The Child Welfare Policy and Practice Group

The Child Welfare Policy and Practice Group is a nonprofit technical assistance organization committed to improving outcomes by improving practice. Its work has spanned over twenty states and focuses on the development of front-line practice that is strengths, needs and family team based, individualized and dedicated to safety, stability, permanence and well-being. Its technical assistance includes practice model development, strategic planning for practice model implementation, curriculum development, training and training of trainers, practice coaching and practice evaluation.
violence. And the field has attended to child behaviors that are the consequence of trauma, instability and loss, often manifested as anger and defiance, depression and aggression. A pattern of system responses to these behaviors has evolved and can be found in many systems, reflected in court orders and case plans. For example, a large proportion of parents are expected to participate in parenting classes, counseling, and substance abuse treatment. It is common for foster children and youth engaging in defiant or aggressive behavior to be referred to therapy, anger management programs and group home/residential settings.

Too often, however, this disproportionate focus on symptoms overlooks the child and family history and experience that underlies and produces these challenging behaviors. As a consequence, the underlying causes of neglect and abuse may not be adequately addressed and many families are again subjects of additional reports of abuse and neglect. Where children are concerned, inattention to needs can lead to instability, increasingly more restrictive placement settings and the complete absence of permanency.

What is an Underlying Need?
Webster’s Dictionary defines a need as, “A lack of something useful, desired or required; A condition in which help is required”, which partially speaks to the meaning of needs. More specifically in regard to child and family functioning, needs describe the condition or state causing the behaviors (or symptoms) to occur. So for example a youth responding to a history of separation and loss by fighting, running away and using drugs might have as one significant need, the need to understand that his parents’ lack of care giving does not mean that he is not worth love and commitment. There could be many ways to help this youth strengthen his sense of self-worth beyond counseling.

Trend pattern reflected in results of Qualitative Service Reviews conducted in 15 different child welfare systems.
Why Distinguish Needs From Services?
If there is a unifying element within much of the current child welfare planning for children and their families, it is that such plans are almost universally service driven. By service driven it is meant that services are often substituted for needs, as in “John needs mental health counseling.” Mental health counseling, like parenting classes, substance abuse treatment and residential treatment are services not needs. Defining needs as services skips the important step of understanding why a person might need a particular support and leads to the “cookie cutter” plans where one size seems to fit all. To some extent, we think first of services rather than needs because the provider service array is organized programmatically – agencies tend offer fairly rigid categories of services or programs that the child and family is expected to fit into. It is also convenient for practitioners to jump to services quickly because of the time constraints in which child and family service systems operate. Identifying needs might seem to take more time. Actually effective needs identification takes less time overall because it leads to more effective interventions. To assess and plan effectively, the child and family strengths and causes for behaviors needing attention should be identified first, followed by matching of services and supports to needs.

What are Examples of the Differences between Needs and Services?
The simplest place to begin in understanding underlying needs is in review of some actual case examples.

Mental Health Conditions
Not uncommonly we will encounter parents with mental illness that can provide adequate care giving as long as they take appropriate medication and stay connected to a mental health practitioner. If they stop taking medication, their condition can deteriorate to the point that their children are neglected. So what are such parent needs likely to be?

Probably not parenting classes, our old standby, because the parent may have demonstrated that she can provide adequate care giving if she maintains the appropriate treatment regimen (also, a parenting class is a service, not a need). Traditionally, a court might also order her to follow her medication regimen. Is that likely to result in compliance with the court’s order? In most cases the answer is no, unless accompanied by a support responsive to need.

What this parent, who loves her children and wants them to receive adequate care needs is to first understand that she has a serious mental illness.
Because she doesn’t fully understand the necessity of lifelong attention to treatment, when she feels better she stops taking her medications. When thinking about how to help her maintain adequate care giving, knowing that a primary need is for her to understand her mental illness, an appropriate intervention would be quite different than parenting classes. Instead, cognitive therapy directed at increasing understanding of mental illness, more frequent in-home medication monitoring and a family crisis plan might be more effective supports.

**Domestic Violence**

Victims of domestic violence that become known to child welfare are often referred to or ordered to attend domestic violence classes to address their victimization, which may be valuable to many. But in many cases, the victim’s choice to remain in an abusive relationship is driven by a complex set of factors that go beyond the focus of brief domestic violence interventions. In such cases, victims that are isolated from other relationships and emotionally and economically dependent on the abusive partner may have needs that include:

- Understanding the effects that witnessing domestic violence has on children
- Developing other emotionally supportive relationships beyond that of the partner
- Acquiring employment skills that will provide greater economic self-sufficiency
- Strengthening self-esteem by experiencing success in an area of strength

Identifying these discrete underlying needs reveals multiple opportunities to match services and supports to needs that may be beyond what a single service can provide.

