

Taking it to the Streets: Family Therapy and Family-Centered Services

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This article examines the interconnections between family therapy, specifically postmodern and poststructural approaches, and family-centered services. It introduces particular applications of family-centered services such as systems of care, wraparound, family-driven care, the recovery movement, and family group conferencing and then summarizes the heart of family-centered approaches as a shift in how services are provided to families. It examines the “fit” between the values and principles of family-centered practice and postmodern/poststructural approaches and then offers particular ideas and practices from these approaches that can help frontline workers inhabit a spirit of respect, connection, curiosity and hope in their work.

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In reflecting on the future of family therapy, we should probably start with an acknowledgment that there are many family therapies and many possible future directions. Family therapy is anything but homogeneous. In this article, I’m going to focus mainly on what I know best—postmodern or poststructural approaches in public sector mental health, child welfare, and health care contexts.¹ I will undertake both a personal and professional accounting of the interface of family therapy and frontline public sector practice. More than 10 years ago, Pulleyblank Coffey, Olson, and Sessions (2001) documented the impact of managed care and other developments in public sector services on family therapy in community mental health centers. Based on interviews with managed care providers, researchers, family therapy trainers, and clinicians, they traced out intertwined trends of the medicalization of mental health, the rise of time consuming paperwork requirements, and funder reimbursement changes that encouraged agencies to move from salaried positions to “fee-for-service” positions in which clinicians are paid on an hourly basis for clients that they see. This all had a number of consequences. The trend toward a biomedical psychiatry that privileges diagnosis and psychopharmacology and often downplays the role of psychotherapy marginalized family therapy as an adjunct to medication and individual therapy with identified clients. Time consuming paperwork with a focus on

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¹Postmodernist and poststructuralist approaches share a number of commonalities and distinct differences. There are clearly some epistemological problems in conflating the two. However, I think the similarities outweigh differences and frontline workers in family-centered services are less interested in the philosophical distinctions from whence these ideas and practices come and more interested in what is going to be immediately useful in their efforts to help beleaguered children, youth, and families. With that in mind, I will use the phrase “postmodern/poststructural approaches” throughout this article.

cost containment and legal liability issues structured the ways clinicians think and practice. As a result, frontline clinicians increasingly adopted a pragmatic orientation not based on therapeutic principles. As one psychiatrist interviewed put it, “Procedures are replacing theories.” Time previously spent on training, consultation, and supervision was now taken up by paperwork with a resorting erosion of clinical ideas and imagination as protocols and procedures replaced critical thinking. Munro (2004, p. 1090) refers to this development as “protocolization.” Finally, the reorganization of agencies into fee-for-service structures disrupted team cohesion and deprived clinicians of opportunities for reflection and shared learning. As one program director interviewed put it, “Fee for service has created a collection of private practitioners here. So instead of me having a staff, I have a collection of entrepreneurs.” This trend contributed to greater isolation of clinicians, reduction in training in agencies, and encouragement of an atheoretical, primarily pragmatic approach to practice. Pulleyblank Coffee, Olson, and Sessions (2001) concluded that family therapy’s knowledge of human systems was in danger of being disqualified and lost with damaging consequences for the care of children. Since then, these trends have continued and have been exacerbated. The combination of a resurgent medical model, the proliferation of the psychopharmacology industry, paperwork requirements that increasingly drive practice, funding cutbacks leading to increased productivity demands and reduced opportunities for supervision and training, and the assumption that only practice frameworks that have been “empirically proven” to be effective are legitimate have taken quite a toll on staff morale, commitment, and creativity. As public sector agencies have moved into “triage” mode, it becomes increasingly difficult to have conversations about practice. All of this contributes to an unfortunate sense of family therapy on the wane in the public sector. While there are still pockets of innovative family therapy teams across the country, family therapy has not revolutionized health and human services in the ways that many of us had hoped.

However, over this same period of time, there has been phenomenal growth in what can broadly be referred to as family-centered services. While there are many different definitions of family-centered services, they all share a common set of values and principles, which include an emphasis on culturally responsive, strength-based, collaborative, and accountable partnerships with families (Allen & Petr, 1996). Examples of family-centered approaches include systems of care and wraparound in behavioral health, the recovery movement in mental and physical health, family group conferencing in child welfare, and family-driven care across all of these contexts. In the United States alone, a modest estimate predicts that up to one million people will be doing some kind of home-based, community-centered work by 2020 (Bureau of Labor Statistics, 2012–2013). That number may be pushed upward as the healthcare industry discovers what mental health already knows. Practical and supportive home and community centered services can help people and families achieve their highest level of health and well-being at a relatively low cost.

EXAMINING THE TERRAIN OF FAMILY-CENTERED SERVICES

Let’s take a look at systems of care, wraparound, family-driven services, the recovery movement, and family group conferencing (also known as family group decision making) as current examples of implementing the values and principles of family-centered services.

Systems of Care

System of care as an overall approach to organizing helping services was initially defined by Stroul and Friedman (1986). A more recent definition describes it as:

A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community and throughout life. (Stroul, Blau, & Friedman, 2010, p. 6)

The impetus for a system of care approach arose out of concerns that children with emotional and behavioral challenges were not getting the help they needed. Services were often provided in restrictive out-of-home settings and there were few community-based services available. Child-serving systems rarely worked together, families were often blamed and not involved as partners in their child's care and agencies, and systems rarely considered or addressed cultural differences among the people they served. Systems of care have attempted to address these concerns through a range of services and supports backed by an organizing framework and value base. The core values of systems of care emphasize helping efforts that are (Stroul et al., 2010):

- (1) Family-driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
- (2) Community based, with a locus of services, as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
- (3) Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

From the beginning, there was an emphasis on maintaining flexibility in implementation to fit the local context. As Hernandez and Hodges (2003) put it, "Systems of care are not clean packages." They vary considerably from community to community and are not "single, bounded, well-defined units." While different communities have implemented systems of care in different ways and no two are exactly alike, the philosophy and value base remain constant. Systems of care are an attempt to move away from categorical services housed within separate silos to holistically help families across agency and program boundaries. Systems of care contend that all life domains and needs should be considered rather than addressing mental health treatment needs in isolation and so are organized around 8 overlapping dimensions—mental health services, social services, educational services, health services, substance abuse services, vocational services, recreational services, and operational services (Pires, 2002). Systems of care have expanded from the initial concern with children with serious emotional challenges and are now being applied to children and families involved with multiple agencies, including juvenile justice and the child welfare system. Increasingly, there is a focus on all eligible children in a jurisdiction who depend on public systems for behavioral health services.

