

Ramsey County Train the Trainers Guide



The Golden Thread:

Linking safety Assessment, Safety Planning, Assessment of Family Functioning and Behaviorally Based Case Planning

**Funded by the Children's Bureau, Administration for Children and Families, U.S.
Department of Health and Human Services**

Grant #90CA1753

Ramsey County Community Human Services Department

St. Paul, Minnesota

Table of Contents

BACKGROUND AND OVERVIEW	2
STAGE ONE: REVIEW EXISTING INFORMATION AND THE TRANSFER MEETING	7
STAGE TWO: ENGAGING WITH THE FAMILY/DEVELOPING OF A COMPREHENSIVE FAMILY FUNCTIONAL ASSESSMENT	11
STAGE THREE: DEVELOPMENT OF CASE PLAN, FAMILY TEAM MEETINGS AND INTENTIONAL VISITATION PRACTICES	17
STAGE FOUR: ONGOING ASSESSMENT	25
STAGE FIVE: CASE CLOSURE	28
REFERENCES	30
APPENDIX	31

Background and Overview



Slides 3-25 address the background to the practice shift including honoring the Ramsey County practice foundation, evidence based practices and critical thinking and analysis.

Trainer should emphasize that the intent of this new practice approach is to enhance caseworker's skills in understanding the family functioning that contributes to children being unsafe or at risk and designing a case plan that has optimal chance at successfully changing behaviors.



Slide 7 highlights that this practice approach was developed based on the following foundations of quality practice:

- Engagement and relationship-building
- Involvement of families and youth in identifying their own needs and strengths
- Cultural grounding
- Family is a system
- Identifying and including extended family and service providers
- Individually tailored approach for families
- All children are individualized
- Empathy, authenticity, and transparency

NOTE: Trainer may want to ask participants about the way that they operationalized these practice principles today—so that participants see that they are already practicing in this way—and that this new practice is the natural evolution of their work.



Slide 9-24 launches the discussion of Evidence Based Practices and why of child protection systems to adopt evidence based practices in its system reform and practice improvement efforts.

Trainer note that two specific evidence based practices are critical to the implementation of this practice approach; *Family Engagement and Critical Thinking and Analysis*

Slide 10 highlights research from a variety of settings emphasize that families do better in changing behaviors that caused children to be unsafe and maintaining those changes when the efforts of the various people involved in their life are focused ensuring that the family is fully engaged in the process.

Trainer Note that each of these research studies have helped move us from the idea that family engagement is a nice social work practice to the idea that family engagement is correlated with child safety. The MN Alternative Response research leads the field in showing that when families are engaged the children are safer (decrease in recurrence of maltreatment).

Slide 11 provides concrete reasons why family engagement is better for children. Trainer needs to help folks understand that the only way that the Comprehensive Family Functional Assessment will actually work is through fully engaging families in the process.

Slide 12 helps to define Family Engagement stating that it **results from three things:**

- Families believe that what they say matters—that we have communicated to them that their perspective and voice matter
- Our Assessments and case plan development are interactive, joint processes with parents and other in their circle of support.
- Families are active parts of evaluating the effectiveness of services –they have a voice in determining if they are working or not

Slide 13 describes A Family Oriented way to think about assessment in child welfare services. Trainer should take some time to walk through each aspect of this slide possibly depicting how the Social Intervention Model is different from the traditional “investigative” approach and further promotes family engagement.



Slides 14-16 focus on the danger of judging families and how this judgment impacts our ability to engage families as part of the process. Trainer should take some time on slide 16 asking to identify barriers that exist or the system may create for families becoming engaged. Trainer should also ask participants to identify some of the ways we can tell that families are engaged in partnership with the agency.

Slide 17 provides an opportunity for the trainer to remind participants of all of the work that has been done in Ramsey County on cultural sensitivity and reducing disproportionality and disparate outcomes for children and families of color in the child welfare system.

Slides 18-24 introduce the concept of Critical Thinking and Analysis.

Critical thinking is the intellectually disciplined process of actively and skillfully conceptualizing, applying, analyzing, synthesizing, and/or evaluating information gathered from, or generated by, observation, experience, reflection, reasoning, or communication, as a guide to belief and action.¹ A well cultivated critical thinker:

- Raises vital questions and problems, formulating them clearly and precisely;
- Gathers and assesses relevant information, using abstract ideas to interpret it effectively, comes to well-reasoned conclusions and solutions, testing them against relevant criteria and standards;
- Thinks open-mindedly within alternative systems of thought, recognizing and assessing, as need be, their assumptions, implications, and practical consequences; and
- Communicates effectively with others in figuring out solutions to complex problems.

Slide 20 highlights the results of critical thinking. When a social worker implements an approach to critical thinking and analysis the research teaches us the following occurs:

- There is an increase accuracy of decisions
- They avoid cognitive biases (see green box below)
- They recognize errors and mistakes as learning opportunities
- They more accurately assess likelihood of attaining hoped-for outcomes

¹ Michael Scriven & Richard Paul. (February 2005). National Council for Excellence in Critical Thinking Instructions.

- They make valuable contributions at case conferences
- They develop effective plans
- They respect and have empathy for others
- They continue to learn and enhance their skills



TRAINER: A NOTE ABOUT COGNITIVE BIASES. Confirmation bias is a type of cognitive bias in which people tend to seek out information which agrees with previously held beliefs. They also lend more weight to informational input which supports their beliefs, while discarding contradictory information. The confirmation bias is one of the most common cognitive biases, and it can also be the most dangerous, because it can lead people into very poor decisions on the basis of questionable information.

Slide 23 highlights the ways that supervisors can create opportunities to support and advance the critical thinking of their staff. Trainer should take the time to ensure that supervisors understand each of these supervisory dynamics.

