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Family-Directed Structural Assessment: Facilitating Strengths-Based Family Assessment and Engagement

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It is well documented that families are not consistently asked about their service provision preferences, and their voice is often not heard in the helping process (Kapp & Propp, 2002; Palmer, Maiter, & Manji, 2006; Williamson & Gray, 2011). Furthermore, the literature also indicates that child and family outcomes are generally better when the family is meaningfully engaged in the service provision process (Dawson & Berry, 2002; Littell & Tajima, 2000; Smith, Oliver, Boyce, & Innocenti, 2000). The Family-Directed Structural Assessment Tool (FDSAT) potentially addresses some of these issues (McLendon, McLendon, & Petr, 2005). This assessment tool, which has been in development since 2004, is a strengths-based, family-driven approach to assessing and engaging families in the service provision process by enabling family members to self-identify positive dynamics within and external to their family, as well as articulate areas of concern.

This assessment tool was initially conceptualized within the context of a therapeutic family camp co-facilitated by the manuscript author. In addition to utilization in therapeutic family camp (McLendon, McLendon, Petr, Kapp, & Mooradian, 2009), the FDSAT has been used in a traditional outpatient setting (McLendon, Radohl, Petr, McLendon, & Murphy, 2008), residential treatment (McLendon, McLendon, & Hatch, 2012), and in child welfare (McLendon, McLendon, Dickerson, Lyons, & Tapp, 2012). This article provides a brief overview of the FDSAT and use of the "common language" of the assessment tool to facilitate ongoing work. Examples of application of the tool in each of the service provision settings articulated above are provided. A case study utilizing the adult FDSAT is then presented. Finally, implications regarding the use of FDSAT and strengths-based family work, as well as current projects, are addressed.

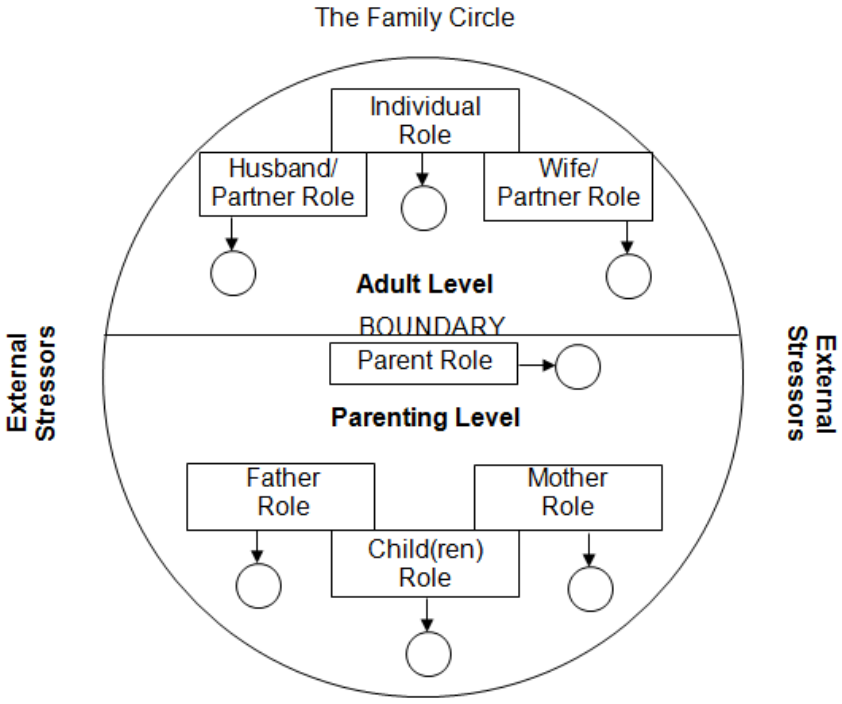
Overview of the Family-Directed Structural Assessment Tool

Group work theory is the foundation of the FDSAT as the family, itself, is tasked with ultimately identifying areas of concern and developing a plan of action (Anderson, 1997). The service provider is very much present as a guide; however, the adult family members are responsible for being the catalyst for change. The assessment tool is also structural in nature as the "family circle" is the first item presented on the tool. There is a clear connection to the work of Minuchin (1974) in that there are specific boundaries and roles articulated via the assessment tool. These components of the tool will be discussed in more depth in later sections of the manuscript. Finally, the tool is strengths oriented, reflecting the extensive work of Rapp (1998), in that it is not diagnostically driven.