Wraparound

Wraparound is a particular planning process that grew out of systems of care. In it, a team of family members, natural supports, and professional helpers come together in a facilitated process to create, implement, and monitor an individualized plan to help a child (VanDenBerg, Bruns, & Burchard, 2003). Services are "wrapped around" the child and family in their natural environments. The planning process is based on the strengths and culture of the youth and their family, is community based (using a mix of formal and informal supports), is driven by the needs of the family rather than by the services that are

available or reimbursable, and is culturally relevant, flexible, and coordinated across agencies. A core hypothesis driving wraparound is that if the needs of a youth and family are met, it is likely that they will have a good (or at least improved) life. Toward this end, wraparound teams often have flexible funding to try to help address particular needs in creative ways based on “out of the box” thinking (e.g., helping a child access art or dance classes or helping an isolated mother join a local quilting group).

Wraparound began more as a framework than a specific model or approach. It emphasized the importance of flexible adaptations to fit local contexts. However, out of concerns that it was being diluted, a group of wraparound leaders created the National Wraparound Initiative to bring experts in the field together to more clearly articulate the core principles of wraparound and identify four distinct phases (engagement and team preparation, initial plan development, implementation, and transition) with major goals and activities for each phase (Walker et al., 2004). Fidelity measures were developed in an attempt to maintain rigor, but in a rather revolutionary way focused on assessing fidelity to overall principles rather than to a particular model (Bruns, 2008).

Wraparound has been an attempt to put families in a leadership role of the help they receive. The family drives care planning by determining an overall vision of how they will know when things are better; who should be on the team (unless custody lies with child welfare, in which case child welfare must have a place at the table); identifying goals and desired outcomes of services regarding specific needs; evaluating the effectiveness of services; and having a meaningful role in all decisions, including those that impact funding of services. Family traditions, values, and heritage are seen as sources of great strength and natural supports such as extended family members, friends, neighbors, members of faith communities, contacts at daycare, school, camp or in the community are actively involved in order to find normalizing and sustainable resources that will help children and families move forward in their lives long after professional involvement comes to an end.

Empowering families and youth as drivers of the team process provides them an experience of “voice and choice” in which their goals, preferences, needs, and strengths guide all efforts. The personal expertise the family has about itself and its community is viewed as equally important to the expertise that professionals on the team have about their respective disciplines and agencies. Full inclusion of the youth and family as partners in the team process is expressed by the core concept “nothing about us without us.” This phrase means that no decisions are made about care plans without parent or caregiver participation, but does not preclude communications between team members that do not include the family. Family and youth perspectives are intentionally elicited and prioritized during all phases of the wrap process. Planning is grounded in family members’ perspectives and the team strives to provide options and choices such that the plan reflects family values and preferences. While wraparound is a collaborative process, family members’ perspectives must be the most influential. This comes with recognition that family perspectives are unlikely to be sufficiently impactful unless intentional activity occurs to ensure that their voice and choice drives the process. The stigmatization and blame that families have encountered coupled with power differences in social and educational status and dominant professional and cultural beliefs that professionals are “experts whose role is to ‘fix’ the family” can lead teams to discount rather than prioritize family members’ perspectives during group discussions and decision making. As a result, great care is taken to insure active family influence and participation in the process.

The team is facilitated by a care coordinator or care manager and frequently there is also a paid family partner or family support specialist, who helps support family voice and choice in the planning process. The family partner is a person who has had experience raising a youth with emotional and behavioral challenges and ideally comes from a similar

cultural background as the family. In meetings, the care coordinator and family partner have a primary responsibility to support a “no shame, no blame” atmosphere in which mutual respect is encouraged and recrimination and disrespect between team members is actively discouraged. There is an expectation that the plan is a work in progress and when there are inevitable setbacks, the focus is on revising the plan rather than blaming the “noncompliant” family.

The inclusion of family partners has been invaluable in helping agencies both engage families and rethink taken-for-granted ways of working. Ellen Walnum (2007), a Norwegian woman who has worked in a similar context, refers to this role as an “experience consultant.” Programs that have successfully incorporated family partners or experience consultants have come to realize the significant contribution they can make in bringing experiential knowledge as well as professional knowledge to the table and legitimizing both kinds of knowledges. Family partners have a unique position within the helping system. They have been in a position of being helped and are now a helping professional. Their lived experience helps them engage angry, fearful, or distrustful parents and they can explain to parents how the helping system works. When parents have a better understanding of how the system works, they are in a better position to interact with that system in ways that help them get better help. Family partners also have been extremely helpful in assisting programs to reflect on taken-for-granted practices that may have inadvertent negative effects on youth and families.

Family-Driven Care

Attempts to promote a spirit of “voice and choice” and “nothing about us without us” in helping efforts have been driven both by professional desires to provide more respectful and responsive services and by over 30 major state-level class action suits that have focused on the lack of creative service alternatives for families and the use of overly restrictive residential and institutional placements (VanDenBerg et al., 2003). These suits have resulted in settlements promoting the use of wraparound in a number of states and have forced changes in the flexibility of Medicaid funding for behavioral health needs. In the 1990s, families struggling to find helpful care came together and shared their experiences of feeling disempowered by helpers and blamed for their children’s problems, their sense of being viewed as dysfunctional and excluded from decision making about help for their children, their feeling overwhelmed and isolated by a lack of information and the alphabet soup of acronyms commonly used in professional language. They felt intimidated by unequal power relationships, blamed and disrespected by paid helpers, and unwelcomed and marginalized in professional contexts. Parents were expected to follow treatment directives and families that disagreed with these plans, didn’t understand them, or simply did not have the resources to follow them were often labeled noncompliant, denied services, or determined to be unfit to raise their children (Osher et al., 2011). Consumer groups such as the National Federation of Families for Children’s Mental Health and the National Alliance for the Mentally Ill led the way in developing a continuously evolving definition of family-driven care (Osher, Osher, & Blau, 2006). The most current definition is:

Family-driven means families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory, and nation. This includes: choosing culturally and linguistically competent supports, services, and providers; setting goals; designing, implementing, and evaluating programs; monitoring outcomes; and partnering in funding decisions. (National Federation of Families for Children’s Mental Health, 2008)

There are a lot of misconceptions about what family-driven care really means. As Osher et al. (2011, p. 5) put it:

Much of the training in human psychology and behavioral health adheres to a medical model that places the professional in a position of an expert who has the special knowledge and skills to determine what is wrong with a patient and prescribe the right treatment to cure the problem. It is, therefore, not surprising for professionals to be skeptical and anxious when first introduced to the concept of family-driven care. The image that is likely to come to mind is being run over by a bulldozer. However, once professionals fully understand the intent behind the definition and they experience the benefits of practicing their craft in accordance with the principles of family-driven care, they typically find greater satisfaction with their work and see better outcomes for the children and families with whom they work. Their mental image changes to one of taking a journey together. They see themselves in a car with the family in the driver's seat as they themselves read the maps and guide books, look out for landmarks and hazards, feed the passengers in the back seat, and make suggestions to get safely to the destination.