- ✓ Controlled, non-random supervision
- ✓ Use a standardized process and criteria during consultative supervision (Refer to the Supervisory Tool)
- ✓ Avoid impulsive solution finding
- ✓ Focus attention on the decision making process
- ✓ Know what you do not know
- ✓ Seek to reduce the influence of irrelevant information
- ✓ Explore; probe to understand
- ✓ Balance contradictory information and seek rationale
- ✓ Understand worker perceptions and the basis
- ✓ Consider alternative explanations
- ✓ Maintain a healthy dose of skepticism



Slides 25-26 describe the Five Stages (ten steps) of the Comprehensive Family Functional Assessment Practice Approach. It is important that the trainer provide an overview of these five stages and ten steps. **REMEMBER: Tell them what you are going to tell them, then tell them, then tell them what you told them!**

Stage 1: Transfer Communication and Information Review

- 1) Workers will review existing documentation and engage in a transfer communication with the intake worker.

Stage 2: Conducting a Comprehensive Family Functional Assessment

- 2) Following this review, workers will meet with the family and begin the engagement process that will ensure the family's meaningful involvement throughout the case.
- 3) Workers will interview children, parents, and other relevant caregivers with special attention paid to the inclusion of fathers.
- 4) Workers will then meet with families and possibly staff from other relevant agencies to coordinate case planning and create a plan for future communication.
- 5) Specialized assessments (e.g. to address mental health concerns) will be carried out or appropriate referral made for assessment elsewhere.

Stage 3: Behaviorally Based Case Plan Development

- 6) Workers will use clinical judgment in consultation with supervisors and families to develop case plans including intentional visitation practices.
- 7) Workers will document all relevant case information in a timely manner.

Stage 4: Ongoing (Continuous Assessment)

- 8) Workers will conduct ongoing assessments of progress and needs.
- 9) Workers will exchange information with family members, service providers, and courts, updating service plans regularly.

Stage 5: Case Closure

- 10) Workers will reassess safety issues and child risks of the entire family prior to case closure.

STAGE ONE: REVIEW EXISTING INFORMATION AND THE TRANSFER MEETING

Slides 27-30 describe the content of the Transfer Meeting. The trainer should emphasize the Transfer Guide Tool and how it is used as a tool within the Transfer Meeting.

Help the participants to fully understand the information that needs to be shared in the Transfer Meeting specifically including:

- Describe the specific safety threats identified in the safety assessment.
- Describe the behaviors or conditions of caregivers that contributed to the children being unsafe or at risk.
- Describe the safety plan that was put in place (in home or out of home). If the safety plan is an in-home plan, define how the safety plan is controlling or managing the safety threats.
- Describe any safety threats to the worker that may exist.

Slide 30 provides a visual image of the transfer meeting content.



Trainer remember that some adults learn much better from visual depictions than they do from words...so refer to this visual chart when trying to help participants understand the required content of the Transfer Meeting. **Refer to Transfer Guide in Appendix.**

Transfer Guide for Communications Between Intake and Ongoing

Initial Transfer Meeting:

1. Concise description of the reason(s) the family came to the attention of the system.
2. Results of the safety and risk assessment—“The child was found to be unsafe due to the presence of the following safety threats....”

3. Description of the safety plan that was put in place and how it is managing or controlling the identified safety threats.
4. Description of the behaviors or conditions of the caregiver's that have to change in order for the child to be safe or to minimize child risk.

Add this to court presentation or case staffings:

5. Describe the interventions that were put in place to change the behaviors or conditions that caused the children to be unsafe or at risk.
6. Success of the interventions in changing the behaviors or conditions that caused the children to be unsafe.



Trainer should highlight the following best practice tips:

- Ensure that you fully understand the safety threats that caused children to be unsafe...“substance abuse” is not a safety threat—how it gets acted out in parenting (or lack thereof) is the safety threat.
- Family’s history with CP—even if they were not “substantiated” what has been the family’s involvement in CP or other systems (such as Domestic Violence, etc.)
- Make sure you learn who else might have additional family information (i.e. community providers that have supported the family previously, kin who were identified but not contacted, etc.)
- Safety threats specific to each child –learn what these safety threats actually look like on a day to day basis.
- Level of family engagement with the system and if they were deemed to be “resistant” what that looked like. Sometimes resistant is just another word for fear.
- Learn about the protective capacities of the family and how they are being used to keep children safe (specific to an in-home safety plan).
- Learn about the natural supports (relatives and kin) as opposed to “artificial supports (community centers, agencies, etc.)

Slides 31-33 provide a reminder to participants of what has to be reviewed prior to meeting with the family for the first time. The information from the Transfer Meeting coupled with any historical information provides the worker with the ability to “hit the ground running” when meeting with the family.

Trainer should highlight on **Side 31** why this review is more effective in serving families. It may be valuable to ask participants how reviewing this information has helped them to better serve families in the past.

- Ongoing workers will better understand client's situation—and fully understand the threats of safety.
- Ongoing worker will understand if this family has been involved in the system previously which should heighten the seriousness of the potential for child maltreatment.
- Clients will not have to repeat information and will feel that what they have said previously has been heard and remembered
- More efficient use of time
- Informs worker that there are concrete needs that likely will need to be dealt with immediately
- Allows worker to prepare internally for the issues they will be confronting

Slide 32 specifically cites the documents that should be reviewed prior to the Child Protection Worker making the initial contact:

➤ Case With No Previous Child Protection Case Management

- The abuse and/or neglect report that necessitated the investigation
- The investigation summary including the specific safety threats identified and the safety plan that is in place to control or manage the safety threats
- Any collateral reports related to the investigation, i.e., police, medical, school reports

➤ Case With Previous Child Protection Case Management

- Add to documents above: Intake reports, Intake summaries, closing summaries
- Review:
 - Safety threats identified in the past
 - Safety plan put in place and whether or not they were effective at controlling or managing safety threats
 - What interventions and services were tried in the past and which were most successful in changing behaviors that caused children to be unsafe
 - Court history
 - Level of family's cooperation

Slide 33 emphasizes that a review of the information will provide the worker with a high level sense of family functioning. This does not replace the Functional Assessment that will be completed and will provide more in-depth information of the causes of the behavior in the family that result in safety threats. However, it does help the worker understand where they may want to focus some of their initial conversations with the family.