Instead, the Family-Directed Structural Assessment Tool enables families to self-identify dynamics and supports that are helpful to them.

The core of the Family-Directed Structural Assessment Tool is a visual depiction of a "family circle." This circle introduces the concept of an external boundary around the family and helps to establish the idea that adult family members are responsible for the health and well-being of family functioning within the family circle. It also introduces the concept of an internal boundary within the family circle that separates adult level issues from parenting level responsibilities (McLendon, McLendon, & Petr, 2005). This assessment tool and use of a "family circle" differs most significantly from eco-maps and other forms of "mapping" in the sense that the roles in circle are scored by adult family members. This allows family dynamics to *necessarily* be determined and articulated by family members *themselves.* While eco-maps and genograms potentially give "voice" to family perspectives, the FDSAT *directly* reflects adult family members' concrete assessment of family functioning via the assigning of scores to particular roles. The family circle is included as Figure 1 below and further discussion of the scoring mechanism follows.

Figure. 1.



The FDSAT allows adult family members to rate aspects of family functioning on a four point scale (1=positive, 2=more positive than negative, 3=more negative than positive, 4=negative). The first dimension that adult family members rate is the five "core issues" that are emotional/relationship characteristics of family functioning. These five core issues are: commitment (the willingness to see situations through despite difference and conflict), empowerment (the degree to which one believes his/her opinion is valued and respected by other family members), control of self (the ability to change behaviors in order to bring about reduced conflict or improved relationships), credibility (the ability to say what one will or will not do and the ability to carry through), and consistency (the ability to be predictable on an ongoing basis).

Adult family members also rate familial roles, including the adult level roles of husband/partner, wife/partner, individual role (adult family members' satisfaction with their own functioning outside of their roles as a partner, mother, father, and parent); and parenting level roles including father (the individual relationship between the father and child(ren)), mother (the individual relationship between the mother and child(ren)), parent (the ability of the two parents to work together for the health, education, and welfare of the child(ren), and child(ren) (the level of functioning of the child(ren) within the family). Not only do adult family members rate themselves on these core issues and roles, they also rate their partner on each of these aspects of functioning (e.g., husband rates himself on commitment, he also rates the degree to which he thinks his wife is committed to improving family functioning, etc.). Adult family members also rate 16 external stressors that are impacting the family (e.g., ex-relationships, finances, living conditions, social services, health care, etc.). The use of the assessment tool allows families and service providers to identify strengths as well as prioritize areas of concern (McLendon, McLendon, & Petr, 2005).

There is also a child version of the assessment tool that allows children to rate their parents/caretakers on each of the core issues using the same 1-4 scale (e.g., "empowerment" – "Do your parents listen to each other and respect each other's opinion?"); allows them to rate themselves (e.g., "commitment" – "How willing are you to make things in your family better?"); and enables them to apply each core issue to specific areas of concern (e.g., "control of self" – "When you think about your goal of not hitting people when you become angry, rate yourself on your ability to 'walk away' when you feel like becoming violent."). A Spanish language version of the adult assessment tool has been developed as well as a gender-neutral adaptation of the adult assessment

tool. While a Spanish language version of the assessment tool has been developed, it is important to note that the large majority of families involved in the research projects described below were Caucasian. This is likely due to the preponderance of the Caucasian population in the geographic area in which the research projects were conducted. However, the assessment tool is designed to be inclusive of various cultures and traditions. It provides only generic definitions of roles with adult family members being responsible for defining the expectations and responsibilities of those roles.