**Oppositional/Defiant Behavior**

We all struggle with addressing the needs of youth that excessively test authority, disregard accepted behavioral norms, engage in defiant and aggressive behavior and in some cases, run away. Assessments of children with behaviors like these are too often limited to labeling and frequently reflect an overreliance on a “program” that will deal with the behavioral issues—often a structured congregate setting that is disconnected with the environment the youth will return to. Again if we start with understanding underlying needs, we are more likely to identify solutions that are individualized and address the causes of the behavior.

Many foster youth expressing underlying needs through the behaviors referenced have in common a history of trauma and loss (of family and prior caregivers due to multiple moves). It would be common for youth with such histories to have underlying needs that include:

- Frequent normalized contact with family
- Understanding of the normality of anger over so many losses
- Understanding that parental inability to provide adequate care does not mean he or she is unlovable
- Mastery of techniques for self-calming when explosive anger is threatening
- The experience of success in an area of interest
- A need for structure and predictability
- A need for greater control over life decisions

In actual practice, these needs would be described in the youth and family’s words.
As mentioned previously, there is a temptation to seek the right program to address these needs, which in many cases means the youth must move to the location where the services are housed. However, if needs are specifically identified there would be no reason why supports to address these needs could not be connected to the youth in a normalized, family based setting, often in his or her current living arrangement. Interventions might include:

- Cessation of conditioning family visits on behavior
- Increased frequency of family visits
- Increased attention to reunification
- Adding a clinician skilled in dealing with trauma issues to the child and family team
- Providing a mentor to support pursuit of interests that provide an opportunity for success
- Enlisting a behavioral coach to help the current caregiver design the structure and behavioral incentives needed and to coach the child in de-escalation techniques
- Allowing greater youth influence in case decisions

**Barriers to Needs-Based Practice**

*Child and Family Involvement*

To understand underlying needs, child and family involvement in communicating their experiences and indentifying needs are essential. Needs-based assessment requires good engagement skills as well as assessment skills.

*Policy, Systems and Structure*

Because systems construct policy, child and family plan designs and information systems around service driven practice, fitting needs-based assessment and plans into information system structures like SACWIS or templates for court reports can be a challenge. Drop down lists of needs (or concerns as some systems label them) in case management information systems and court orders where activity based plans (attend parenting classes) are the norm can clash with a more textured understanding of the child and family. Even when staff are mastering needs-based practice, incompatible system structures can force staff to default to traditional practice.

Because service contracts tend to be programmatically oriented rather than having the flexibility to be individualized, needs-based planning can be stymied by inflexible contracts and the lack of flexible dollars. Efforts to shift to needs-based practice must attend not only to strengthening practice skills; they must also help diversify the service array.

*Practice Orientation*

Dr. Marty Beyer, who coined the term “strengths/needs-based” in collaboration with others in the 1980’s, explains that a needs-based approach involves a different way of thinking. As previously mentioned, the field has taught practitioners to think about needs as services to the extent that service driven practice is the dominant practice culture in which we operate. Clinicians, case managers, providers and the courts all tend to substitute services for needs, so placing needs first is unfamiliar to colleagues and agency partners alike.
Part of shifting to a needs-based practice environment requires helping partners to think about practice differently as well.

Different skills are involved in needs-based practice. Engagement has to be genuine and assessment has to be deeper than cataloging symptoms. Matching services to needs employs a level of creativity not normally fostered in public systems. Fortunately, modest levels of training, coaching and regular practice can quickly develop the basic skills needed.

The Needs-Based Plan
The following case example describes the improvement in the functioning of a youth with significant mental health needs once traditional deficit focused, service-driven planning was replaced with needs-based practice.

The Role of Strengths in Needs-Based Practice
A subsequent issue will address the use of child and family strengths in planning.

What I Need Is My Family

Jennice Floyd, LCSW, MSW
The Child Welfare Policy and Practice Group

James didn’t know that Rachael, who had raised him since six months of age, was not his Mom. When this was revealed to him in the 8th grade, everything he believed about himself left him feeling empty, lost and unconnected.