Family-driven care assigns the primary decision-making role to families in the care of their children (a basic expectation we have of all families). However, the elevation of family voice does not mean the suppression of professional voice. The intent of family-driven care is for families and professionals to equally share both responsibility for making decisions and accountability for the outcomes in a way that puts families on an equal footing with professionals. Decisions cannot be made alone and neither party can refuse to take some responsibility for making changes when things are not going well.

The working definition of family-driven care has also included an evolving set of guiding principles. These include, but are not limited to: providers sharing decision making with families and youth; families being provided complete information to make informed decisions and choices; availability of peer support activities; agency leaders allocating staff, training, and resources to make family-driven care a reality in their organizations; and a focus on cultural and linguistic competence (Caldwell, Kuppinger, Hust, Lambert, & Levy, 2012). The Substance Abuse and Mental Health Services Administration has developed guidelines for how the implementation of family-driven care might be reviewed and evaluated, and federal agencies have incorporated these guidelines into their requirements for programs seeking funding.

The Recovery Movement

The mental health recovery movement is another significant trend in health and human services. It views helping as a process of overcoming the negative impact of a psychiatric disability despite its continued presence with a focus on strengths and skills, hopes and desires, and connections and supports. It encourages a shift from symptom reduction to improvement in functioning, resilience, and adaptation. In 2004, the U.S. Department of Health and Human Services recommended that public mental health organizations adopt a "recovery" orientation to severe and persistent mental illness, including those dually diagnosed with mental health and substance abuse issues. Recovery-oriented models are rapidly expanding across public agencies; a development that will only continue with the rise of Integrated Care, a movement in which health care teams consider all behavioral and physical health conditions at the same time with a focus on individually tailored treatment geared to the whole person. Recovery models represent a significant paradigm shift closely aligned with core values and principles of family-centered services, including a focus on possibilities, collaborative partnerships, and accountability to those served. The U.S. Department of Health and Human Services (2004) has formally defined recovery as a "a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving

to achieve his or her full potential” (p. 2). I think we can extend this definition further and expand the focus from just mental health problems to a broader consideration of challenges that arise at individual, relational, and socio-cultural levels. As healthcare reform begins to sweep through most all health and human service systems, these ideas become more valuable and relevant for more people than ever before.

Family Group Conferencing

Family Group Conferencing (FGC, also known as Family Group Decision Making) is a structured and facilitated process that actively incorporates family members and their extended networks as key participants in crafting and implementing plans to support safety, permanency, and well-being for children in child welfare and juvenile justice systems. It was first legislated in New Zealand in 1989 through the Children, Young Persons, and Their Families Act and since has spread to many jurisdictions around the world. Currently more than 25 states in the U.S. and 30 countries internationally have some form of Family Group Conferencing, although none have adopted it as comprehensively as New Zealand. Family Group Conferencing borrows heavily from decision-making practices of the Maori people in New Zealand—practices that are uncannily congruent with those of indigenous populations in other parts of the world (Doolan, 2013). The New Zealand act uses the generic term “family group” so that families themselves can define this crucial component of identity. The Act also gives families a legal right to have a safe and structured dialogue process aimed at developing consensus around child safety before the state can exercise its powers of compulsion (Doolan, 2006).

The key features of FGC are preparation and planning before the meeting, the meeting itself, and ongoing monitoring and review of the plan following the meeting (Mirsky, 2003). Preparation is designed to ensure that families, their extended networks, social workers, and other invited professionals have a clear understanding of roles and what they’re being asked to do. It is important that family members receive any relevant reports before the meeting so that there are no surprises. Adequate preparation and planning can be the difference between the success and failure of the FGC meetings. The process requires a balance between convening a meeting quickly and insuring broad family representation with a solid understanding of the process. When done well, the planning process helps the remaining stages progress more smoothly. Preparation requirements include ensuring safety for the child during the preparation phase, defining with the family and key stakeholders who should be included in the meeting, building a connection with participants to increase the chances of a transparent, honest, and respectful process, clearly defining and communicating the meeting’s purpose and participants’ roles before, during, and after the meeting, managing unresolved family issues while also communicating that issues unrelated to protecting the child will not be discussed at the meeting, and coordinating all meeting logistics (Merkel-Holguin, 2013).

The meeting itself typically involves many participants and has four stages. The *Introduction* begins in ways that are culturally and traditionally relevant to the family with the coordinator welcoming all participants and reiterating the meeting’s purpose and process in order to reach agreement about the meeting’s goal and each participant’s role. In the *Information-Sharing* stage, the social worker who conducted the investigation straightforwardly and respectfully presents the facts of the situation to all of the participants. Other involved professionals then share related information and family members are given the opportunity to ask questions of clarification. During this stage, there is often an explicit consideration of family strengths, based on the belief that this will contribute to the development of a better plan. In this stage, professionals are encouraged not to state opinions or give recommendations to the family in order to support the family in formulat-

ing their own plan during the next stage of *Private Time*. Strict adherence to the Family Group Conferencing model in this stage requires that both professionals and other non-family members (e.g., neighbors, friends) are asked not to participate in the family meeting, leaving only family members to discuss their situation in private. Private time is important to encourage honest conversations within the family in order to develop a safe and enduring plan. Providing family groups with time to meet on their own to work through the information they've been given and formulate their responses and plans is an empowering process that enables them to apply their knowledge and expertise in a familiar setting and in ways that are consistent with their ethnic and cultural decision-making practices. Often in this stage, professionals remain available for questions and assistance if needed. The final stage of the meeting itself is the *Decision*. Once a family arrives at a decision about how to care for and protect the child, the remaining participants return and the family presents and explains their plan. The plan is evaluated by statutory authorities with respect to safety and legal issues and resources may be sought to help implement the plan. New Zealand law requires that participants come to agreement and provides veto power for parents, guardians, social workers, the coordinator, and the child's lawyer. When agency concerns are adequately addressed, preference is given to a family group's plan over any other possible plan. International data show that families and referring workers accept the plans that have been developed 95% of the time (Merkel-Holguin, Nixon, & Burford, 2003). If there is disagreement with the final decision, dissenting views are presented to family court. It has been found that when family members become more aware of safety issues, they themselves move strongly to protect children from further abusive experiences. In a review of treatment plans developed in Family Group Conferences, 78% of professionals considered the plans successful after 18–24 months—a result orthodox practice might envy (Lupton & Stevens, 1997). Merkel-Holguin et al. (2003), summarizing research about Family Group Conferencing, highlight that it leads to higher satisfaction, better communication, better working relationships, and less conflict among workers and families. Effective plans were developed in a wide range of high-risk cases. Placement duration had been reduced, children were more likely to be placed with extended family rather than in nonfamily care, and, at a fiscal level, there was cost neutrality or savings.