STAGE TWO: ENGAGING WITH THE FAMILY/DEVELOPING OF A COMPREHENSIVE FAMILY FUNCTIONAL ASSESSMENT

Overview

Slide 35 provides the framework and the intent for a strong family centered assessment. The slide emphasizes the need to create the golden thread between the safety and risk assessment, and the comprehensive functional assessment that helps us understand the causal nature of the behaviors and how best change those behaviors.

Slide 36 introduces the concept of transparency—and the need to make certain that families are fully apprised of the process, why we are seeking to gather information and what we will do with this information.



NOTE Trainer should emphasize that the family should be encouraged to engage in self-assessment about what they believe is happening and why they are now involved with the agency. Be aware and mindful of possible cultural factors. If appropriate, ask about cultural context of family issues.

In the first meeting with family the worker meets with family, builds rapport and engagement and demonstrates unconditional positive regard (be open and non-judgmental). It is important to note that MN research on Alternative Response suggests that there is a direct correlation between family engagement and child safety.

Slide 37-40 moves the conversation into the details and the specific domain areas of the Family Functional Assessment.

Trainers at this point bring out the Family Functional Assessment tool and walk the participants through each section, emphasizing that over several meetings they will meet with the family and assess the family functioning in the following key domain areas:

- Parenting/bonding/including history of how parents were cared for/parented
- Living conditions/finances/housing food /basic needs and any immediate situations which may present as an emergency such as no utilities, unable to pay rent or mortgage.
- Kinship/neighbor care options– family connections–support system
- Caregivers mental health

- Domestic violence
- Parents health
- Parent substance Use

For each child in the family:

- Child mental health/substance abuse
- Child health
- Child's developmental educational needs



Trainer emphasize that all meetings with children are opportunities to:

- Gather information
- Assess overall health, activity levels, development, communication skills, build rapport
- Ensure that children understand next steps and agency's intent to help family
- Explain court involvement, if pertinent, and what to expect in court hearings

Additionally on **Slide 42** trainers should emphasize that it is critical to consult with relevant stakeholders involved with family. "Relevant" stakeholders include individuals involved in the child/family's life who may provide additional insight/information about child/family functioning. They include family and kin, friends, neighbors, and providers. The purpose of these meetings is to gain a better understanding of the needs related to safety, permanency, and child well-being; determine effective ways of engaging the family in changing behaviors; and identify what has been the impact of services provided. These conversations take place within a context of a shared understanding of the areas of common concern in working with families.

Finally, encourage participants to talk with any providers active with the family to:

- Clarify the provider's role
- Clarify what services are provided
- Clarify family's needs

Slide 43 stresses that a comprehensive assessment of family functioning completed early in the process of serving a family, helps the decision making by the worker on which areas to focus on

and increases the likelihood of that the services utilized will be targeted on addressing the issues that caused children to be unsafe.



NOTE: Trainers should also alert participants to the **Possible Questions to Engage Caregivers located in the Appendix of their Practice Guide.** Explain that these questions were compiled in a telephone interview with over 30 very skilled practitioners from across the country. The practitioners were asked to share what they believe to be assessment questions that elicit maximum information. Also share that Insoo Kim Berg (Solution Focused Therapy) indicated many times that what separates a good practitioner from a very good practitioner is the wealth of assessment questions that they have in their “tool box”. Some families simply require different approaches in order to feel safe enough to share information.

Slides 45-50 Focus on the Difference Between A Strength and A Protective Capacity

On Slide 47 Trainers should discuss the following: Barry Duncan completed a 27 year longitudinal study of individuals served in a community mental health setting. He was trying to learn what caused individuals to sustain new and learned behavior over a period of time. He found that people who had been able to change behavior and sustain this change attributed their success to three things:

1. Their practitioner started from a place of building on what they were already doing well (55% of change was attributed to this). The work of Bill O’Hanlon (1999) has helped to further this learning. O’Hanlon² suggests that active discussion about strengths with a family has the effect of intensifying these strengths. A strengths approach assumes that the birth family has what it needs to identify solutions to its own problems. Often when we do not seek to fully understand the birth family’s strengths, or we do not take the time to identify birth family strengths we simply do not know how to build upon strengths in the day to day interaction with birth families. This is a skill set that needs to be enhanced.
2. Their practitioner created relationship with them and helped them to develop relationships with others that could support the change process. (30% of change was attributed to this).

² **In Search of Solutions: A New Direction in Psychotherapy.** New York: Norton (January 1989). Co-authored with Michele Weiner-Davis.

3. Their practitioner generated hopefulness—that things were going to get better and that they had some control over this. (15% of change was attributed to this).



Tell the story of the work in Louisiana where the social workers decided to ask the following question following every visit with family “As a result of our time together are you more hopeful or hopeless? If they say more hopeless the worker sits back down. While this may take more time at that point, it ultimately saves tremendous time as it communicates to the family that what they say matters and that you are fully invested in their success.

Trainer may also want to tell this story: It seems that one year; there was a class of students who were so unruly that they burned out two different teachers. One teacher took early retirement and the other decided to get out of teaching altogether. This class was so bad that substitute teachers began to refuse to take it. So the district called a teacher who had applied for a job but hadn't made the cut that year. They asked her if she would be willing to come in and finish out the year in return for the promise of a full-time position the next year. She eagerly accepted.

The principal decided not to warn the teacher about the class, afraid that she would be scared off if she heard what she was up against. After the new teacher had been on the job for a month, the principal sat in on a class to see how things were going. To his amazement, the students were well-behaved and enthusiastic. After the students had filed out of the classroom, the principal stayed behind to congratulate the teacher on a job well done. She thanked him but insisted that he deserved thanks for giving her such a special class, such a great class, for her first assignment. The principal hemmed and hawed and told her that he really didn't deserve any thanks.

She laughed and told him, "You see, I discovered your little secret on my first day here. I looked in the desk drawer and found the list of the students' IQ scores. I knew I had a challenging group of kids here, so bright and rambunctious that I would really have to work to make school interesting for them because they are so intelligent." She slid the drawer open and the principal saw the list with the students' names and the numbers 136, 145, 127, 128, and so on written next to the names.

