THE UNIVERSITY OF TENNESSEE
COLLEGE OF SOCIAL WORK

SW 503 - FOUNDATIONS OF SOCIAL WORK PRACTICE II
Course Outline
Spring 2004

Dr. Johnson [office phone/with voice mail: 901-448-4460]
Email: tjohns38@utk.edu
Office hours: Monday: 5:00 pm -6:00pm
Tuesday: 12:00pm-1:00pm
And by appointment

Required ****Readings**: Electronic Reserves at UTK Library: www.lib.utk.edu

Continued texts from SW 501 Foundations of Practice I:
Hepworth, Rooney and Larsen. Direct Social Work Practice.
Lowenberg & Dolgoff. Ethical Decisions for Social Work Practice.

Course Grade Point Distribution	Point Assignment distribution	
95-100 = A	Assign. #1	20
89-94 = B+	Assign. #2	25
83-88 = B	Assign. #3	15
77-82 = C+	Assign. #4	20
71-76 = C	Preparedness &	
70 & below = F	participation	20
		100 points

Evaluation policies and Grading Criteria for ALL course work:

1. Written work must be completed and submitted on time; permission to submit a paper later than its official due date must be obtained from the instructor PRIOR to one (1) hour before the assignment is due; papers submitted late without prior permission will not be accepted.
2. Assignments must follow the format given in the assignment description/outline.
3. Assignments must demonstrate the ability to integrate theories, concepts and practice approaches/interventions as requested in the description(s) of assignment(s)
4. All written assignments must be identified by Social Security Numbers ONLY---NO NAMES.
5. Spelling errors, syntactical errors or verb tense errors in written out-of-class assignments: ONE (1) point will be deducted for each.
6. Attendance and participation evidencing preparedness for class discussions & activities is expected.

Course Session Schedule & Assigned Readings**

Social Work with Families

Session 1 & 2 & 3 **Weeks of Jan. 13th & 27th & Feb. 3rd**

Topics: Overview of course: Learning expectations
Family-centered social work practice from a generalist perspective
Ethical dilemmas in work with families

Readings:

**Abramson, M. (1996). Reflections on knowing oneself ethically: Toward a working framework for social work practice. Families in Society: The Journal of Contemporary Social Work, 77(4), 195-202.

**Gelman, S., Pollack, D., & Weiner, M. (1999). Confidentiality of social work records in the computer age. Social Work, 44(3), 243-252.

**Hartman, A., & Laird, J. (1983). Assessment in time: The intergenerational assessment. In Family-centered Social Work Practice, A. Hartman & J. Laird (pp. 211-230). New York: The Free Press.

** Hartman, A., & Laird, J. (1998). Moral and ethical issues in working with lesbians and gay men. Families-in-Society: The Journal of Contemporary Social Work, 79(3): 263-276.

**McPhatter, A. (1991). Assessment revisited: A comprehensive approach to understanding family dynamics. Families in Society: The Journal of Contemporary Social Work, 72(1), 11-22.

**Milstein, K. (2000). Confidentiality in direct social work practice: Inevitable challenges and ethical dilemmas. Families in Society: The Journal of Contemporary Social Work, 81(3), 270-282.

** Reamer, F. (1997). Managing ethics under managed care. Families in Society: The Journal of Contemporary Social Work, 78(1), 96-101.

Resources (included in this outline):
Characteristics of Systems
Concepts of Family-centered Social Work Practice
Emotional Tasks of Family Development
Family Lifespan Development
Ethical Dilemmas in Family-centered Practice

Video: Going Home

Session 4 **Week of Feb. 10th**

Topic: Assessing the family system and its ecological context

Assignment #1 DUE by noon Thursday, Feb. 13th

Readings:

** DeJong, P., & Miller, S. (1995). How to interview for client strengths. Social Work, 40(6), 729-736.

**Devore, W., & Schlesinger, G. (1999). Ethnic-sensitive practice with families. In Ethnic Sensitive Social Work Practice, W. Devorse & G. Schlesinger (pp. 243-260). Boston, MA: Allyn & Bacon.

**Early, T., & GlenMaye, L. (2000). Valuing families: Social work practice from a strengths perspective. Social Work, 45(2), 118-130.

**Laird, J. (1996). Family-centered practice with lesbian and gay families. Families-in-Society: The Journal of Contemporary Social Work, 77(9), 559-72.

**Gant, L., & Gutierrez, L. (1996). Effects of culturally sophisticated agencies on Latino Social Workers. Social Work, 41(6), 624-631.

**Hartman, A., & Laird, J. (1983). The family in space: Ecological assessment. In Family-centered Social Work Practice, A. Hartman & J. Laird (pp. 157-186). New York: The Free Press.

**Keigher. (1997). America's most cruel xenophobia. Health and Social Work, 22(3), 232-237

**McPhatter, A. (1991). Assessment revisited: A comprehensive approach to understanding family dynamics. Families in Society: The Journal of Contemporary Social Work, 72(1),11-22.

**Morrow, D. 2000. Coming out to families: Guidelines for intervention with gay and lesbian clients. Journal Family Social Work, 5(2), 53-66.