THE HEART OF FAMILY-CENTERED SERVICES

As we look across the various applications of family-centered philosophy and practice, what are the cross-cutting themes? These applications have developed in different contexts, but all hold a shared set of values and principles that could be summarized in the following way (Madsen, 2007; Madsen & Gillespie, 2014):

- Striving for cultural curiosity and honoring family expertise
- Believing in possibilities and eliciting resourcefulness
- Working in partnership and on family turf
- Engaging in empowering practices and making our work accountable to the people we serve

In thinking about helping efforts, it can be useful to draw on a cross-cultural metaphor and think about families and helpers as distinct cultures, each with beliefs and preferred styles of interacting. Helping efforts can then be seen as a cross-cultural negotiation in which families and helpers interact in a mutually influencing relationship. In this interaction, family actions may be more understandable through the family's lens than through the helper's lens. To fully understand family complexity, it is useful to approach each family as a unique microculture and to learn as much as possible about their particular

culture. We can think about entering each family as an anthropologist looking to elicit their meaning rather than assign professional meaning. This endeavor can be supported by entering with a stance of “not knowing” or cultural curiosity.

When we enter a culture, what we look for profoundly shapes what we see. All families have particular competencies and know-how as well as capacities to grow, learn, and change. Our work proceeds quicker and elicits less “resistance” when we focus on what is and could be. A belief in possibilities does not ignore or minimize problems in family life. In fact, viewing families as different from and more than the difficulties in their lives allows us to simultaneously acknowledge the severity of problems and elicit, elaborate, and appreciate family resourcefulness in addressing those problems. In this way, we can maintain a belief in resourcefulness without romanticizing families.

If we believe that families are the experts on their lives and often have more resourcefulness than we realize, our work together can become a collaborative process that draws on the skills and know-how of both parties. The goal is to develop a cooperative relationship in which the family is an active participant. Cooperation is a two-way street, and helpers as well as families can be noncooperative. Since we as helpers hold a leadership position in the relationship, a collaborative relationship begins with us finding ways to cooperate with the people we serve and fit helping efforts to their context rather than expect that they will fit to our traditions and practices.

Finally, helping efforts have effects. Professional actions may contribute to people’s participation and influence in developing the lives they prefer and may disqualify, constrain, or supplant people’s participation and influence in their lives. Despite our best intentions, helpers’ actions may have disempowering effects. One way to avoid inadvertent disempowerment is to make our work accountable to the people we are working with and actively solicit feedback about the effects of our actions. In this way we can become accountable allies working with families rather than experts acting on them.

At this point, I’ll move from a professional description of family-centered services to a personal rendering of some of my own efforts to bring family therapy ideas into frontline practice. Throughout my career, I have been a “boundary spanner” between the down and dirty world of frontline practice and the more esoteric world of postmodern and poststructural family therapy. I believe each arena has a lot to contribute to the other. In the early 1990s, I was hired by an agency providing home-based therapy to help staff develop their family therapy skills. I entered with a certain degree of hubris. I had a lot of family therapy training and experience and believed staff would benefit from that. I soon learned that I would become the student rather than the teacher. While many of the front-line staff were experienced home-based workers, they were not “technically proficient” therapists. They had neither an articulated conceptual framework nor a set of techniques from which to draw. And yet, they were very successful with families who had not responded to previous services. This was puzzling. It challenged much of what I had learned as a family therapist. These folks knew little about family therapy and yet were doing great work with families. How was I to make sense of this? In talking with workers and family members, consistent themes emerged. Workers didn’t see families as some dysfunctional “other.” They described family members as “regular folks” struggling with understandable challenges. While some might describe these workers as naive, they preferred to think of themselves as “experienced optimists.” Family members with whom I spoke repeatedly said things like, “The workers were so respectful. They were the first professionals who really listened to me. They treated my kid like a normal kid, not some mental case. I liked talking to them because no matter how hopeless I felt, they always believed I could do better.”

As I pondered the apparent paradox of staff without formal training doing effective work with families generally considered unreachable, I became convinced that the foundation of clinical effectiveness lies in the attitude or relational stance with which we

approach families. I think this is particularly true with families designated as “difficult.” At its heart, this work is about how we are with people, about the attitude or relational stance with which we approach them, about the ways in which we as helpers position ourselves with those we serve. Although this assertion is a simple and perhaps commonsensical one, I believe it has profound implications and represents a significant change from how much of health and human services currently operate. This assertion is confirmed by the common factors literature which consists of 40 years of studies examining contributions to good outcomes in psychotherapy (Duncan, Miller, Wambold, & Hubble, 2010). There is a consistent finding that forty percent of therapy outcomes are attributable to client factors, referring to what people do in their lives outside of therapy. Thirty percent is attributable to common factors like relationship, empathy, respect, and genuineness. Fifteen percent is attributable to shared hope and expected change (which could also be seen as a relationship factor). And only fifteen percent is attributable to technique, that is, what practitioners do in therapy. This literature suggests some rethinking for how we approach helping. If client factors are the single most powerful contributor to good helping, then it makes sense to find better ways to draw on the resourcefulness of people and communities. If relationship and hope can be considered together as one factor, then relational stance takes center stage. Research on the power of the alliance reflects over a thousand findings and is one of the best predictors of good outcomes (Duncan, Miller, & Sparks, 2004). Research from child welfare replicate these findings, suggesting that the best outcomes for youth and families occur when there are constructive working relationships between workers and families and among collaborating professionals (Cashmore, 2002; MacKinnon, 1998; Thoburn, Lewis, & Shemmings, 1995; Trotter, 2006).

Family-centered services represent not just a shift in *what* services are provided, but *how* services are provided. If we accept the proposition that a key component of effective helping efforts overall lies in a shift in relational positioning from *experts* with specialized knowledge repairing dysfunction to *allies* assisting people to envision and move toward desired lives, we can then evaluate our conceptual models and our helping practices by the ways in which they position us with the people we serve. Figure 1 offers a graphic depiction of that (Madsen & Gillespie, 2014).