He exclaimed, "Those aren't their IQ scores--those are their locker numbers!" Too late. The teacher had already expected the students to be bright and gifted--and they had responded positively to her positive view and her positive handling of them.

Trainer should ask workers to think about a family they are serving, and identify a protective capacity of the family and a strength of the family. Help them to see the difference. Remember to emphasize that a protective capacity can be relied upon immediately to protect children.

Slide 48 focuses on the definition of protective capacities and how they are different than strengths. Protective capacity is a CPS concept that has been around for a long time but just got this label within the past few years. Fundamentally, the concept is concerned with the question of whether a parent can and will protect his or her child. A protective capacity is a specific quality that can be observed and understood to be part of the way a parent thinks, feels and acts that makes him or her protective.

Slide 49 highlights the various kinds of protective capacities. Trainer should take the time to discuss each with the participants—emphasizing that a protective capacity PROTECTS CHILDREN. This is what makes it different than a strength. When children are unsafe in their parents care—this means that a parent has DIMINISHED PROTECTIVE CAPACITY and the focus of our work is to change this.

- Personal and parenting behavioral, cognitive and emotional characteristics that specifically and directly can be associated with being protective of one's young.
*These are unique strengths that contribute to being protective. Some might think of these characteristics as somewhere close to an instinct for protectiveness similar to a mother bear's protective nature particularly with regard to priority and intensity.*³
- Cognitive Protective Capacity refers to specific intellectual, knowledge, understanding and perceptions that contribute to protective vigilance. Here are some examples of cognitive characteristics:
 - Accurate perception of a child
 - Recognition of a child's needs
 - Understanding protective role
 - Intellectually able

³ Action for Child Protection. 2003

- Understands and recognizes threats
- Emotional Protective Capacity refers to specific feelings, attitudes and identification with the child and motivation that result in parenting and protective vigilance. Here are some examples of emotional characteristics:
 - Emotional bond with the child
 - Positive attachment with the child
 - Love, sensitivity and empathy for the child
 - Stability and emotional control
 - Effectively meets own emotional needs
- Behavioral Protective Capacity refers to specific action, activity and performance that is consistent with and results in parenting and protective vigilance. Here are some examples of behavioral characteristics:
 - Physical capacity and energy
 - Ability to set aside own needs
 - Adaptive
 - Assertive and responsive
 - Takes action
 - Impulse control
 - History of being protective

The Chart on **Slide 50** is often very effective in helping participants see the difference between a strength and a protective capacity.

STAGE THREE: DEVELOPMENT OF CASE PLAN, FAMILY TEAM MEETINGS AND INTENTIONAL VISITATION PRACTICES



Trainer should provide the following overview for this section:

The purpose of a comprehensive family functional assessment is to provide the information necessary to determine the functioning of the family and how it contributes to child safety, permanency and well being. Once the functioning of the family is understood, the family and the worker can partner to develop a case plan that has optimal chance at changing behaviors that caused children to be unsafe as well as contribute to the child’s overall well being.

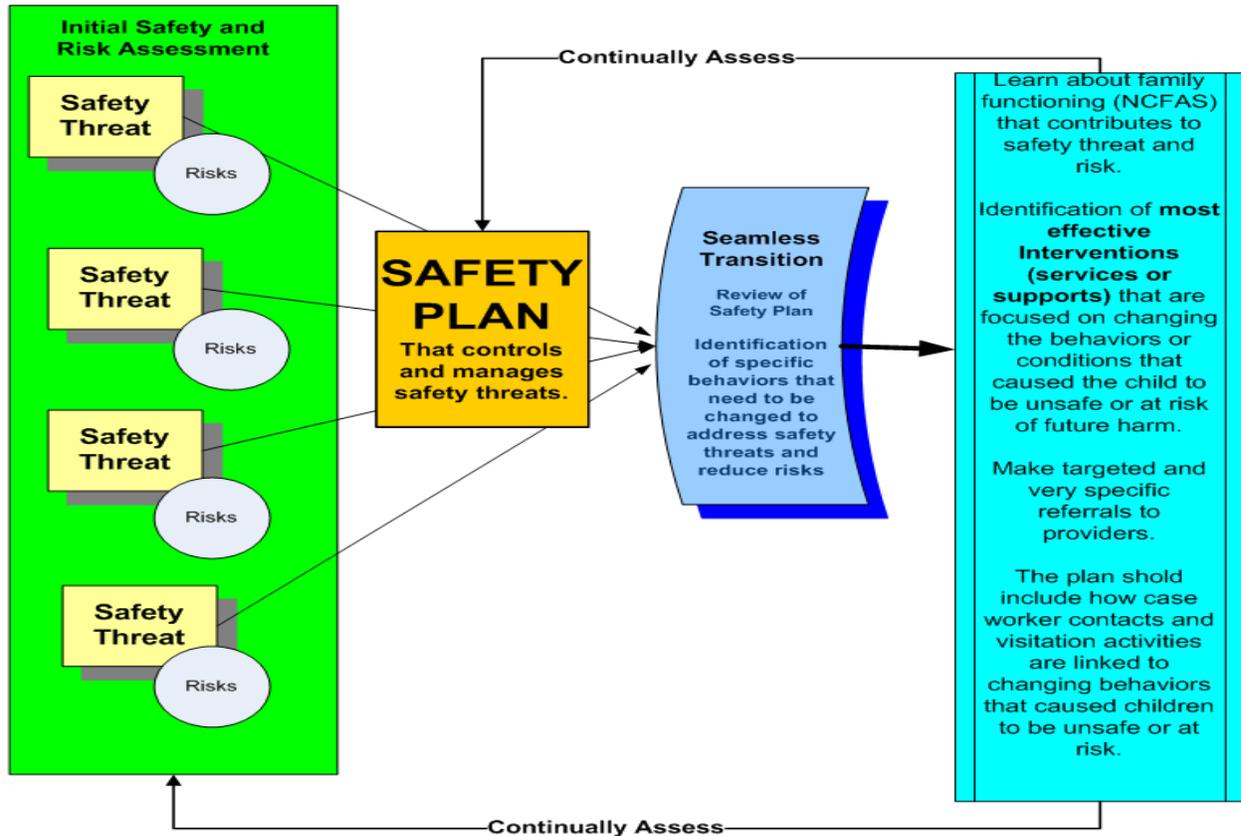
The case plan should be completed only after analyzing all information the worker has collected. **Trainer NOTE: The case plan should reflect the “golden thread” that connects the planned services to the needs that have been identified.**