**Swigonski, M. E. (1996). Challenging privilege through Africentric social work practice. Social Work, 41, 153-161.

**Weaver. (1999). Indigenous people and the social work profession: Defining culturally competent services. Social Work, 44(3), 217-225.

Handouts: Transgenerational family mapping
Activity: The worker's family of origin and the use of self
Video: Love and Work: One Woman's Study of her Family of Origin

Session 5 & 6 & 7 Weeks of Feb. 17th, 24th & March 3rd

Topic: Transgenerational family assessment
Cultural assessment of families
Intervening with families

Readings:

**Al-Krenawi, A., & Graham, J. (2000). Culturally sensitive social work practice with Arab clients in mental health settings. Health and Social Work, 25(1), 9-22.

**Alter, C. & Egan, M. (1997). Logic modeling: A tool for teaching critical thinking in social work practice. Journal of Social Work Education, 33(l), 85-102.

**Cnaan, R., & Bodie, S. Charitable choice and faith-based welfare: A call for social work. Social Work, 47(3), 224-235.

**Congress, E. (1994). The use of culturagrams to assess and empower culturally diverse families. Families in Society: The Journal of Contemporary Social Work, 75(9), 531-540

**Dosser, D., Smith, A., Markowski, E., & Cain, H. (2001). Including families' spiritual beliefs and their faith communities in systems of care. Journal of Family Social Work, 5(3), 63-78.

**Hall, R. (2002). Biracial sensitive practice: Expanding social services to an invisible population. Journal of Human Behavior, 5(2), 29-44.

**Hartman, A., & Laird, J. (1983). The family unit as a resource and target of change. In Family-centered Social Work Practice, A. Hartman & J. Laird (pp. 305-325). New York: The Free Press.

**Kellar, J., & McDade, K. (1997). Cultural diversity and help-seeking behavior: Sources of help and obstacles to support for parents. Journal of Multicultural Social Work, 5(1/2), 63-78.

**Mayo, Y. Machismo, fatherhood and the Latino family: Understanding the concept. (1997). Journal of Multicultural Social Work, 5, 49-61.

**Pellebon, D., & Anderson, S. (1999). Understanding the life issues of spiritually-based clients. Families in Society: The Journal of Contemporary Social Work, 80(3), 229-238.

**Voss, R., Douville, V., Solder, A., & Twiss, G. (1999). Tribal and Shamanic-based social work practice: A Lakota perspective. Social Work, 44(3), 228-241.

Handouts: Logic Modeling: Assessment and Goal Statements
Activity: Dorothy Miller: 3 perspectives, 3 assessments, and 3 results (included in this outline)
Part 1: Assignment #2: application of theory/concept>>interventions

Session 8 & 9 **Weeks of March 10th & 24th** **[week of March 17th – Break]**
Assignment #2 DUE by Wednesday, March 12th @ 12:00pm
Topics: Empowerment practice & the Strengths perspective
Ethical conflicts: Client vs. agency/managed care needs (included in this outline)

Readings:

**Baines, D. (1998). Feminist social work in the inner city: The challenges of race, class, and gender. Affilia, 12(3), 297-317.

**Carter, C. (1997). Using African-centered principles in family-preservation services. Families in Society: The Journal of Contemporary Social Work, 78(5), 531-538.

**Castex, G. (1994). Providing services to Hispanic/Latino populations: Profiles in diversity. Social Work, 39(3), 288-296.

**Congress. E.P. (2000). What social workers should know about ethics: Understanding and resolving practice dilemmas. Advances in Social Work, 1(1), 1-27.

**Davidson, J., & Davidson, T. (1996). Confidentiality and managed care: Ethical and legal concerns. Health and Social Work, 21(3), 208-215.

**Furstenberg, A., & Rounds, K. (1995). Self-efficacy as a target for social work intervention. Families in Society: The Journal of Contemporary Social Work, 76(10), 587-595.

**Reamer, F. (1997). Managing ethics under managed care. Families in Society: The Journal of Contemporary Social Work, 78(1), 96-101.

**Ronneau, J., & Poertner, J. (1993). Identification and use of strengths: A family system approach. Children Today, 22(2), 20-23.

Activity: Logic Modeling: Objectives and methods
Family and Ecological mapping combined as an assessment tool
Video: Practice with Black Families - Nancy Boyd-Franklin (Parts 1 & 2)

Social work with groups

Sessions 10 & 11 Weeks of March 31st & April 7th
Assignment #3 DUE by 12:00pm on Friday, April 11th
Topic: Group work: Supportive, psycho-educational and task-centered groups
Readings:
Hepworth, Rooney, Larsen. Ch. 17: Intervention in Social Work Groups
Dolgoff & Lowenstein. Ch. 18: The Professional Relationship: Limits, dilemmas & problems
**Gambrill, E. (1997). Working with groups and families. In Social Work Practice: A Critical Thinker's Guide, E. Gambrill (pp. 517-590). New York: Oxford University Press.