It is important to point out that the adult assessment tool has been used successfully with single parents. While single parents may not rate themselves in the husband/partner or wife/partner role, they will always rate themselves as an individual, as a father or mother (the individual relationship with the child(ren)), and as a parent (the ability to advocate for the health, education, and welfare of their child(ren)) (McLendon, Radohl, Petr, McLendon, & Murphy, 2008).

Use of the assessment tools allows a great deal of information to be gathered very quickly. Administration of the adult tool takes approximately one hour, and administration of the child version takes approximately 15 minutes. When the tools are completed, service providers have a clear picture of the emotional/relationship functioning of the family, health of familial roles, and how stressors external to the family are impacting the unit. Perhaps most importantly, this information is *from the family's perspective*. It is not a diagnostic impression created by a clinician. Instead, it is a wealth of insight and information offered by the family itself. Building on the idea that these tools are self reports, their administration tends to be a non-threatening process in the sense that they are offered to the family as an opportunity to express to service providers how they, themselves, perceive family functioning (McLendon, McLendon, & Hatch, 2012). It is important to point out that the Family-Directed Structural Assessment Tools have been used by all levels of service providers (e.g., case managers, Bachelor's and Master's level workers) who are trained in their administration.

Use of the "Common Language" of the FDSAT in Ongoing Work

Another dynamic which use of the Family-Directed Structural Assessment Tools can create is a "common language" among family members and service providers. By training service providers in the implementation of the assessment tools and, consequently, service providers educating family members in the vocabulary of the tools, a mechanism for "helping families to help themselves" outside of the formal helping process is

potentially created. For example, if two children in a family are constantly becoming physically aggressive toward one another, the common language of the core issues can be employed by the parent(s) (e.g., Control of Self – What specific behaviors need to change in order to address the problem? Commitment - How important is it to the children to resolve this problem? Empowerment – Do they feel like their opinion is valued and respected when talking about the problem? Credibility – Do they think they will be able to state what they will or will not do and follow through? Consistency – How predictable can they be in their actions?) This "common language" provides families with tools to problem solve outside of the structured service provision environment. Application of this model to therapeutic camping, a traditional outpatient setting, residential treatment, and child welfare will now be discussed. An overview of a case study will then be presented.

Therapeutic Family Camping Program

The Family-Directed Structural Assessment Tool was initially conceptualized to facilitate the gathering of information in a therapeutic family camp. The camp was created in 1993 with the use of the FDSAT commencing at that time. Formal evaluation, as discussed below, began in 2003. Because the adult assessment tool can gather a great deal of information very quickly, it was well suited to the camp format. Specifically, the camp was three days in length and included fifteen hours of adult group work based on assessment from administration of the adult FDSAT and corresponding work with children. The child version of the FDSAT did not exist at that time; however, children were taught the core issues and activities specific to the language of the FDSAT were facilitated in group work (e.g., drawing what the core issues personally meant to each child). Conditions were primitive, and adventure-based activities were included (e.g., bridge building team-based exercise) (McLendon, McLendon, Petr, Kapp, & Mooradian, 2009).

The results of the adult and child group work were brought together in two ways. First, in the aforementioned adventure-based activities, the bridge building teams were coached to utilize the language of core issues in the activity (e.g., "I am not feeling empowered when I talk about my plan for completing the project."). Families then debriefed following the activity, again being encouraged to utilize the core issue language (e.g., "Sam's commitment to building the bridge seemed questionable. He said he would do something and then didn't follow through….his credibility seemed lacking."). Second, there was a family group which concluded the camp in which families identified concrete goals using the language of the FDSAT and, in particular, core issues.

During an inquiry that took place in FY 2003 and 2004, families who attended the therapeutic wilderness camp and utilized the FDSAT demonstrated statistically significant change in family functioning. (McLendon, McLendon, Petr, Kapp, & Mooradian, 2009). This quasi-experimental study took place via a Midwestern Community Mental Health Center (CMHC). There was a treatment group (n=25 families) that received services via the utilization of the FDSAT within the context of the therapeutic camping program. This intervention was in addition to regular CMHC services. There was also a comparison group (n=15 families) that received only regular CMHC services. Comparison group families received usual CMHC services from providers not trained in the use of the FDSAT.