Here is where postmodern and poststructural ideas and practices become particularly relevant for family-centered services. Postmodern/poststructural approaches embody the same shift in relational positioning that family-centered services has called for. I believe that there is a natural affinity and useful fit between the heart of family-centered services and postmodern/poststructural ideas and practices.

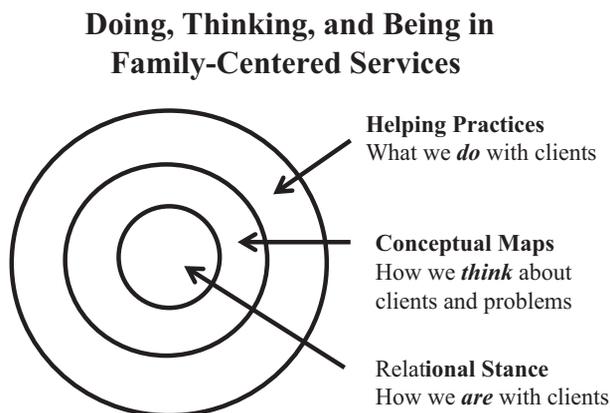


FIGURE 1. Relational Stance as the Heart of Family-Centered Services.

FAMILY THERAPY CONTRIBUTIONS TO FAMILY-CENTERED PRACTICE—A CAUTIONARY NOTE

In a follow up to the original examination of family therapy in community mental health (discussed at the beginning of this article), Ellen Pulleyblank Coffey (2004) studied a number of innovative family-centered programs. She noted important accomplishments at a macroprogrammatic level and raised concerns at a micro level that less attention had been paid to the actual conversations between helpers and families. She found that workers were often operating without a clear framework to guide their work and important contributions from family therapy about building resilience, engaging families, sustaining working relationships, and hosting therapeutic conversations were not being utilized. There have been a number of efforts to bring different family therapy approaches into home-based and family-centered services (e.g., Berg, 1994; Berg & Kelly, 2000; Boyd-Franklin & Bry, 2000; Christensen, Todahl, & Barrett, 1999; Gehart, 2012a,b; Henggeler, Cunningham, Schoenwald, & Borduin, 2009, Henggeler, Schoenwald, Rowland & Cunningham, 2002; Madsen, 1999, 2007, 2009, 2011, 2014; Madsen & Gillespie, 2014; Minuchin, Colapinto, & Minuchin, 2006; Parker, 2014; Root & Madsen, 2013; Swartz, 2004; Turnell, 2010; Turnell & Edwards, 1999; Turnell & Essex, 2006). Here, I will focus in particular on postmodern/poststructural contributions.

Many frontline workers in family-centered services explicitly claim that they are not therapists. For example, wraparound adamantly maintains that it is not therapy. A number of frontline workers, who find themselves near the bottom of the professional class system, often embrace an antitherapy stance (e.g., Therapy literature is not relevant for me because I don't do that "therapisty stuff."). In that context, it is very important for family therapy teachers not to teach "family therapy" to family-centered workers nor take on a role of developing them as family therapists. That effort runs the risk of coming across as colonizing and provoking the same response most commonly engendered by colonial efforts (political resistance that is often mistaken as psychological resistance). We can utilize family-centered values and principles to guide training and consultation efforts, positioning ourselves in what Michael White (1997, 2007) described as a decentered, but influential position. From this position, we can elicit, elaborate, and acknowledge existing best practices and then build on them by (tentatively) offering ideas and practices that participants may find helpful. In this way, we are honoring both learned experience (accumulated family therapy knowledge) and lived experience (the knowledge gained by frontline workers in the course of doing their work on an everyday basis). While both types of knowledge are important, the latter is often sidelined with an emphasis on the former. However, lived experience has much to contribute to our collective knowledge base. As Paolo Freire (1981) put it, "You learn to swim in the water not in the library." Family-centered practice is grounded in a stance of cultural curiosity, a belief in family resourcefulness, a preference to partnership, and a commitment to accountability to those we serve. Family therapy efforts to contribute to family-centered services can benefit from adherence to the same guiding principles. With this in mind, I want to humbly offer some specific ways in which postmodern/poststructural approaches within family therapy might contribute to the development of enhanced family-centered practice.

POSTMODERN/POSTSTRUCTURAL CONTRIBUTIONS TO FAMILY-CENTERED PRACTICE

While a spirit of respect, connection, curiosity, and hope is at the heart of both family-centered and postmodern/poststructural practice, it does not work to simply exhort

workers to ground their work in the values and principles of culturally responsive, strength-based, collaborative, and accountable practice. That call is too big, too vague, and likely to produce a response of “Yeah sure, whatever. . .” However, postmodern and post-structural approaches offer a set of ideas and practices that can help workers embody the spirit of these values and principles in their daily work. Let’s look at a number of these, beginning with the usefulness of a story metaphor to help explain why relational stance is such a powerful “intervention.”

The Usefulness of a Story Metaphor

Life is complicated and filled with way too many events for us to be able to hold them all in our consciousness. As a result, we organize our lives through stories to provide a framework for making sense of the world. A story line consists of events in a sequence across time organized according to a theme or plot (Morgan, 2000). At any point, there are multiple stories of identity available to us and no single story can adequately capture the broad range of all our experiences. As a result, there are always events that fall outside any single story. However, over time, particular life stories are drawn upon as an organizing framework and become the dominant story that gets told about who we are, what is important to us, and of what we are capable. These life stories make our world coherent and understandable. At the same time, in the words of Michael White and David Epston (1990, p. 11), life stories “prune from experience” those events that do not fit within them. Life stories shape our experience of life by promoting selective attention to some experiences and selective inattention to others. The stories of our lives are not simply our own. They are received from and embedded in family of origin and broader cultural stories that organize our sense of self and our relation to the world. In addition, these are not just stories that are held, but stories that are enacted in our interactions with others. In that way, interactions between helpers and families have the potential to invite people to live out particular life stories. These stories have profound effects on people’s experience of life and their sense of self in the process. Here is an example of that from a story told by Margie, a woman who sought many different kinds of help over the years (Madsen & Gillespie, 2014):

I used to have this wizard of a therapist who I met with multiple times a week for many years. He was brilliant and I probably wouldn’t be alive today if it wasn’t for him. I felt like he did great work, given the material he had to work with (me). After our meetings, I would come out aware of how broken I was and how lucky I was to have him to help me. More recently, I’ve been meeting with my outreach worker and she’s pretty good; not as smart as that therapist, but I have to say it has never occurred to me when I walk away from those meetings that I’m broken. I come away feeling strong and confident and believe I can take on my life and that feeling has been incredibly helpful.