**Lee, M-Y, Greeene, G., & Rhenscheld, J. (1999). A model of short-term solution-focused group treatment of male domestic violence offenders. Journal of Family Social Work, 3(2), 39-57.
**McKay, M., Gonzales, J., Stone, S., Ryland, D., & Kohner, K. (1994). Multiple family therapy groups: A responsive intervention model for inner city families. Social Work with Groups, 18(4), 41-56.

Handouts: Field agency/system assessment form [preparatory to Assign. #4]
Resources: Characteristics/dynamics of group work [included in this outline]
Activity: Planning agency based group work

Care coordination & Evaluating Practice
Sessions 12 & 13 Weeks of April 14th & 21st
Topics: The context and practice of care coordination
Intra- agency and Inter-agency teams in care coordination
Evaluation of practice effectiveness
***Preparatory form for Assignment #4 in class activity April 21st

Readings:
Dolgoff & Lowenstein Ch: 11: Changing world/Changing problems

**Hall, S. (1996). The community-centered board model of managed care for people with developmental disabilities. Health and Social Work, 21(3), 225-229.

**Indyk et al. (1993). A community-based approach to HIV case management: Systematizing the unmanageable. Social Work, 38(4), 380-387.

**Martin, L., Peters, C., & Glisson, C. (1998). Factors affecting case management recommendations for children entering state custody. Social Service Review, 72(4), 521-544.

** Naleppa, M. J., & Reid, W. (1998). Task-centered case management for the elderly: Developing a practice model. Research on Social Work Practice, 8(l), 63 -85.

** Purcell, D. W., DeGroff, A. S., & Wolitski, R. J. (1998). HIV prevention case management: Current practice and future directions. Health and Social Work, 23(4), 282-289.

**Seltzer, M., Litchfield, L., Kapust, L., & Mayer, J. (1992). Professional and family collaboration in case management: A hospital-based replication of a community-based study. Social Work in Health Care, 17(1), 1-22.

Resources:	CC Continuum: Focus & Social Work Roles [included in this outline] Case Study: Carolyn Sniff Legal Brief [included in this outline]
Activity:	The MAT: School-based care coordination for SED children The Patch: The neighborhood approach to CC w/high-risk families Logic modeling: Outcomes and Practice Evaluation
Session 14	**Week of April 28th**
Activity:	In class Assignment #4 Course evaluations

Assignments

Assignment #1 **20 points**

1-Create a three generation family map of your family of origin/intimacy with yourself at the bottom-most level include a 'key' for your symbols on the map; <u>and</u> include on your family map your family system's ecological map <u>and</u> identify each of the following on the map of your family system;.

- -relationships
- -triangles
- -boundaries
- -alliances/collusion
- -dates of birth, death, marriage, divorce, separation, ages, etc.

2-Attach a double spaced and typewritten narrative in which you (2 page max.):

a)- identify ONE META rule for your transgenerational family and include descriptions of 2 demonstrations of that rule in your family

b)- identify TWO transgenerational family rules

c)- identify the developmental stage of your <u>multigenerational/transgenerational</u> system AND provide your justification/rationale that identification

d)- identify two cultural patterns/beliefs transmitted to you through your family systems and discuss:

(1) How are these patterns/beliefs useful in your professional social work practice

(2) How might they patterns/beliefs be barriers in your professional social work practice

<u>Maximum total three (3) pages</u>, double spaced, typewritten, APA format [map is the third page]

Assignment #2 **25 points**

A. View one of the following films:
American Beauty
In the Bedroom
Moonstruck
Far from Heaven

B. Create a 3-generation map of the family in the film, noting relationships, boundaries, triangles, and alliances/collusions, and approximate ages, significant dates on the map.
C. Identify, analyze and assess—<u>using family system & family developmental theories and concepts</u>—three difficulties/issues/problems depicted in the film. That is, explain how/why each of these three issues is/are present using concepts from family systems and family life-span development theories incorporating the information provided by the family map [above in "B"].
D. Assess, identify and describe the family's risk and strength factors.
E. Provide a comprehensive Problem Statement based on your answers to "B, C, and D" above.
F.

(1) Delineate worker and family interventions/tasks/methods to address **One** of the issues/difficulties/problems you identify in "C" above that incorporates the family's strengths you identified in "D" above.

(2) Incorporate in these worker and family interventions/tasks/methods how you would utilize this family's culture, class, race, ethnicity, spirituality to work effectively with them?

G.

(1) What personal AND professional ethical and value conflicts might you experience in actually working with this family?
(2) How would you resolve these ethical/value conflict(s)?

Maximum five (5) pages, double spaced, typewritten, APA margins & font [map is an additional page].

Assignment #3 **15 points**

1 –

a) Identify a client population in your field placement or your employing agency which you see as having unmet needs which could be served by group work but are not currently being met through groupwork;
b) identify the unmet psychosocial need of that client population.

2-

a). Identify the type of group you are recommending.

b). Provide a conceptual rationale for your recommendation in "a" above..

c). State **one** objective for the group you identify in "1" above.