Families that attended the three day camp also attended a half-day follow up camp six weeks following the initial three day camp. The FDSAT was re-administered at that time, progress regarding goals identified at the three day camp was reviewed, and a plan for future work was created. All families, both treatment and comparison, were mailed tools at post-six months baseline to collect final data. Results from paired-sample *t* tests (as measured by the adult FDSAT and the Family Adaptability and Cohesion Evaluation Scale II) (Olsen & Tiesel, 1991) indicated that treatment family functioning improved to a statistically significant degree over six months' time, while comparison family functioning did not improve (McLendon, McLendon, Petr, Kapp, & Mooradian, 2009).

Outpatient Setting

The FDSAT allows for family progress to be easily measured, thus this approach to assessing families is particularly well suited to the managed care environment in which many outpatient clinicians now function. The FDSAT moves beyond a pathological conceptualization of family struggles. Instead, it is a goal-oriented process that enables families to identify strengths, allows for the provision of concrete skills, and is designed to be utilized by the family both inside and outside of the clinical setting (McLendon, McLendon, & Petr, 2005). As articulated previously, it creates a "common language" that can potentially assist families in addressing concerns that arise outside the formal service provision setting. (e. g., A particular concern arises. Is it a parenting level issue or an adult level issue? Does it involve an external stressor? How committed are family members to addressing the concern [commitment]? To what extent do family members value and respect each other's opinions in the matter [empowerment]? Are there control of self [behavioral] issues that need to change [control of self]? To what extent can family members state what they will or will not due in regard to the concern and

demonstrate the ability to follow through [credibility]? How predictable, on an ongoing basis, can family members be with respect to resolving the issue [consistency]?)

Following the statistically significant results in the family camping program, FDSAT research shifted to teaching use of the FDSAT and determining if service providers found the model useful. Two Midwestern mental health centers were trained by FDSAT creators for one year. Participating service providers then utilized the assessment tool with families on their caseload. Finally, FDSAT trainers completed supervision rating scales regarding service provider proficiency with the use and language of the assessment tool; service providers completed surveys measuring their proficiency in the use of the FDSAT and corresponding language as well as their satisfaction with the assessment tool and project; and participating families completed project satisfaction surveys (Family-Directed Structural Training Project, 2006).

During FY 2007 and 2008, training and supervision continued at the two CMHCs with an added component of family outcome data collection. Training continued to include all levels of service providers, including in-home therapists, outpatient therapists, case managers, parent support specialists (people who had children in the state sponsored CMHC system who provided support services to other parents), and attendant care workers. Data were collected from families participating in the study as well as from families who received only usual CMHC services and did not receive services via the FDSAT and corresponding language (i.e., core issues, roles, boundaries, external stressors). The purpose of this was to measure the effectiveness of FDSAT in improving family and child functioning by comparing outcomes from both groups of families.

Paired-samples *t* tests were utilized to examine outcomes for families who received the family intervention and usual CMHC services (treatment group; N=26 families) versus families who received only usual CMHC services (comparison group; N=25 families). Families receiving services via the FDSAT improved to a statistically significant degree on all FDSAT core issues and five of seven FDSAT roles. The treatment group, as opposed to the comparison group, showed significant improvement on family cohesion (as measured by the Family Adaptability and Cohesion Evaluation Scale II) (Olsen & Tiesel, 1991). Outcomes suggest that use of this family assessment and corresponding language can be effectively used to strengthen family functioning of children with emotional and behavioral difficulties (McLendon, Radohl, Petr, McLendon, & Murphy, 2008).