When families have been active parts of an assessment process that identifies how the family functions that impacts child safety, family strengths and protective capacities it is much easier to put that information to use in creating a service plan that really addresses what the family needs to safely care for their children. The least effective strategy in service planning is for the worker to develop a plan in the office and bring this plan to the families. This process communicates to the family that the worker “knows best” about what they need and minimizes the birth family’s control over their own destiny. It also negates the opportunity for the team members to actively participate in the planning. As in the process of assessment, service planning and service plan review are opportunities to build relationship and should not be short circuited.

This process should be transparent – the worker should share the tools and information being used to build the service plan. The child welfare caseworker is in an excellent position to coordinate and involve other service providers, specialized resources, and the family’s resources toward changing behaviors or conditions that caused children to be unsafe.

Slide 52 depicts the chart below. Trainer should spend some time making certain that participants understand the flow and how each piece links to the other. Trainer you will be reviewing this guide several times throughout the training.

Partnership With Families Enhances Effective Safety and Risk Assessment, Safety Planning and Case Planning



Slide 53 asks that workers consider what to include in the case plan in order to ensure that the case plan has optimal chance at changing the behaviors or conditions that cause children to be unsafe.

Slide 54 defines the elements of a Strong Case Plan:

- Is directly linked to the safety assessment.
- Describes in behavioral terms that families can fully understand what needs to change in order for children to be safe or enhance child well being.
- Identifies specific interventions and actions to address and facilitate the changes necessary for children to be safe

- Includes an ongoing assessment of how protective factors/capacities are supporting children in being safe.
- Includes family's self-identified strengths in the service planning process as a vehicle for motivate.
- Should be viewed by the family as achievable and realistic.

Trainer—remind participants that “People tend to support and be successful in directions that they themselves create.”

Slide 55 provides a construct for how to decide how to develop and focus the case plan. There are times when we learn (either in the initial assessment of safety or in the assessment of family functioning) that the caregivers do not possess the capacities to safely care for their children. This may be due to the fact that the caregivers have significant cognitive limitations, mental illness that cannot be controlled through medication or therapy or physical disabilities that are impacting the day to day care of the child. When this is the case, our role moves from seeking to change behaviors that caused children to be unsafe and instead developing a “wrap” around the children to ensure their safety. This “wrap” may involve kin, community members, or an array of services.

Trainer in Slide 56-57 you are highlighting the important concept that case plans have to focus on changing behaviors that result in children being unsafe or at risk of future maltreatment and NOT simply on compliance to a set of tasks (completion of services.)

Trainer should emphasize that in compliance based Service Planning we write plans that describe a series of services the caregivers should complete and then evaluate if the family “did what they were supposed to do—i.e. completed tasks”. However, in behaviorally based Service Planning we describe the behaviors that need to occur, plan for interventions that support changes in behavior and then we evaluate if the behavior changes are occurring.



Ask workers to think about the families they have worked with over the past year.

- Has there ever been a time when a caregiver was NOT “compliant to a set of tasks but was successful in changing behaviors?
- Has there ever been a time when a caregiver was compliant to a set of tasks but NOT successful in changing behaviors?

Trainers may want to ask “On a scale of 1-10, one being that workers mostly do compliance based service planning and 10 being that most of their service plans are behaviorally based, where would you fall? Then ask them “What would it take to improve your skills in this area?”

This should be an energizing and helpful conversation to the room where workers build on one another’s ideas to improve their skills in building behaviorally based case plans.

Slides 88-96 are examples of behaviorally based case language. These can also be found in the appendix of this TOT tool. When discussing behaviorally based case planning, workers often want examples—so you may want to refer to these during the discussion. A Word document of these examples are also included in the appendix of this TOT Guide.

Slide 58 emphasizes that when making referrals to community providers the worker need to make detailed referrals to community partners that focus their efforts. As challenging as this may be, in the absence of this kind of specific direction we may not get the support that we need from providers to change the behaviors of caregivers that caused children to be unsafe or at risk. This requires enhanced focus and clarity in the referral process.



Slide 59-65 discusses the Family Team Meeting process.

Trainer should emphasize that conducting a family meeting with the parents, children, and identified providers, family and friends can assist the worker and family in designing a case plan that has optimal change of success and is supported by individuals who care about the child and their family.

Trainers make sure that each of the topic areas is discussed. ASK participants to talk about ways that they honor culture, honor voice and ensure full family engagement in team meetings.

In order to best serve families of diverse backgrounds we believe one needs to possess “cultural humility”. Cultural humility “involves the curiosity and motivation to understand the web of meaning in which children and families live, and the reflective capacity to examine our own cultural values and assumptions. It requires a commitment to appreciating the similarities and differences between one’s own culturally shaped goals and priorities and those of the children and families. It requires as well an obligation to ‘rein in’ our power and authority, so that the

voices of children and family members can be fully valued and heard.” These meetings help provide a fuller picture of the family situation and networks, and they help clarify who can be involved in the change process as the worker develops the case plan. Exploring the family’s broader connections to faith communities, tribal or cultural bonds, and neighbors helps families focus on the resources that not only define them but could also help address their current needs.

In preparation for a team meeting the worker should:

- With parents identify key people
- Obtain parental consent to contact all key people and invite them to the meetings
- Prepare each invitee by explaining how family meetings work and the issues that will be discussed
- Clarify what the participants have contributed in terms of assisting with identified needs and the parents’ views about this
- Support family meeting participants in planning how each might help the family
- Identify and review what the participants have committed to do
- Consider whether there are any people who should not be present due to safety issues

Further refine the case plan using the information gathered at the 30 day meeting. This may or may not be the case.