3-Describe *either* the steps/tasks of the pre-planning/planning stage you would implement in preparation for this group **or** the steps/tasks you would implement in the initial session(s) of the client group itself.

Maximum two (2) pages, double spaced, typewritten, APA margins & font.

Assignment #4 **20 points** **In class during Last session**

Description of this in class assignment using Logic Modeling for inter-agency system of care coordination planning will be distributed in a timely manner.

Additional Suggested Readings for SW 503 Practice 2

Abramson, J., & Mizrahi, T. 1996. When social workers and physicians collaborate: Positive and negative interdisciplinary experiences. Social Work, 41(3), 270-281.

Applewhite, S. 1995. Curanderismo: Demystifying the health beliefs and practices of elderly Mexican Americans. Health and Social Work, 20(4), 247-253.

Congress, E. P., & Lyons, B.P., 1992. Cultural differences in health beliefs: Implications for social work practice in health care settings. Social Work in Health Care, 17(3), 81-96.

Dykeman, C., Nelson, J., & Appleton, V., 1995. Building strong working alliances with American Indian families. Social Work in Education, 17(30, 148154.

Fong, L.G.W., & Gibbs, J.T. 1995. Facilitating services to multicultural communities in a dominant culture setting: An organizational perspective. Administration in Social Work, 19(2), 1-24.

Gowdy, E., & Pearlmutter, S. 1994. Economic self-sufficiency is a road I'm on: The results of focus group research with low-income women. In Building on Women's Strengths: A Social Work Agenda for the Twenty-first Century, edited by L. Davis, 81-113. New York: The Haworth Press.

Mancoske, R., & Hunzeker, J. 1994. Advocating for community services coordination: An empowerment perspective for planning AIDS services. Journal of Community Practice, 1(3), 49-59.

Matthews, L. 1996. Culturally competent models in human services organizations. The Haworth Press, 131-135.

Rounds, K., et al. 1994. Practice with culturally diverse families of young children with disabilities. Families in Society: The Journal of Contemporary Human Services, January, 3-15.

Sunley, R. 1997. Advocacy in the new world of managed care. Families in Society: The Journal of Contemporary Human Services, January/February, 84-93.

Wesley, C. 1996. Social work and end-of-life decisions: Self-determination and the common good. Health and Social Work, 21(2), 115-121.

Resources for SW 503

Characteristics of any/all human systems

The MAJOR purpose and over-riding unspoken desire of all systems is perpetuity

Mutuality

Power

An internal structure which distributes and maintains power

Periods of stability ? change

Transactions ? confusion/struggle/uproar/re-alignment

Repeating patterns >>>

- Which organize
- Which determine "how to solve" transitions/uproar/problems
- Which are governed by unspoken/unconscious rules
  - (and a Meta rule: the rule about when a rule may be changed and how it/they can be/are allowed to be changed)

Subsystems>>> age, gender, power, relationship

- Alliances
- Collusions
- Triangles

Boundaries

Complementarity

Dynamic tension between individuals inside the 'system' and between the system and its environmental 'other' systems

Concepts of Family Centered Social Work Practice

(thinking family systems)

Boundaries:

Clarity flexibility open/closed

Separateness/connectedness:

Emeshment disengagement transactions

Differentiation fusion

Internal Structure:

Clarity flexibility triangles

Collusions alliances

Power

Roles

Rule Systems

Cultural context

Communication

Strengths/Stressors

Family lifespan development

Leaving home

- Accepting emotional/financial responsibility for self
- Differentiation of self from FOO
- Letting go
- Developing adult relationships with 'children'

Joining of families through coupling

- Formation of a 'couple'
- Commitment to new family system
- Accepting new members into the family system
- Realignment of relationships in FOO

Families with young children

- Adjusting the couple system
- Joining as parents
- Accepting new members into the family system
- Realignment of relationships in FOO

Families with teens

- Increasing family system flexibility and boundaries
- Shifting the parent-child relationship(s)
- Shifting focus to: independent children & dependent grandparents
- Re-focus on the 'couple'

Launching children and moving on

- Accepting multitude of entrances and exits
- Renegotiation of the couple
- Realignment of family with 'another family'
- Realignment of family to the 'older generation'
- Dealing with disabilities and death

Families in later life

- Accepting shifting generational boundaries
- Maintaining one's own and the couple's emotional well being

Emotional Tasks of Family Development

Couple Formation

Intimacy versus idealization

Couple develops realistic mutual expectations

Couple develops a dyadic bond

Individuals in couple differentiate from foo

1st born addition to family

Replenishing versus self-preoccupation

Family develops mutually nurturing system
Family develops patterns within it

School-aged children in family

Individuation of family members versus pseudomutuality

Parents separate their own identities from child's/children's
Family enables a supportive system outside the family
Family members develop individual lives outside the family

Teens in the family

Companionship versus isolation

Parent-child relationships based on independence of child/children
Couple develops relationship beyond child/children & parental focus

Adult children leaving family

Regrouping versus binding-expulsion dichotomy

Family re-organizes around generational lines
Parent-child relationships become adult-adult relationships