Residential Treatment

Residential treatment is defined as services delivered in settings in which youth with behavioral and emotional problems reside away from their families, outside the home, in a therapeutic, non-family setting, while being less restrictive than inpatient psychiatric care (Hair, 2005; Pierpont & McGinty, 2004). According to the U.S. Department of Health and Human Services, over 30,000 youth and children lived in residential care during the year 2000 (Substance Abuse and Mental Health Services Administration, 2002). Upon entering treatment, these young people are often experiencing a multitude of difficulties including psychiatrically diagnosed problems of conduct, mood, and substance abuse; tendencies to engage in violent behaviors; under-developed social skills and impulse control; poor academic performance; and have often had contact with law enforcement (Foltz, 2004). Moreover, these youth tend to come from low income homes with histories of family dysfunction, including alcohol and drug abuse; unstable, unpredictable relationships; violence and abuse (Foltz, 2004).

Clearly, this is a challenging population to serve. Yet, while there is a growing emphasis on specification of standards of treatment and care, as well as child and family outcomes, there is currently no national set of indicators to guide service provision in these settings (Lieberman, 2004). Furthermore, several authors cite the need for more family involvement in residential treatment and point to improved outcomes for children *and* families when families are included in a youth's care (Demmitt & Joanning, 1998; Gorske, Srebalus, & Walls, 2003; Stage, 1999). Yet there are also no "best practices" or even broad guidelines suggesting what *types or methods* of family therapy/interventions might provide efficacious outcomes with this population.

The FDSAT has recently been implemented in a residential treatment facility. As documented in McLendon, McLendon, and Hatch (2012), the executive director of the facility indicates that use of the FDSAT helps to address barriers to parental engagement in residential treatment. Specifically, he cites the assessment tool engages families in a non-threatening manner via the strengths-based language (thereby reducing parental defensiveness); helps divorced parents identify that they still have a role as parents to their child; and assists in addressing distance between the youth's home and treatment facility, as the assessment tool is being productively implemented via the telephone.

Child Welfare

Effectively engaging families in child welfare services has historically been, and continues to be, a challenge for child welfare workers as

demonstrated by pervasively low levels of parent engagement and participation in services (Alpert, 2005; Kemp, Marcenko, Hoagwood, & Vesneski, 2009; Littell, 2001; Robertson, 2006). As articulated in the introduction of this manuscript, it has been documented that familial/caregiver involvement in this service provision system positively contributes to family outcomes (Dawson & Berry, 2002), and that parental investment leads to better outcomes for children (Gladstone et al., 2012; Pennell, Edwards, & Burford, 2010; Smith et al., 2000). Moreover, parents/caregivers generally voice a desire to be involved in their children's care (Kapp & Propp, 2002).

Strategies to effectively engage parents and caregivers and honor this desire to be treated with dignity include the following: early outreach and responsiveness to *parents'* self-identified needs and active inclusion in treatment planning and decision-making (Kemp et al., 2009), providing emotional support (e.g., listening to and giving recognition to families' feelings) (Palmer, Maiter, & Manji, 2006), helping families define and identify problematic issues and design measures to address these problems (Dawson & Berry, 2002), facilitating parent choice in how services are delivered, and approaching working relationship from a partnership perspective (Palmer et al., 2006).

The brief literature review that provides context for this section of this manuscript describes four key issues in reference to engaging parents in child welfare services, including that parents generally desire to be involved in service provision and are more likely to do so when they are treated with respect and their "voice" is heard, timely identification of the need for concrete resources increases parent involvement, meaningful parent engagement leads to better outcomes for children and families, and there appear to be no *specific* assessment tools currently being used which address these gaps in the literature regarding service provision.

During the 2010-2011 academic year, two bachelor of social work students were trained to use the adult Family-Directed Structural Assessment Tool and implemented it in their child welfare field placement setting. According to the students, the assessment tool proved to potentially address areas of challenging dynamics of service provision as articulated in the preceding paragraph. Specifically, it quickly engaged parents in a non-threatening manner, as it was strengths-based and completed by the parents themselves. It also helped parents identify and immediately discuss needed resources and supports, and provided the family and worker with a plethora of information about the structure and function of the family in a very short amount of time. It also supplied the workers with a concrete tool to facilitate the engagement process. Finally,

the FDSAT offers a great deal of flexibility in that it can be utilized with single parent families, grandparents raising grandchildren, cohabitating partners, or any variety of familial organization (McLendon, McLendon, Dickerson, Lyons, & Tapp, 2012).

