding of their needs.

As a result of the 1980 Adoption Assistance and Child Welfare Act (PL 96-272), the Family Preservation and Support Act of 1993 (PL 103-66), and the Safe and Stable Family Program in 1997, the scope and purposes of child welfare programs require a comprehensive plan of family-centered services:

1. To help families manage the tasks of daily living, adequately nurture children, and remedy problem situations
2. To make "reasonable efforts" to keep children and youth in their own homes whenever possible rather than placing them in foster care
3. To safeguard children from dangerous living situations, and protect the right of every child to grow up with a sense of well-being, belonging, and permanence

The basic concepts and values of family-centered practice are influenced by family systems and ecological theories. Family systems theory assumed that emotional and behavioral problems of individuals are maintained through patterns of interaction within the family. Thus, the goal of intervention is to evaluate and change these patterns of behavior and to help the family interact in more effective ways.

Ecological theories emphasize that the behavior of individuals and families is a function of their adaptation to the demands of the broader context. Thus, the approach to intervention includes strengthening the interactions between the family and other systems (for example, informal helpers, community agencies, and schools) that have an impact on their lives. They believe that these other systems in the community are an integral part of the decision-

making and intervention process.

In practice, shifting the focus from the child to the family has often been viewed in child welfare as creating a dichotomy between the goals of protecting children and preserving and supporting families. But effective family-centered practice depends on a clear understanding of the relationship between these two goals. The belief that the best approach to protect children is to strengthen families acknowledges that there are times in the lives of families when they may be weak from exposure to stressors such as poverty, poor housing, substance abuse, domestic violence, or mental illness. Furthermore, help and timely intervention may not be available, some families may respond minimally or not at all to efforts to help them; and still others may require long-term help and support. Consequently, it becomes necessary to determine if out-of-home care is needed. When it is the plan of choice, the task is to manage placements in ways that minimize, as far as possible, the pain and bewilderment of separation and assure that children who go into care will be protected and well nurtured pending completion of a permanent plan.

The Essential Components of Family-Centered Practice in Child Welfare

1. The family unit is the focus of attention.
Family-centered practice works with the family as a collective unit, insuring the safety and well-being of family members.

2. Strengthening the capacity of families to function effectively is emphasized.
The primary purpose of family-centered practice is to strengthen the family's potential for carrying out their responsibilities.

3. Families are engaged in designing all aspects of the policies, services, and program evaluation.
Family-centered practitioners partner with families to use their expert knowledge throughout the decision- and goal-making processes and provide individualized, culturally-responsive, and relevant services for each family.

4. Families are linked with more comprehensive, diverse, and community-based networks of supports and services.
Family-centered interventions assist in mobilizing resources to maximize communication, shared planning, and collaboration among the several community and/or neighborhood systems that are directly involved in the family.

Family-centered practice in child welfare prescribes a continuum of services at five levels of intervention:

1. Prevention through education and other developmental services that can be useful for all families
2. Supportive, problem-solving, and crisis intervention assistance for families coping with problems or crises of life and the normal processes of growth and development
3. Rehabilitation of seriously disorganized families and protection of children at risk, including protective services to restore family functioning and to prevent family breakup
4. Out-of-home care and support for children at risk in their own homes, including

placement, supervision, and consultation as well as family rehabilitation and reunification

5. Permanent planning for children in placement, either by reunification with their biological families or by plans for adoption or permanent guardianship. Follow-up and emancipation services are included.

To be successful, family-centered practice requires a different organization and management structure-a way of working with other agencies. It is, in essence, a different way of doing business.

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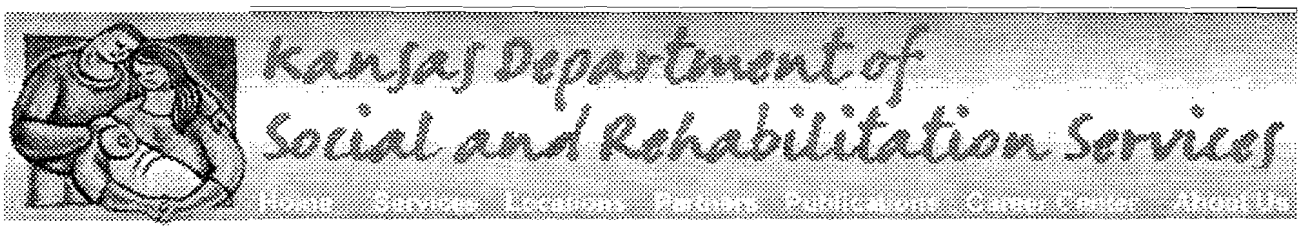

Family Centered Systems of Care

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Interagency collaboration recognizes that it takes several partners to bring together the resources to assist children and families to be successful. The Collaborations based on the community's ownership and commitment to support children and families. Click here to learn more about Interagency collaboration.

Individualized Strengths-based care and planning help families and communities build on their capabilities. Each family is unique and brings capabilities, as well as concerns; potential, as well as challenges. This holistic approach takes into account the whole person and allows each family to capitalize on their strengths. Click here to learn more about Individualized Strengths-based care.

Cultural competence conveys respect, preserves dignity, creates communication, and enhances self-determination. A culturally competent system increases the likelihood of success. A Culturally competent system consists of Planning teams and stakeholder groups that are representative of their cultural constituents, as well as, Policies and procedures that are sensitive to varying cultural practices and beliefs. "Cultural competence" is an important goal in systems of care. It means that each providerorganization must show respect for and respond to individual differences and special needs. Services must be provided in the appropriate cultural context and without discrimination related to race, national origin, income level, religion, gender, sexual orientation, age, or physical disability, to name a few. Culturally competent caregivers are aware of the impact of their own culture on their relationships with consumers and know about and respect cultural and ethnic differences. They adapt their skills to meet each family's values and customs. For more information on cultural competence, call 1-800-789-2647. Click here to learn more about cultural competence.

Youth & Family involvement occurs at all levels: planning, policy developments, social marketing, care coordination, evaluation and advocacy. Systems actively support and engage families, recognizing and drawing on their knowledge and skills. Moreover, Family involvement increases the likelihood of successful outcomes. The importance of this principle cannot be overstated. If there were one principle that is more important than the others, this would be it. Click here to learn more about Youth & Family involvement.

Community-based services maintains families in a familiar, less threatening context. The critical bonds between the family, friends, school, and natural supports are retained. Communities retain control and ownership of the system, reflecting community strengths, needs, values, and day-to-day realities. Click here to learn more about Community-based

services.

Accountability means that partners commit to results in their service, process, and financial outcomes. Responsibility for meeting or not meeting outcomes is shared between service providers for positive outcomes, regardless of where the child and family enter the system.Therefore, children and adolescents at risk for out of home placement and their families need many kinds of services from a variety of sources, such as schools, community mental health centers, and social service organizations. Click here to learn more about Accountability.

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