Couple on their own again

Recovery versus despair

Couple relationship is mutually nurturing/dynamic w/o child focus

Aging/retiring family

Mutual aid versus uselessness

Family develops nurturing relationships among/between generations

Selected Interventions in Family-centered Social Work Practice

Educating
Normalizing
Reframing
Circular questioning
Reinforcing strengths
Coaching
Boundary marking
Homework assigning
Open-ended questions
'Wonderings'

Characteristics of groups

Task groups (educational, support, work	Therapy groups

groups, etc.)		
Bonds	For the task to be completed	Through personal individual issues
Roles	Through interaction &/or as assigned	Through interaction; “grouping”
Communication	Discussion toward task completion	Open
Procedures	Formal rules/roles	Flexible & evolving; leader is formally designated (i.e., sw-er)
Composition	By division of labor; appropriate to task	Based in ‘common ground’
Self-disclosure	Expected to be ‘low’	Expected to be ‘high’

Types of groups

Task **Psycho-educational** **Support** **Self-help** **<Therapy**

Dynamics of groups

Cohesiveness—

Structure— **Open or closed**

Ongoing or time limited

Frequency

Duration of each meeting

Process—

Norms—established within the group & shaped by the externalities of the group & identified by the leader; includes racial/ethnic, SEC, culture of internal & external environments

Power struggles---evolve over time –may be amongst members or between member(s) and the group formal leader

Care Coordination (Case Management)

Advantages of Care Coordination (case management)

---non-interference with worker/client relationship

---adaptability to transient change(s)

---accountability

---market share acquisition

---increased efficiency of service provision

---decreased 'gaps'/redundancies in service provision

Disadvantages of Care Coordination (case management)

---definitional ambiguity

---territoriality

---complexity

---power/authority conflicts

---ethical conflicts
- √ quality versus revenue
- √ loyalty to client versus to agency needs
- √ multiple 'captains'

The Continuum of Care Coordination Models

Coordination of Service>>>>>>>>>>>>>>>>>>>>>>>>>>Coordination of Service Systems

	Coordination of Service	Coordination of Service Systems
Focus	=Client	=Programs/population of clients
SW Roles	Assessor	Assessor
	Planner	Planner
	Broker	Developer
	Advocate	Negotiator
	Monitor	Monitor
	Provider	Coordinator
	Evaluator of intervention(s)	Evaluator of service systems

Ethical Conflicts: Case Studies

The Dilemma of Huntington's Disease

Roberta Jackson is eager to have a baby. She has just asked you as her social worker not to tell her husband or family members that she has a genetic marker that identifies her as a carrier of Huntington's disease. Huntington's is a disease for which there is no cure but symptoms and the disease itself will not show up for 20 to 30 years from now. Roberta hopes a cure will have been discovered before that time. This is an inherited condition that potentially affects all family members and inflicts premature senility on those affected. She is afraid that her husband will not be willing to have a child if he knows about her genetic condition.

Limited Number of Visits

Pat is a social work practitioner in a multi-service social service agency. Pat works primarily with clients with alcohol and drug problems. Most of her clients are covered by health insurance, but the insurance companies are demanding full records-partly in order to be sure that its clients are being served by properly accredited professionals. Pat thinks they are also demanding full records because, "if they can find any little thing that doesn't look right to them, they can disallow the claim. So they are going to try to get as much information as possible."

But it is not in Pat's clients' best interests to have information that they are being treated for drug dependency or alcoholism getting back to their employers or even to the insurance companies. She had a client who gave permission for his insurance company to look at his files, but was later denied life insurance by the company because, it said, alcoholics die younger. The insurance company found out from the records the client released that he was in treatment for alcoholism. In addition, an employer can make life difficult for those of its employees it knows have been in treatment for drug dependency or alcoholism.

So one of Pat's problems is that she is caught in the middle, especially if the client refuses to give permission for her to reveal their record. She also thinks it is a mistake for clients to give her permission to reveal their records. She thinks that information ought to remain confidential. But if clients do ask her to send their records on to their health insurance companies and a company then refuses payment, the hospital will have to pick up the cost for those clients who cannot pay for the therapy themselves.

One consequence of this problem is that the hospital has dropped its outpatient program. Too many of the clients in that program were being supported by the hospital. It also limited the number of sessions for those in therapy in the hospital to ten unless the hospital can determine ahead-of-time that they will be covered by insurance or are able to pay their own way.

Three Assessments: Three Perspectives: Three Results

Dorothy Miller originally came to the attention of the child protection agency when she sought medical care for one of her children at an urban hospital. Dorothy is African-American, 22 years old, and a single, never-married parent with five children. At the time of her first contact with the Department of Human Services, her youngest child (age 2 months) was hospitalized and diagnosed as failure-to-thrive. He was near death. Over the following few months, the CPS worker attempted to give Dorothy help with a number of child-related problems. Day care was found for two of the children in order to provide her with some respite

from childcare. The Special Education District evaluated one child and placed in a preschool, which provided speech therapy. Homemaker services and public health nursing were extended. Nevertheless, the youngest child did not achieve normal growth and development and was hospitalized a number of times with pneumonia.