Worker should consult with their supervisor regarding the content of the case plan—ensuring that it is specifically linked to identified safety threats.

Slide 66-73 discuss intentional visitation practices as part of the case planning and service delivery process.

Trainers provide this backdrop to the conversation. Historically conducting visitation may have been viewed as one thing among many things that workers have to do, (something to be checked off) RATHER than visits being intentionally planned and focused on building protective capacities and changing behaviors that caused children to be unsafe or at risk of future harm.

In this model of practice the visitation activities are explicitly linked to helping parents change the behaviors that caused children to be unsafe or at risk of future harm. This means that the visitation activities need to be carefully planned and everyone involved in the visitation process

must be aware of the focus of the visit activities. (This includes visitation center staff, case aides, kin or others involved in supporting the visitation efforts.

The visitation plan serves as an agreement between the agency serving the child in placement and the child's family. It clarifies the structure of visiting, logistics, necessary tasks that are linked to learning new parenting skills—changing parenting behaviors that caused children to be unsafe or at risk of future harm, and the roles and responsibilities of placement caregivers, family members, and agency staff. A written plan reassures children and their families that the agency is invested in protecting family relationships. Research on parental visiting of children in foster care indicates a strong relationship between the development of a visiting plan and actual visitation by parents. Child welfare worker attitudes and behaviors that express encouragement for visiting also have a positive influence on parent visitation.⁴



Describe Arizona Case Example: A worker in Arizona had this effective strategy to integrate visitation and the safety threats that were identified in the case plan.

A single Mom of a three, two and one year old had significant issues with use of drugs and alcohol. She did not drink or use drugs in front of the child and she did not leave the children alone to use drugs. What she did do was to leave her children at basically any friend she could find at home. One of these times, the friend became fed up and contacted child protective services, asking that “CPS come and get these children as she did not know where their Mom was or when she was coming home.”

The safety assessment concluded two things, that 1) the children were unsupervised due to the fact that Mom dropped them off at friends houses not even checking to see if the friends wanted to or could adequately take care of them and 2) Mom did not attend to their basic needs—dropping them off without food or formula, clothing, diapers, toys etc.

The children were placed in care living with Resource Parents who had a strong history of working in partnership with birth families. The worker decided to engage the Resource Mom in helping to role model parenting and supporting the Mom in having her children safely return home.

⁴ Center for Advanced Studies on Child Welfare. (1997).

The Resource Mom agreed to have the birth Mom visit in her home two days a week—one four hour visit on a Monday morning and one four hour visit on a Wednesday evening. The social worker supported the third visit which occurred in the afternoon in parks, and local church settings.

The worker asked that the Mom pack three diaper bags for each of the four hour visits-- one diaper bag for each child. The reason that this was important was because the safety threat indicated that the birth Mom did not meet the children's basic needs—remember she dropped them off without food, clothing, diaper changes, toys, etc?

The first visit the Mom came to the visit with 4 ounces of formula, one diaper and no changes of clothes. The Resource Mom simply helped the Mom use the diaper when the baby needed changing (which occurred about 15 minutes into the visit) and then asked the Mom “what are we going to use for the rest of the visit?” The Resource Mom did not judge, did not preach, just simply asked Mom to be part of the problem solving process.

During the next visit Mom did a much better job and by the third visit Mom nearly had each diaper bag packed so that her children's needs were met for an entire four hour visit.

Then the worker began to focus on helping Mom choose better caregivers. She asked Mom to identify the characteristics of a good caregiver for her children. Mom started slowly...indicating that the caregivers had to be home, and after that was not sure...

Through several sessions with the Mom, the worker helped her to build a “characteristics list” of people who with these characteristics, could safely take care of her children. As she looked down the completed list, Mom started to say “oh no...” and finally she said...”I have to get me some new friends...!”

Mom became acutely aware that she did not have a pool of friends who could adequately care for her children. Most were involved in the use of substances and did not have the characteristics of individuals she wanted to care for her children. The worker began to help Mom to build a new support group.

Based on the effective work by the social worker and Resource Mom, the children were home in 3 months and have not returned to care.

Trainer Should Ask: Do you notice in this case example what we did NOT spend all of our time focusing on? (The answer is Mom's substance use). Mom may have continued to use substances, but the worker remained in contact with the family for 6 months following reunification and the children were well taken care of and Mom's drinking had minimized

significantly. She maintained her employment and no longer leaves the children with caregivers who are not able to safely care for her children.

Slide 72 transfers theory to action. Following each visit the worker or the person supporting the worker in the visitation asks the birth parents the following question:

- Did the visit activities help them to develop the behaviors so that they can more safely care for their children?
- What else do they think that they could do or what else other skills to they need to develop to safely parent their children

Finally **Slide 73** honors the fact that it is nearly impossible to actually facilitate effective intentional visitation practices without the support of a team of individuals. This is why we discussed Family Team Meetings PRIOR to Intentional Visitation Practices. **Engaging families in the process of supporting visitation will reduce the workload pressures on the worker and will expand the resources available to support visitation.**

STAGE FOUR: ONGOING ASSESSMENT

In this module, the goal is to help participants fully understand the link between ongoing assessment and making permanency decisions.

Ongoing Assessment is an active process that requires that workers continually examine if the services and supports provided to the family are successful in helping families to change behaviors or conditions that caused children to be unsafe or at risk.