Challenges in the Implementation of the Family-Directed Structural Assessment Tool across Settings

There are several challenges in implementing the FDSAT across settings. The first of these is the fact that most, if not all, service providers in mental health, residential care, and child welfare are already expected to complete a myriad of paperwork. It is yet another "form" to complete, and this can be unappealing to service providers.

The FDSAT also requires a commitment in terms of time as the adult version can take up to one-and-one-half hours to initially complete. Therefore, even if workers are enthusiastic to utilize the tool, limitations on the amount of time that can be spent with a family can be a barrier.

The training to become certified to utilize the FDSAT consists, minimally, of 20 hours of intensive instruction. If an agency wishes to implement the tool via all appropriate providers this is a significant commitment in terms of service production hours that are devoted to training. Moreover, it has been the author's observation that high turn-over rates in agencies that wish to utilize the FDSAT necessitate ongoing training of new workers (McLendon, Radohl, Petr, McLendon, & Murphy, 2008). Thus, if agencies do not have the resources to train new employees on a regular basis, high turnover rates of workers can potentially become a barrier to effective agency utilization of the FDSAT.

Finally, if the child is the identified client, particular billing codes and practices may require that the child be present in the session for reimbursement to be facilitated. It is strongly recommended that the adult assessment tool be completed in a private session with only adult family members present. Because adults are considered to be the fulcrum of power and source of change in a family, they necessarily need time to assess strengths, areas of concern, and determine a plan of action to address needs in the family. Therefore, protocol for reimbursement may present a challenge to the adult assessment tool being utilized to its maximum potential. This is a particularly important note in reference to future actions regarding policy formulation.

Case Study Utilizing the Family-Directed Structural Assessment Tool

The following case study summarizes the key points in the utilization of the adult and child Family-Directed Structural Assessment Tools with a family whose identifying characteristics have been altered to protect confidentiality. As previously articulated, the assessment tools enable a significant amount of information to be collected. Therefore, only the most crucial elements identified in the assessment process are highlighted. The process summarized in the following paragraphs generally requires three hours of service provision time.

John and Jane Doe sought services at a community mental health center after their twelve year old son, John Jr., was discharged from a state psychiatric facility. They had been married for 15 years and had one son. This was the first marriage for both of them. John was a manager at a manufacturing plant, and Jane ran a business out of the home. Their son displayed disruptive behavior since the age of eight with constant problems with physical violence at home and at school. Law enforcement had been summoned to the home on several occasions. This was the first hospitalization for John Jr., and the family had not sought outpatient services previously. After a stay of nine weeks, he was discharged, and the family was referred to the outpatient center.

John and Jane completed the FDSAT with the clinician while John Jr. completed the child assessment tool with a case manager. In reference to core issues, both John and Jane were very committed to improving family functioning and believed each other were committed, as well (i.e., ratings on 1's and 2's). This indicated a familial strength upon which to build. A significant family dynamic was discovered when the adults rated themselves and each other a "3" on empowerment (believing that people in the family respect and value their opinion and that they can affect change). When John Jr. was asked to rate this core issue he rated it a "4" in reference to his parents and himself. In other words, no one in family believed that anyone listened to or valued the opinion of anyone else in the family. Jane also rated John a "3" on credibility (articulating what he would or would not do and demonstrating the ability to follow through), and John also rated himself poorly on this core issue. An example of this issue with credibility was demonstrated by John stating he would come home from work each night by 6:00 in order to be of assistance with John Jr.'s evening routine. Despite this statement, he regularly did not come home until 8:00 or later.