<u>First Assessment</u>

The DHS worker's case notes indicate that she felt Dorothy was being resistive-failing to be home for the community nurse, failing to keep medical appointments, requesting termination of the homemakers' services, failing to follow through with medical treatment, leaving her children unattended in the home. When the middle child sustained accidental but very serious injury in the home, the agency petitioned the Court for custody of all the children. The summary statement in the petition reads as follows:

> The Agency is requesting temporary custody. The mother has not provided proper supervision of her children. She has refused services of the agency to help her understand and handle the needs of her children. The youngest child has been hospitalized three times since birth. This child is considerably below the norm for weight for her age and has other critical health problems. Her most recent hospitalization was caused by neglect of the mother, as was the recent accident which injured the middle child. Because of having so many children, the mother did not take the proper precautions to prevent this accident from happening.

The agency was granted temporary custody of the five children. Three months later the three oldest children were returned to Dorothy, but the two youngest remained in the foster home-although the baby, because her health problems were so severe, had gone through three placements. During this time period, Dorothy gave birth to her sixth child.

Six months after the custody hearing, the Department referred the Miler family to a multi-disciplinary diagnostic team for the purpose of determining whether Dorothy would be able to manage all six of her children. The caseworker stated in the referral that Dorothy's resistive behavior had continued: she continued not to keep medical appointments, she would not be home for the workers, etc. The agency felt that the home environment lacked proper stimulation as documented by the fact that the three older children were not functioning at their age levels (could not identify colors, numbers, alphabet, nor own name). In general, the agency described Dorothy with negatives: lacking initiative, uncooperative, and unable to handle all her children.

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Second Assessment

The Diagnostic Team (social worker, psychologist, pediatricians, and educational specialist) came to a somewhat different conclusion because they focused on a different set of data. First, the Team pointed out that Dorothy, over the past year, had been suffering from situation depression due to the fact that the man with whom she had lived, and who was the father of her six children, had left her to marry another woman. The Team felt that Dorothy's lack of energy and initiative was due, in part, to the grief associated with this loss.

Secondly, the Team felt that Dorothy's behavior also could be explained by the fact that she was caught between two cultures. She had been born in Mississippi where she had lived with her mother until childhood, and then had been raised by her grandmother. This pattern was a historical and prevalent adaptation to the exigencies of economic survival in an agricultural economy where all able-bodied men and women had to work in the fields. Dorothy had come north at age seventeen and soon after established the relationship with the man with whom she would live for the next six years. In the rural South, large families might be an economic asset; also large families could provide family members to share in child-rearing tasks. In the Northern urban center, however, this pattern was no longer functional and the Team saw Dorothy as suffering from this cultural bind.

Thirdly, the Team pointed out that Dorothy was not purposefully neglecting her children's medical care. After all, the reason she had been identified in the first place was that she had taken the baby to the hospital. The psychologist wrote that:

> ...Dorothy is not an appointment-oriented person. She has little sense of time and probably forgets appointments quite easily. The Team believes that this personality factor, coupled with the fact that there is no public health care facility in her area, is one reason for Dorothy's negligence in seeking consistent medical help for her children.

Finally, the Team found that Dorothy, although she knew she was dependent on public support, was a proud woman and, therefore, had strong feelings of resentment, rebellion anger, and hostility toward the White professionals. Wanting to do what was best for her children, but feeling "downtrodden" (Dorothy's word) when accepting help, resulted in an ambivalence which manifested itself in her passive/aggressive behavior.

The team concluded its evaluation by observing that Dorothy truly cared for her children, that there was a strong emotional bond between them (except possibly between her and the baby who, had been removed from Dorothy's care at two months, that Dorothy was a very good housekeeper, and that the two children still in placement should be returned. The Team recommended that Dorothy continue to receive homemaker, nursing, and day care services, and that she should attend a self-help group for single mothers in order to improve her parenting skills. Because of the obvious need to provide medical supervision of the children, the Team also recommended that the Department retain guardianship of the children for one year. Because of Dorothy's obvious hostility toward the White caseworker that had removed her children, the Team recommended changing caseworkers. In short, the Team's perception was that Dorothy was a victim of the clash between her past and present environments. They concluded that with sensitive and consistent services she could be helped to improve those parenting skills which were in question: consistency in seeking medical care for her children and appropriate age specific cognitive stimulation for her children.

Dorothy Miller originally came to the attention of the child protection agency when she sought medical care for one of her children at an urban hospital. Dorothy is African-American, 22 years old, and a single, never-married parent with five children. At the time of her first

contact with the Department of Human Services, her youngest child (age 2 months) was hospitalized and diagnosed as failure-to-thrive. He was near death. Over the following few months, the CPS worker attempted to give Dorothy help with a number of child-related problems. Day care was found for two of the children in order to provide her with some respite from childcare. The Special Education District evaluated one child and placed in a preschool, which provided speech therapy. Homemaker services and public health nursing were extended. Nevertheless, the youngest child did not achieve normal growth and development and was hospitalized a number of times with pneumonia.