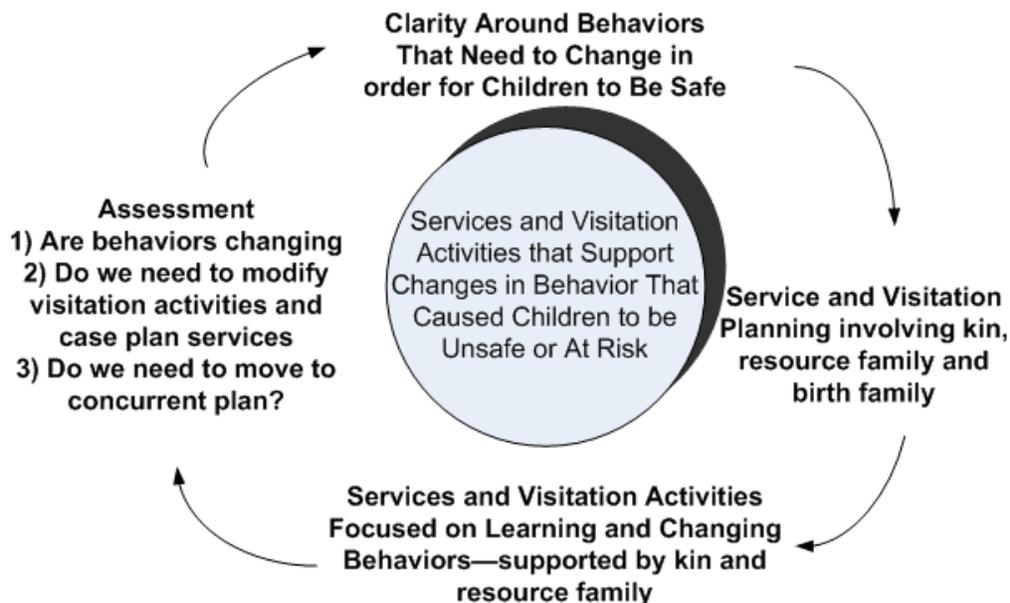
Slides 74-82 focus on workers developing a **Mindset of “Continuous or Ongoing Assessment”**

Assessing the progress of families in changing behaviors that caused children to be unsafe is the foundation of the ongoing assessment of process. The purpose of ongoing assessment is not to evaluate the compliance of the family but to evaluate the efficacy of the interventions in changing behaviors or conditions that caused children to be unsafe.



Trainers should walk through Slide 75 (below) helping participants to see the links.

Continuous Assessment





Trainers should spend some time linking the various components of the case decision making process.

Trainers emphasize on Slide 77 that a case plan is really just a hypothesis. It is our best thinking about the mix and match of services required to actually change behaviors or conditions that caused children to be unsafe. After constructing the case plan with the family we need to test the hypothesis—(delivery services) to determine if we did in fact pull together the right array of services.

Slide 79 provides an array of options on how to assess if behaviors have changed...such as scaling questions, or charts that families can help construct that visually depict progress in changing behaviors.

Slide 80 emphasizes that Case Plan reviews should occur whenever:

- Families make progress in changing behaviors or conditions that caused children to be unsafe
- When families face setbacks
- Parent's stage of readiness to change evolves or deteriorates
- New information is received (e.g., parent reveals history of abuse)
- Family circumstances change (e.g., parent moves in or out of household)
- Any time any member of the team requests it.

Slides 81-84 provide a high level overview of how this approach to ongoing assessment naturally leads to effective Concurrent Planning practices.

Trainers need to note that as we all are aware, there are times, regardless of the services provided and the intentional visitation practice efforts, when parents cannot make the changes required to keep their children safe.

Slide 82 provides a definition of Concurrent Planning. Trainer it is important to stress that concurrent planning

is not merely stating “adoption” or legal guardianship on the case plan. Concurrent Planning is

Concurrent Planning is more than simply stating an option of adoption or legal guardianship. It implies a set of activities that will ensure that there is a permanent, legal adult who knows the child and cares for the child ready to be able to seamlessly transition into providing care.

initiating a set of activities that ensure that when a child needs an alternate legal, permanent caregiver we have done the work to ensure that they have one!

When our ongoing assessment of progress causes us to have concerns that the family cannot make the changes required, we activate the Concurrent Planning process, ensuring that individuals (preferably kin) have been identified and are going through the process that will enable them to care for the children on a permanent basis (foster care licensure, adoption certification process, or legal guardianship).

Slide 84 highlights many of the possible activities that might be initiated in order to ensure that a legal permanent option is ready if the child needs it. Help workers understand that there is work to be done BEFORE the final concurrent plan (details about who, when, where) can be established.

STAGE FIVE: CASE CLOSURE



Trainer should provide the following background as you enter into the discussion surrounding case closure:

Case closure is a significant decision that should reflect the removal of the threats to child safety and the building of a support system for the family that can assist in addressing any ongoing risks that may exist.

Permanency usually initiates a period of transition for the child and family. Post-permanency services are typically required to support families and children as they work to achieve a new equilibrium.

Once post-permanency services are provided, case closure becomes a possibility, and the child and family's situation are re-assessed in the new context. Questions similar to those raised in the beginning phase of the case are explored and answered prior to making the final determination to close the case:

Slide 86 provides a set of specific questions that should be answered by the worker (in concert with their supervisor) to determine if the case should be closed.

- Have the safety threats that were identified been brought under control?
- How do the child and the parents view their situation and the possibility of case closure?
- If the child has been reunified with his or her parents, do the parents continue to demonstrate the changes in behaviors (enhanced protective capacities) that were required for the children to be safe?
- What kinship resources continue to be available to provide ongoing support to the family, including resources of the tribe or clan to which the family belongs?
- What specific community services are needed and utilized by the child or youth and the parents to support their current level of functioning and prevent reoccurrence of those problems that required service?

Workers will reassess whether or not the behaviors that caused the children to be unsafe at case closure and will consult with the supervisor.

Slide 87 outlines the specific forms that must be completed at the point of closing the case:

- SDM risk reassessment
- RCW 1478 case closing form
- MN Safety Assessment
- Case closing interview
- Satisfaction survey regarding services provided (separate from worker performance.)
[To be developed]

References

Children's Bureau. (2009). Schene, Pat. Comprehensive Family Assessment Guidelines for Child Welfare. [Electronic Version] from http://www.acf.hhs.gov/programs/cb/pubs/family_assessment/index.htm.

Contra Costa County Children and Family Services. (2008). Comprehensive Assessments for Positive Family Outcomes (CAPFO) Demonstration Project. Launch Version Starship CAPFA Operator's Manual.

Minnesota Department of Human Services. (2006). Family Centered Practice Guide: Engaging Assessing, and Building Strengths with Families.