Margie experienced herself in very different ways in her interactions with the wizard of a therapist and her “ordinary” outreach worker. While she talked about similar issues with both helpers, she came away from one feeling broken and from the other feeling strong and confident. From a postmodern/poststructural perspective, Margie’s sense of self is not a fixed identity to be discovered, but rather something that evolves and changes in the course of interacting with others. In this instance, Margie’s interaction with the second helper invited an experience of feeling stronger and more confident and helped to construct a different identity that is likely to carry her farther in life than an identity of being broken and in need of repair by an expert in the field. Helping interactions have powerful effects on how people see themselves. They shape the experience of helping and can open or close possibilities in life. In this way, relational connection is both a foundation for effective helping and a powerful “intervention” in its own right.

Definitional Ceremonies

Narrative approaches have drawn from cultural anthropologist Barbara Meyerhoff's (1982, 1986) use of the phrase "definitional ceremonies" to develop some interesting witnessing practices (Russell & Carey, 2004; White, 1995, 2000). Without going into the details of Meyerhoff's work, I want to extend the phrase "definitional ceremony" to a way of thinking about every interaction we as helpers have with the people we serve. White (2007, p. 165) has framed definitional ceremonies as:

Rituals that acknowledge and 'regrade' people's lives, in contrast to many rituals of contemporary culture that judge and degrade people's lives. In many of the degrading rituals, peoples' lives are measured against socially constructed norms, and they are judged to be inadequate, incompetent, disordered, and often a failure in terms of their identities.

The notion of definitional ceremonies can organize our thinking about every interaction with the people we serve. Each time we meet with someone, we are offering them the opportunity to live out a story that shapes their life. The ways in which we structure our interactions with them have the potential to elicit stories that will regrade and lift them up, or unintentionally degrade and drag them down. We can organize formal and informal contacts with people as "definitional ceremonies" with an eye toward questions such as, "What might be people's experience of this interaction? How might they experience themselves in it? And, what can we do to enhance the possibility that they will have an experience that carries them forward rather than limits them?" Our work can be organized by thinking about every helping interaction as a definitional ceremony that can open possibilities for the emergence of new identities.

Here are two examples of this process in helping work. An outreach worker working with a teenager struggling with impulsivity takes him to a pool hall and teaches him how to think several shots ahead, shooting the cue ball not only with the intention of knocking a ball in, but also lining up the cue ball for his next shot. He then moves to helping the boy think two shots ahead. Rather than talking about the boy's impulsivity, he is helping him enact planfulness. Similarly, a worker driving a mother to a school meeting has a conversation with her about how she would like to respond to others in the upcoming meeting, helps her think through how she might do that, and sees the meeting as an opportunity to enact a different narrative and way of being in life. On the drive back after the meeting, the worker finds ways to acknowledge how the mother was different in the meeting with a goal of supporting her in living out a different life story.

Walking and Talking

Clinical work and case management have traditionally been seen as quite distinct. This distinction reflects the class system of health and human services that elevates the efforts of some and obscures the good work of others. How do we strike a balance between acknowledging that much of family-centered services is not therapy and yet is profoundly therapeutic? One contribution to this effort comes from reframing this distinction as one between "sitting and talking" and "walking and talking" (Madsen & Gillespie, 2014). Historically, talk therapy has consisted of a series of scheduled appointments where clients come to an office to talk with an expert therapist. In individual therapy, they are provided with a compassionate space where they can express themselves, work through issues, and develop insight into inner conflicts. This could be described as "sitting and talking" and has a long history of being valued and helpful. Family therapy has shifted this significantly with an emphasis on setting up enactments that invite a different experience, reframing that offers a different take on existing situations, or questions that open up new possibilities. However, across these different approaches, the work occurs within the

professional's office. In contrast, case management in family-centered services is often seen as a process where helpers link clients with services and assist with practical aspects of life. Helping efforts are often divided into these two categories of doing therapy or providing case management. The metaphor of "walking and talking" offers a way to transcend this traditional dichotomy by capturing a way of working that combines practical assistance with purposeful conversation. In this endeavor, workers journey alongside the people they serve to help with routine needs, ongoing problems, and difficult life dilemmas. Practical helping combined with purposeful conversation can work best when organized around the stories that shape people's experience of their lives. Within this frame, the work is not about "sitting and talking" with people, but "walking and talking" alongside them in ways that open up opportunities for them to experience themselves differently and change their life stories. The combination of using a story metaphor, viewing helping interactions as definitional ceremonies, and reframing family-centered services as a process of walking and talking has the potential to enhance family-centered services in significant ways. This combination encourages a consciousness about the ways in which every helping interaction holds the potential to invite the enactment of particular life stories. Something as simple as playing pool or giving a person a ride can become life changing. These everyday interactions hold the potential with purposeful intention to become transformative moments. It requires a shift in thinking from "I'm just providing transportation" to "I'm helping to change lives." That might be a bit intimidating or quite exciting. Clearly, this requires a thoughtful focus with significant support, but if we are willing to invest in that support, astonishing things can happen.

The Crucial Importance of Vision

Helping efforts have often begun with questions of "What is the problem and what caused it?" or "What is the problem and what maintains it?" While these are common approaches, there is a danger that beginning with an examination of the problem draws us further into it. As Cooperrider (2000) has suggested, what we give attention to grows. With that in mind, we can shift our initial focus to an organizing question of "What might be a future with fewer problems and what constrains us from getting there?" Appreciative inquiry and solution-focused approaches offer a number of ways to organize our work around visions of possible futures (Berg, 1994; Cooperrider, Sorenson, Whitney, & Yaeger, 2000; de Shazer, 1985, 1988; Durrant, 1993). A focus on possibilities (what life could look like rather than what is wrong) can lift people out of the immediacy of problems and provide a better foundation for responding to challenges. Eliciting a vision of possibilities implicitly conveys that alternatives are possible and, when traced out in detail, provides clues about the path to get there. Such a vision also becomes a way to collaboratively develop goals. As helpers, we often hold models in our head about how families should function, which are inevitably influenced by our own values. If we begin by helping families develop a vision of preferred directions in life, that vision can guide helping efforts. In this way, the development of envisioned possibilities enhances collaboration and keeps our work focused and accountable to the people we serve.