Third Assessment

Sometime shortly after the Diagnostic Team's report was completed, another assessment of the Miller family was obtained. An African-American social work named Jackie Kelly, who had a MSW degree Columbia University, came to the city to lead a workshop for local human service professionals on culturally competent social work practice. In addition to her position as the director of a multi-agency substance abuse program in lower Manhattan, Ms. Miller was the director of a mental health center and family service agency in New York City. Jackie Kelly reviewed all of the material in the Miller case file as a teaching case in the workshop.

After reviewing the case, Ms. Kelly diagnosed Dorothy Miller not as seriously dysfunctional and not as a victim, but as a fundamentally healthy person who was surviving the stress of living with poverty. Ms. Kelly pointed out that environmental stress is the major factor that must be considered when evaluating families and that its effects are often confused with intra-familial dysfunction. As she put it to the workshop:

> We have to get away from this pathology model. Because, when we see pathology in everything, we come at clients negatively and then cannot help these families develop their strengths. Any family that is here, that is alive and is not waiting around the corner to mug you, that is not in stores stealing, that is not running around setting fires, that is not dealing drugs, that is not committing murder, are strong families. Strong because it means they have not succumbed to the stresses of poverty that impact their daily life and they have not succumbed to the accompanying rage.

Ms. Kelly agreed with the Team that Dorothy Miller had suffered some depression when she lost her man and that the grief had interfered with her ability to care for her children. That Dorothy had some level of intro -psychic dysfunction with attendant features of alienation, depression, and low self-esteem was a diagnosis with which she did not quarrel. But the fact that Dorothy was coping at all, that she had finished high school, that she hadn't abandoned her children, but maintained a nurturing bond and was capable of feeling the pain and rage of losing a loving relationship was indicative—in Ms. Kelly's view—that Dorothy had considerable inner strength. Interveners, Ms. Kelly said, must keep the client's inter-psychic dimensions in mind. It is the environment, however, which acts upon the inner world of the client, and is a stronger force in influencing behavior—and it is environment that must be used by the social worker to change problematic behavior.

Just as her evaluation of the case was different from the agency's and the Team's, so, too, was her suggested treatment plan. First, and foremost, she stressed the need for more Black social workers, or more White social workers that have the knowledge and skill to cross cultural barriers:

Too many child protection workers are White, and they may not don't understand the dynamics of what it is they are reaching out to--if you don't get a client at the first point of contact you have lost them. Let me tell you, Black people who receive child protection services

are no more open to receiving them from Black professionals than they are from White professionals.

Secondly, Ms. Kelly stressed the profound need to accept the client as she or he is at the moment, and to focus upon pragmatic, environmental needs. In the case of Dorothy Miller, the needs were many. Ms. Kelly discussed two with the workshop participants. "If it had been me, as a Black social worker working with that client, I wouldn't talk about the medical needs of those kids. They tell me that when asked, this mother said that the only thing she needed to be a good mother was a car. Well, if I lived in this community I would want a car, too. It's hard getting around here with five kids-no cabs, few buses, long distances. I would have started where she was, I would have said, "Okay, fine, you want a car, but this is what you got to do in order to get a car." The steps the woman would have had to take to get a car would have moved her toward improving how she's handling her life, and that would have helped take care of the kids.

Ms. Kelly's recommendations, then, were to listen to the pragmatic sense of what the client was saying. She firmly stated that had a treatment plan been focused on Dorothy Miller getting herself together to get a car, the medical needs of the kids would have been met.

Legal Brief
Carolyn Sniff, Trustee vs County Department of Human Services

DISTRICT COURT

FOURTH JUDICIAL DISTRICT
Personal Injury

Carolyn Sniff, trustee for the
Heirs of Jonathan Miller, and guardian
ad litem for Donovan Millers, a minor

Planitiff, File No. 89-2533
-vs-
County Department of
Human Services, John Doe, Mary Roe,
Jane Doe, Mary Roe II, East Memorial
Medical Center, Eileen Potts, M.D.
Reamer County Nursing Services,
John Doe II and Mary Roe III
Defendants.

BRIEF CASE No. 89-2533

On December 1, twin boys were born to Mary Brown at East Memorial Medical Center; they were placed in the Neonatal Intensive Care Unit (NICU). They were premature – Jonathan weighed 2 lb., 3 oz., and Donovan weighed 3lb., 4 oz. – and had potentially serious medical problems. Jonathan had an undeveloped cardiac system and was placed on a heart monitor; Donovan was diagnosed as having an eye condition that is common in premature infants but that can cause blindness if not treated. Both conditions would require medical care for at least a year.

Mary Brown was 28 years of age, unmarried, and had had no prenatal care. She came to the city from a nearby state to be near the man who was the father of Jonathan and Donovan and of her other two children (Debra, age 3, and Diana, age 2). Mary Brown had not expected to give birth in this unfamiliar city, had no relatives there, had no insurance, medicaid/public assistance or income.