In reference to roles, there was strength in the individual role (each partner rated themselves as a "2"); however, the husband/partner wife/partner roles were characterized by "3's" and "4's." The mother role was scored as a "2" by Jane and a "1" by John which indicated another

significant strength. The father role was an area of concern, as each adult rated it a "3." John articulated that he did not feel that he had a good relationship with John Jr., and Jane wished he would spend more one-on-one time with their son. The parenting role (both adults working together for the health, education, and welfare of the child) was also rated as a "3" by John and Jane. He did not think John Jr. needed to be on psychotropic medication, while Jane adamantly supported it. John also did not think Jane was appropriately advocating for their son at school; however, he was not able to leave work to attend school meetings. Finally, the child role was rated as a "2" by John and a "3" by Jane. Specifically, John stated, "John Jr. has some problems, but he is a good kid." Jane articulated that she felt responsible for all parenting decisions and not supported by John in this process, thus she witnessed and dealt with the vast majority of their son's struggles. There were areas of strength identified via external stressors. Both adults rated living conditions, employment, religion/spirituality, and friends as positive and helpful influences on their family. It was pointed out that having a stable living arrangement was a significant strength, as well as being satisfied with employment. The strength of religion/spirituality and friends contributed to a positive individual role score for both adults.

Areas of concern specific to external stressors that were brought to light via the assessment tool were healthcare/medical (because of John Jr.'s mental health issues and Jane's Type I Diabetes, hypertension, and hypothyroidism), in-laws (Jane felt harshly criticized by her husband's family because of John Jr.'s struggles), finances (the family was having financial difficulties due to medical bills specific to Jane's chronic illnesses), and hobbies/interests (neither adult family member felt there was time or resources for these types of activities).

Returning to core issues, the family was commended for their commitment to improving family functioning indicated via the first core issue. When asked to discuss the scores for empowerment ("3's" and "4's"), Jane stated that she felt alone and unsupported in parenting decisions. This resulted in "3" in the parenting role and a "3" for the child role, as she felt she bore full responsibility for addressing John Jr.'s mental health and behavioral issues without John's support. She also articulated that when she would ask John's input regarding financial and budgeting decisions for the household, he would "brush her off" and did not feel that her concerns were respected or even acknowledged. In reference to the external stressor of in-laws (Jane rated this a "4"), she stated that she repeatedly tried to tell John how she felt so harshly criticized by her in-laws (i.e., his family) but her concerns were not

acknowledged. On the other hand when asked about his empowerment score John replied, “Oh…she asks my opinion, but does what she wants to regardless of what I say. Whether it is decisions about money, John Jr., or whatever. So why bother?” When John Jr. was asked by the case manager to talk about the way in which he scored his parents’ empowerment and his own, the message was that nobody in his family listened to anyone else in the household.

Finally, returning to the adult level roles, the husband/partner wife/partner roles were rated with “3’s” and “4’s.” When asked to talk about these scores John made statements to the effect of, “Because of our work schedules we just don’t have time for each other.” and “The fact that she doesn’t seem to care about what I think or what I have to say frustrates me.” Jane indicated that she felt completely unsupported by John in many facets of family functioning which directly impacted their adult level relationship.

The adult family members were then asked to prioritize areas of concern based on the processing of core issue, role, and external stressor scores as summarized above. John and Jane came to the conclusion that if they started addressing the core issue of empowerment that would potentially improve their husband/partner, wife/partner, and parenting roles. Jane also indicated that if she felt her opinion were valued more in reference to financial decisions and the struggle with her in-laws that those external stressors would improve. Likewise, John stated that if he believed his opinion really mattered to Jane, he would be better able to contribute to the improvement of the various issues. Both adult family members were asked to articulate what they “needed” to feel that their respective opinions were valued and respected. For example, Jane stated that she, very simply, would appreciate John not “walking off” when she attempted to talk with him about parenting or financial issues. John indicated that it would be helpful to him if Jane would really take into consideration his concerns about medicating John Jr., and they could explore alternatives. John Jr. also indicated that empowerment was an area of concern and was asked to talk about actions his parents could take to help him feel that his opinions and ideas were valued. He was also asked to write out three steps he could take to be more respectful of his parents.