The development of a proactive vision can be a process of eliciting hopes for the future (e.g., "What kind of person do you hope your son will be when he grows up? What about your dreams for him are important to you? How would you like to be in your own life to help your hopes for him come true?"). It can also be used to focus on preferred ways of coping in a difficult present (e.g., "As your son continues to struggle with substances, how would you rather respond to him? How would you describe the stance you'd like to hold in this situation? What could help you stay grounded in that stance regardless of any surprises this situation might throw at all of you?"). In this way, the development of a

proactive vision acknowledges problems in life and focuses on preferred ways of being in the face of difficulties. A focus on possibilities does not ignore problems, but comes at them from outside their immediacy. This actually saves time and makes for more effective work.

Here's an example of the usefulness of beginning with vision in a family-centered approach to child welfare. Beth Root is an experienced child protective services (CPS) worker trained in narrative and solution-focused approaches. After building a strong relationship with families and clarifying the concerns that bring her to be involved in their life, she will often ask versions of the following generic question (Root & Madsen, 2013):

Twenty years from now, what is the story you'd hope your kids would tell about their childhood and your role in it as their parent?

The actual questions are adapted to the particularities of the situation and framed in a way that makes them easier to consider. The answers to these questions are usually totally incongruent with the problems that bring families into contact with CPS and provide a solid foundation for examining the discrepancy between parents' best hopes for their children and their parenting and the effects of current parenting actions. When asked about the story they would hope their children would hold about their upbringing, caregivers typically relate some version of "I hope my child would say their childhood was safe, stable, and happy." This is a caregiver's version, in their own language, of the federal mandate of working toward safety, permanency, and well-being. Pursuing a goal that caregivers have articulated is a much more efficient and effective course of action. Beth will often type up a summary of the parents' vision statement on an index card, have it laminated, and give it to them. She'll then follow up by asking them in depth about what makes that vision important to them, how they have been putting pieces of it into action and who can they find to support them in moving toward that vision. This provides a respectful foundation from which to raise questions about problems that pull caregivers away from those better intentions.

New Ways of Thinking and Talking about Problems

Another notion that has the potential to revolutionize family-centered services is the practice of externalizing from narrative therapy in which we move from viewing people as *having or being* a problem (e.g., I have a depressive disorder or I am depressed) to being *in a relationship* with a problem (e.g., Depression is this thing that has influenced in my life and taken quite a toll on me and I also have some influence on the life of this thing Depression). While externalizing has often been seen as a useful intervention for families, I think it is actually more useful as a corrective way of thinking for professionals. Thinking about people as separate from and more than the sum of problems in their lives places helpers in a different relationship with the people we are trying to help. Here is an example of that from child protective services. We can move from thinking about the job of CPS as protecting children from maltreating parents to partnering with parents to protect their children from problems (e.g., frustration, stress, substance misuse) that pull parents away from their better judgment and parenting practices. This simple shift radically repositions workers in their interactions with families and has great potential to minimize shame and blame and to maximize engagement. When people experience themselves as *being in a relationship with* a problem rather than *having or being* a problem, they often experience a sense of relief and an increased ability to do something about the problem. Externalizing creates a space between people and problems that enables people to draw on previously obscured abilities, skills, and know-how to revise their relationships with the problem.

Externalizing also provides a way to untangle the tight knot of blame and responsibility. While our field (and popular culture) has historically sought to get people to "own the

problem” and take responsibility for it, externalizing creates a separation that blames the problem for its effects while helping people take responsibility for their responses to those effects. When this is done thoughtfully and meticulously, it allows us to acknowledge and honor parents’ Vision and ask questions that help them identify externalized problems that can pull them away from being the parents they’d prefer to be. This is very much in line with motivational interviewing’s focus on examining discrepancies between people’s hopes, best intentions, and preferred view of self and the actual effects of their actions (Miller & Rollnick, 2013). This allows us to say, “You’ve said this is important to you and this is an obstacle that gets in the way of that. Given the importance of this Vision to you, what do you want to do about that obstacle?”

Finally, externalizing can help workers develop a more compassionate and connected view of people who engage in off-putting behaviors. For example, when we think of a particular person as being captured by emotions such as rage or hurt or frustration rather than as being rageful or histrionic or frustrating, we may have a more empathic response to them. We can become annoyed with the emotional response and its effects on the person served and those helpers that are involved rather than becoming annoyed with the person or feeling ineffective as helpers. This can be particularly helpful in situations in which both parties are overextended and undersupported.

New Ways of Thinking and Talking about Strengths

In family-centered services, there is a strong emphasis on building on strengths. For example, wraparound usually begins with a strengths and culture discovery to elicit youth and family resourcefulness that can be brought to bear in addressing problems. However, beginning with strengths as a stand-alone entity can lead to a description of strengths that may seem nice (e.g., she’s a good basketball player, he’s artistic), but irrelevant (So what? What has that got to do with these serious problems we’re concerned about?). This can contribute to an unfortunate stereotype of strengths-based practitioners as starry-eyed optimists viewing the world through rose-colored lenses. If we begin by eliciting a vision of hopes and possibilities (e.g., I hope my daughter can make a good transition to a new school or I wish my son could express his anger differently), then we can identify strengths (basketball skills, artistic talents) that can contribute to that vision.

In addition, narrative therapy offers some interesting ways to enrich our conversations about “strengths.” We can move from viewing strengths as characteristics (something a person is) to viewing strengths as practices (something a person does). This shift can lead to richer conversations about strengths, and assist people in cultivating and further developing them. We can begin these conversations by turning adjectives (e.g., I’m a *determined* person) into nouns (e.g., *Determination* has helped me weather a difficult time) and then further turning these externalized nouns into active verb processes. Here are some sample generic questions to help us accomplish that:

- Can you tell me more about this Determination?
- If Determination was not a quality that you have, but something you do, how do you do that? For you, what are the practices of Determination?
- How did you develop those practices? Who and what contributed to the development of those practices?
- What makes that important to you?

From there we can inquire about intentions, values and beliefs, hopes and dreams, and commitments in life that might stand behind these practices. Here are some samples of that:

- When you were doing this Determination, what was your intention? What were you trying to accomplish? What was your purpose in doing that?
- As you think about those intentions, what values and beliefs might sit behind them?
- When you think of those values, what hopes or dreams might they reflect?
- What might those hopes and dreams say about what you are committed to or what you stand for in your life?

This progression of questions was developed by Michael White (2007) and helps us engage in very meaningful conversations about strengths in a short period of time. This particular progression (intentions > values and beliefs > hopes and dreams > commitments in life) is very deliberate. Each set of questions sets the stage for subsequent questions and encourages small steps that support people's ability to consider and respond to these questions. At the same time, this flow represents an overall guideline. They are principles to guide a conversation, not a recipe to be simply followed.