Learning that his birth mom, Brittany had died at age 17 from a drug overdose and that she was Rachael’s sister he became angry for having never heard the truth. He began to grieve his mom’s death and his lost identity. And he kept the thoughts to himself for fear of upsetting Rachael.

James gradually began dealing with things in his own way. He would talk back to Rachel and refuse to go by her rules. Increasingly his disrespectful behavior caught the attention of the school and the community. He was frequently truant from school and was failing the ninth grade, even though up to now he had made excellent grades. Through the IEP process it was learned that his emotional issues were affecting his school performance.

James’ truancy issues and subsequent court appearances revealed that Rachael did not have legal custody. She had only assumed care for him and had never petitioned the court for custody. Now, no one held legal custody. James continued to accrue charges related to selling drugs and was eventually suspended from school.

He received probation for stealing and when he failed to complete the required shoplifting class, he was given an additional 50 hours of community service. Through court services he was given a case manager to help control his disruptive behavior in school and he was referred to substance abuse treatment and counseling. However, these services were eventually stopped, since James failed to comply with any of them. James then entered out-of-home care.

James ran away from his first out-of-home placement and was eventually detained by the police and proceeded to have a number of group home placements. During these placements James would either damage property, assault staff or run away. During this time Rachel was struggling too. She had been placed in an inpatient treatment facility for arthritis and couldn’t visit and support James like she wanted to do.
After assaulting a police officer, James was finally placed in a secure facility outside the city. This placement had behavior oriented therapy designed to control his anger outbursts and keep him from running away. It was there that James was assessed by someone who evaluated what had happened to him and how it had affected him while recognizing his strengths and identifying his underlying needs. It was not until this point that staff began to realize that he was actually very smart, he had some natural athletic ability, was motivated to good behavior through the approval of his family and had a plan for his future.

Staff identified his underlying needs; to be allowed to grieve the loss of his birth mom Rachel, who was now completely bed ridden; to be able to maintain family connections; and he needed a lot of praise and positive activities since he felt such loss and betrayal when he learned that he didn’t belong to Rachel and that the brothers and sisters he knew were only cousins. He felt abandoned and isolated and wanted Rachael and his brothers and sisters back. And he needed to become better prepared for independence quickly.

Armed with this new view of James, the case-worker quickly realized that his current placement neither complemented any of James’ strengths nor could it meet his underlying needs. James was headed on a juvenile justice course.

With James and Rachael, a team was developed and they met at Rachel’s bedside. With the team’s input a new path for him became clear. A placement near his home needed to be found for him; his therapy would now include Rachael by phone so that together they could address his grief/loss (loss of birth mom and loss of Rachael’s health) and reaffirm the love the two of them had always had. Together they addressed the hurt they both had and the love both shared and a cell phone was given to James so that he and Rachael could keep in touch daily. Rachael could then encourage him to complete his homework and would offer the kind of discipline he responded to.

The team also planned for James to spend every Saturday with his family so that he could maintain those connections. He used his skill in math and other subjects to mentor children in his group home through a weekly tutoring program and he became a member of the football team. This plan worked to build his sense of identity and self-worth.

He started learning independent living skills from his new house parents; his desire is to one day return home to help care for Rachael.

When James got a weekend job he was allowed to change his visits to weekday evenings at his Mom’s home. James’s probation officer arranged for his community service hours to be done at the group home and James is excited that his work there is benefitting the place where he and other kids live. James’ behavior improved and so he was placed in the public school system.

James soon transitioned to the IL/Transitional living house where he practiced living independently and he knows that he will still have the support of his house parents and therapist, right next door, if he needs them.
Figuring out what worked for James resulted from truly considering his and his family’s input and having providers that were willing to adjust their services to meet his needs, rather than make him fit their program. James’ team feels successful and they are all proud about the turn-around because they once believed his future was jail.

Tips for Needs-Based Practice

There are few simple principles that will help to remain focused on needs when transitioning from service-driven practice to needs-based practice. These include:

- A service is not a need.
- A program is not need.
- A placement is not a need, it is a setting or living arrangement.
- A symptom is not a need; the need is what causes the symptom.
- When you can’t get beyond thinking of a service, ask yourself, “Mom needs (the service) to accomplish what?” The answer will help identify the need.
- When you start with needs, the possible solutions are multiplied.

Paul Vincent, Director  
pv@childwelfaregroup.org  
428 East Jefferson Street  
Montgomery, AL 36104  
334-264-8300  
Fax 334-264-8310  
Website—http://childwelfaregroup.org