The day after the births, the NICU nursing staff recorded that Mary Brown had not visited the twins, and they asked the social services department to do an assessment. Ellen Clingman, MSW, interviewed Mary Brown and, in the process of taking a social history, noted that Ms. Brown had stayed in bed and not attended the class for mothers who needed training in operating heart monitors. The social worker concurred with the nursing staff that the mother was not bonding with her twins.

Mary Brown was discharged from East Memorial late in the afternoon on December 2. Prior to her discharge, the hospital social worker called the Department of Human Services to ask the intake worker what she thought about the case. Ms. Clingman was told the case did not meet the criteria to merit investigation for abuse or neglect because neither had as yet occurred.

Between December 2 and February 1, Mary Brown visited the NICU only once and did not take the required training. On January 1 Jonathan was discharged, still on the heart monitor; Mary Brown was told that she would have to bring him back for periodic medical check ups. On February 1 Donovan was discharged with the same prescription for follow-up medical care.

When Jonathan was discharged on January 1, the case was referred to the hospital's home nursing department (East Memorial Community Nursing). A community nurse, Jane Tippitt, tried to visit Mary Brown at home on two occasions and sent two letters asking for home appointments, but failed to make direct contact. When Donovan was discharged Jane Tippitt tried once again. On February 3, Nurse Tippitt saw Mary Brown and the twins in their apartment. She examined the twins and found that Jonathan had lost weight while Donovan had not gained, and that

Donovan's eye condition had worsened. She told Ms. Brown it was very important that the twins see the doctor and urged her to immediately make the follow-up appointment. Mary Brown promised she would.

On February 11th, Dr. Eileen Potts, of East Memorial Medical Center, directed her staff to call DHS with a report alleging medical neglect of Jonathan and Donovan. The referral contained the same information as in the first call by the hospital social worker, except that Dr. Potts reported that Mary Brown had not made the necessary medical appointments for the twins even though Ms. Brown told nurse Tippitt that she would. The telephone call was followed by a letter to DHS from Dr. Potts. The DHS intake worker coded the referral 10-B (Medical Neglect High Risk) and sent the case to the investigation unit; the case was assigned to Ted Turner on February 11th. On February 16th East Memorial Community Nursing closed the case and made a referral by letter to Reamer County Nursing Services.

In his deposition taken on April 1st, Ted Turner said that between February 11th and March 6th he tried to contact Mary Brown twice by phone and twice by letter, and made eight phone calls to collaterals. He had difficulty reaching Nurse Tippitt because he kept missing her, but on February 20th he did reach her and found that the hospital had referred the case to Reamer County Nursing. From Nurse Tippitt he learned that the babies were not gaining weight and that they had not had medical check-ups. On February 22nd Mr. Turner sent Mary Brown a registered letter telling her to call him; on February 25th he received notification that she had received the letter, but no phone call from her.

On March 6th Ted Turner changed the code on the Brown case to 3-D (taken corrective action) and closed the case. Case notes dictated by Mr. Turner for closing said, "…Reamer County Nursing Services will contact DHS if there is a failure on the part of the mother to follow through with continued treatment for the children." Mr. Turner's supervisor reviewed the file on March 7th, returned the case to Mr. Turner for further follow-up, and directed him to make an early morning home call as it was necessary to contact the client before closing.

On March 12th Ted Turner found Ms. Brown at home at a new address, interviewed her in the lobby and did not observe the children. He said when deposed that she did not let him in because she was afraid he would wake the babies and he "did not have authority to enter if she said no." He also stated that it was not necessary for him to view the children because failure-to-thrive is a medical problem for which he, as a social worker, did not have the expertise for diagnosis. He also stated that Ms. Brown "appeared to be a decent person" and that she promised to call the hospital that day for referral to a clinic closer to her new home. On March 13th Mr. Turner's DHS supervisor approved the case closing and added the statement that "Dr. Potts will call worker if mother doesn't follow up."

Mr. Turner left for a one-week vacation March 13th through March 20th. In his absence, DHS received two letters. The first, dated March 12, was fromReamer County Nursing Services, in which Nurse Eskel expressed concern because she had not been able to make contact with Mary Brown. The other, dated March 13, was a second letter from Dr. Potts saying that "Mary Brown has not yet made appointments for Donovan and Jonathan to be seen in follow-up." Because the case was closed and because Mr. Turner was on vacation, the letters were placed in a hold basket. Mr. Turner was out sick and did not return from vacation to his regular assignment until April 6th. The letters from Dr. Potts and from Nurse Eskel were seen by him upon his return and sent to the Closed Record Center for filing in the closed record.

On March 20th the two babies were rushed to East Memorial in respiratory arrest. Jonathan also had cardiac arrest. Jonathan died of acute brain swelling caused by anoxic episode caused by dehydration, caused by malnutrition. According to the head ICU nurse, at the time Donovan was admitted he weighted 4lbs. 5oz. The children were so weak they were unable to suck, and it was necessary to draw blood from bone marrow, as efforts to obtain blood in the normal manner did not work. Donovan survived but with permanent brain damage as a result of his condition.