From here, we can further embed the practices of strengths by developing a community of support for them. Here are some sample generic questions for that related to Determination:

- As you think back across your life, who do you think might particularly appreciate your pursuit of Determination in the face of hard times?
- How have those people contributed to your development of Determination?
- If they could witness you putting Determination into practice, what might that tell them about you?
- What's it like for you to be thinking and talking about them right now? Would you like to bring their presence more into your life? If so, what could help you do that?

This guideline as a way of talking about strengths represents a significant shift from how our field has traditionally conceptualized strengths, but once that overall shift has been made, the questions flow pretty smoothly.

The Power of Inquiry

These different ways of thinking about problems and strengths lead to a number of questions that helpers might ask people. Postmodern/poststructural approaches are very much grounded in inquiry. At times, frontline workers in family-centered services who are lacking a clear framework to guide their work can fall into offering suggestions or guidance. However, simple advice is not all that helpful. Research shows its effectiveness is very limited—only 5–10% of people who are offered simple advice, change (Sobell, 2013). With this in mind, we can shift our view of helpfulness from offering useful answers to asking thought-provoking questions. This shift also alters our view of professional expertise. I would like to suggest that postmodern/poststructural helpers are indeed “experts,” but our expertise is in inquiry—we ask really good questions, questions that transform lives. In this way, our expertise shifts from *content* expertise of how people should live their lives (corrective instruction), to *process* expertise of asking questions that help people envision and develop preferred lives (facilitative inquiry). In this vein, Karl Tomm (1988) draws a distinction between *orienting questions* (questions asked about problems, behaviors, or experiences to orient the helper to the situation) and *influencing questions* (questions asked with the intention of influencing people to change their thinking, feeling, or behavior). In his consideration of influencing questions, he further distinguishes between questions that have a *corrective intent* and a *facilitative intent*. Corrective questions often contain embedded suggestions to get a person to change (e.g., Why don't you set limits on

your son rather than giving into him? If you were to use a different tone with your daughter, do you think she might respond differently? Can you see that withdrawing when your partner gets upset just makes things worse?). These are essentially instructions dressed up to look like questions. The helper comes to the conclusion that something is wrong and uses questions to try to get people to change (to think, feel, or behave in more “correct” ways).

Facilitative questions do not attempt to lead or direct, but can open space for people to connect with their resourcefulness for a better life of their own making. These questions might sound something like this: “When you’ve had problems with your son in the past, were there times when things turned out better than expected? What was different then? What was your son doing differently? What were you doing differently? What helped that to happen? What of that might be useful here?” Both corrective and facilitative questioning often intend some kind of change. But the first specifies direction while the second opens space for more self-guided change with specifics that cannot be determined by a helper ahead of time. A study of the effects of inquiry found that facilitative questions contributed to a stronger therapeutic alliance, increased cooperation, and decreased “resistance” (Ryan & Carr, 2001). With this in mind, we can view helping efforts in family-centered services as a process of asking thoughtful questions to help families think their way through complex situations. Training frontline workers in the art and skill of inquiry requires attention to the magnitude of this shift, but can be accomplished once this overall shift in orientation is made.

My own recent work has focused on developing an inquiry-based practice framework for family-centered efforts across many different contexts (Madsen, 2009, 2011, 2014; Madsen & Gillespie, 2014; Root & Madsen, 2013). This is an attempt to offer a simple map that can help frontline workers, supervisors, and administrators think their way through complex situations as well as provide a structure to guide constructive conversations at a clinical, supervisory, or organizational level about challenging issues. The framework is organized around four areas of inquiry as depicted in Figure 2.

In this way, we can begin by getting to know families outside of the problems that bring us to be involved with them and then from that foundation work with them to envision desired futures or preferred ways of coping in a challenging present. From there, we can identify obstacles to and supports for that vision, and develop a concrete plan to draw on supports to address obstacles to get to the vision of preferred directions in life. Viewing both obstacles and supports as externalized entities allows us to examine the relationship between people and problems as well as between people and strengths in order to find ways to *separate* people from problems or obstacles and *connect* people to strengths or supports. This holds the potential to serve as an organizational framework for ongoing helping interactions as well as formal meetings like wraparound or family group conferencing.

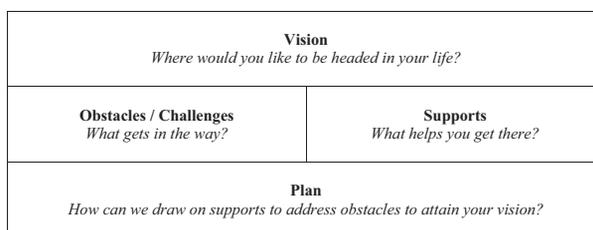


FIGURE 2. Collaborative Helping Map.

SUMMARY

Family-centered services is an area that has been growing and will continue to grow. It represents a shift in *how* helping efforts are undertaken. Family therapy, particularly postmodern/poststructural approaches, has much to contribute and much to learn. A training and consultation approach based in inquiry and shared learning may be the most efficient and effective (as well as the most rewarding) way of approaching this endeavor. If family-centered services are grounded in a spirit of respect, connection, curiosity, and hope, we can view these qualities as practices that can be cultivated and further developed. This focus on the practices of family-centered values and principles opens up the possibility of learning about the ways in which frontline workers are already implementing their best practices, how they developed those practices, and the intentions, values and beliefs, hopes and dreams, and commitments in life that stand behind those practices. Such an investigation can be powerfully acknowledging and transformative and provides a solid foundation to subsequently (and with humility) offer ideas and practices that may help them further extend their existing best practices to cultivate the spirit of this way of working. In this way, ideas and practices such as a story metaphor, definitional ceremonies, walking and talking, vision, re-thinking problems and strengths, and inquiry hold the potential to help the practice of family-centered services rise to a new level based on an appreciation of the level that is already present.

While the focus here has been on the contribution of family therapy to family-centered services, we must also appreciate the myriad ways in which family-centered services might contribute to family therapy. In frontline practice, collaboration is not some esoteric idea, but a basic survival strategy. Meeting clients in their homes or on their own turf shifts the terrain of the work in significant ways. In that context, workers move from expert hosts to humble visitors. While this shift in positioning fits with a postmodern/post-structural turn, family therapy trainers and consultants in this realm have much to learn from frontline practitioners who are putting this into daily practice about the intricacies of how they do that and how we might best support them in that process. In this way, the interface between family therapy and family-centered services holds the potential to be a mutually beneficial adventure.

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