The core issue of John’s credibility was discussed in a similar manner. He indicated he was committed to spending more one-on-one time with his son, thus addressing concerns in the father role. He also committed to taking specific steps at work to move toward coming home regularly by 6:00 to engage more in the parenting role.

This case study offers a complex family with several strengths and areas of concern. No written account of a family assessment can truly do justice to the nuances of the sessions and the processes that take place. However, the preceding section offers an overview of the assessment procedure and ways in which it can facilitate assessment and potential improvement of functioning. Implication for strengths-based practice with families will now be addressed.

Implications for Strengths-Based Practice with Families

The Family-Directed Structural Assessment Tool offers a way in which to engage and assess families in the helping process from a strengths-based, user-friendly perspective. Families are necessarily the experts regarding their lives, and this assessment tool offers a means by which to help them articulate their priorities, areas of concern, and preferences. The tool also offers a way to consistently allow client wishes to guide service provision as they provide an ongoing framework and "common language" among workers and family members. For example, if a family identifies "empowerment" as an area of concern (e.g., no one in the family listens to or values what others have to say), service providers can work with the family on a plan of action to concretely address this concern as well as return to the concern over time and monitor the family's progress. Moreover, familial perspective regarding strengths and problem areas can be continually reassessed through re-administration of the tools as needed.

As demonstrated in the narrative portions of this manuscript and in the case study provided, the assessment tool offers strengths-based/family-centered practitioners a potential means by which to enhance or extend their practice in several ways. First, it enables families and workers to gather and summarize a vast amount of information in a short amount of time. Second, it provides a visual structure (i.e., the family circle) to help families "'organize" roles, functioning, and responsibilities. Many of the families that seek services via the helping settings described in this manuscript are in varying states of disarray and the provision of a visual aid to assist them in organizing family functioning is a simple yet powerful tool. The concept of a "family circle" is certainly not unique to this tool; however, combining this concept with an extensive family self-report assessment mechanism has demonstrated helpful results as previously articulated. Projects currently underway and "next steps" will now be discussed.

Current FDSAT Projects and "Next Steps"

During the past 10 years, the Family-Directed Structural Assessment Tool has been developed to include a child version, gender neutral version, Spanish language FDSAT, an 80-page training manual and two instructional DVDs. The training manual includes instruction on use with two parent families, single parent families, children, scoring of the tool, use in crisis situations, and use in documentation. Hundreds of service providers have been trained throughout the United States, ranging from half-day orientations to two-and-one-half day training seminars. To be certified to utilize the assessment tool, one must minimally complete the two-and-one-half day training seminar.

Currently the use of the FDSAT is being taught in a semester-long elective course in a social work program at Northern Kentucky University. This includes intensive instruction in how the "common language" of the FDSAT can be used in ongoing service provision. Instruction is taking place within Bachelor's and Master's Social Work Programs, both which are fully accredited. When appropriate, students who complete the course are encouraged to utilize the assessment tool and corresponding common language in their field placements and post-graduation places of employment. Supervision and support is offered to the students from the manuscript's author.

"Next Steps" include supporting the use of the FDSAT in student field placement or graduate's places of employment as articulated above. Additionally, the author has been approached by students and community-based service providers interested in the application of the FDSAT to assist veterans and their families. In particular, it seems that the concept of roles and how the responsibilities and expectations of specific roles in the family are negotiated would be of potential assistance to families experiencing deployment and reintegration. This application is ongoing and will be a focus of future work.

Conclusion

Helping families to self-identify strengths and areas of concern is a key component to effectively engaging and retaining families in the social service provision process. The utilization of the Family-Directed Structural Assessment Tool has been demonstrated to enhance these areas of service provision as well as bring about statistically significant improvement in family functioning over time. This article summarizes the application of this assessment tool in a variety of settings, including residential treatment and child welfare programming, environments in which engaging adult family members can be particularly challenging. Finally, implications for strengths-based family work and an overview of current projects are discussed.

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