NRCFCPP & NRCFCP. (2002). Lutz, Lorrie L. Family centered Assessment Guidebook: The Art of Assessment [Electronic Version] from http://www.hunter.cuny.edu/sicwirj/nrcfcpp/downloads/tools/family_centered_assessment_guidebook.pdf.

Prochaska, J.M. & Prochaska, J.O. (2002). In Children's Bureau (2009) Comprehensive Family Assessment Guidelines for Child Welfare. [Electronic Version] from http://www.acf.hhs.gov/programs/cb/pubs/family_assessment/index.htm.

Ramsey County Community Human Services Department. Short Form: Family Centered Assessment Tool.

University of Maryland School of Social Work Center for Families. (2004). Grandparent *Family Connections Intervention Manual*.

APPENDIX

Attachment 1: Transfer Guide for Communications Between Intake and Ongoing

Initial Transfer Meeting:

5. Concise description of the reason(s) the family came to the attention of the system.
6. Results of the safety and risk assessment—“The child was found to be unsafe due to the presence of the following safety threats....”
7. Description of the safety plan that was put in place and how it is managing or controlling the identified safety threats.
8. Description of the behaviors or conditions of the caregiver’s that have to change in order for the child to be safe or to minimize child risk.

Add this to court presentation or case staffings:

7. Describe the interventions that were put in place to change the behaviors or conditions that caused the children to be unsafe or at risk.
8. Success of the interventions in changing the behaviors or conditions that caused the children to be unsafe.

Attachment 2: Possible Questions To Engage Caregivers and Children During the Functional Assessment Process

(These questions have been compiled by the following contributors, Lorrie L. Lutz President of L³ P Associates, LLC; Grandparent Family Connections Intervention Manual and University of Maryland Social Work Center for Families).

NOTE: We would never ask all of these questions but a select few based on the family's dynamics.

A. Family Telling Their Story

- What are your perceptions why the system is involved in your life —or why your child has been removed from your care?
- Do you believe that any of our safety and risk concerns are valid?
- What has your life been like in the past year? Have there been any big events or changes? How are you and your child dealing with these changes?
- Describe your childhood – what was it like growing up in your family?

B. Day To Day Parenting

General Approach to Parenting

- Do you feel that your children are on a par with other kids their age? (Listen to their description of the problem. Talk to referral source. Observe interactions in interview.)
- What's a typical day like for you and your children? (Be sure to ask each person interviewed.)
- How do you get your children to listen to you? (*Observe: Does caregiver overreact or under-react to child behaviors. Does child show evidence of fear of caregiver?*)
- What's it like for you to parent the children? Is it what you expected?
- Parenting is not something that you wake up and know how to do...it is just hard for all of us. Do you ever get lost as a parent?
- (Observe appropriateness of authority role as evidenced by interactions.)
- Do you and your children have the opportunity to eat meals together?
- Scaling question—On a scale of 1-10, where are you at in comparison with where would you like to be as a parent?
- Could you describe each of your children?
- Could you describe a great memory you have of your family.
- When is a time when your child was very successful—what part did you play in that success?
- What is one special way that you show love to your children?

Discipline

- Do your children know pretty much what to expect in terms of how they'll be punished?
- How were you disciplined as a child?
- What is a day in your life as a parent like?
- What is one creative way that you have dealt with your child's frustrating behavior?

Developmental Stimulation

- Is this (the room you're in) where your kids spend most of their time playing? (Observe various toys, books, games. Too much? Too little? Age appropriateness? Determine what the children like to play.)
- What sorts of activities do you and your children do together in your free time? What's your experience been like with your children's schools? Have you been able to meet your children's teachers? Do you like school? How are you doing in school?
- How do the children get along with each other? Do you have to get involved if they fight or do they work it out amongst themselves?

C. Living Conditions/Finances

- How long have you lived here? Are you satisfied with your housing? Your neighborhood? (*Pay attention to safety concerns. Observe the conditions of the household. If possible take the opportunity to view multiple rooms.*) If something needed to be repaired, how would it get fixed? Is your landlord responsive to your requests?
- Do you want to stay here? Are you able to afford the rent or mortgage? Is there anything that will get in the way of your staying in the home?
- What is your primary source of income? I know it's a struggle but if no emergencies arise are you able to pay your monthly expenses with what you receive? If you receive TCA have you been told you need a job to continue to get benefits? Are you able to take care of your family's needs?
- Do you find that you frequently run out of food stamps or money before your next check comes?
- How do you get to appointments and other places? (Assess level of difficulty)
- Where is the best place you ever lived? Why did you like it?
- What would make where you live today more like your best place?
- Have you ever applied for public assistance (TANF, food stamps, day care subsidy, or utility assistance)?

D. Family Connections and Supports

- When you need help with something are there family members or friends you turn to? What about your neighbors?
- How supportive is your family? Can you rely on them?
- Is finding adequate child care a major concern for you?
- Do you feel comfortable with your child's babysitter or do you wish you could find someone else?
- (Look on intake for children's health care provider) Where do your children go for health care? Where do you go? How satisfied are you with the care you receive? What about dental care?
- Can you tell me a little about the 3 most important relationships in your life right now?
- Do you currently have any physical condition that makes it hard to care for the home, yourself, the children? In the past, have you had difficulty caring for the home, yourself, or the children? How about emotional stresses that may have made it difficult to care for yourself, the home, or the children?
- How does your family have fun? What activities do you and your child like to do outside of the home?
- Who do you trust?
- Are you involved with any church or community group?
- Sometimes when you don't know how you are going to feed your children, it is hard to focus on anything else---do you ever struggle like this? Who helps you during these times?

E. Caregiver History

You have told me a lot about you and your family, including your needs. It would help if I knew more about you. I'd like to ask you some questions about things that may be difficult to talk about. Your answers will help me to understand you and your family better, but please let me know if there's anything you don't feel comfortable discussing.

- What was your childhood like? Who'd you live with? When you look back do you feel positive about your childhood?
- Have you or anyone else in your family been a victim of sexual abuse? What about domestic violence? (If yes, find out if they received counseling.)
- Do you use alcohol or any other substance? (If yes) How much? How often? Have you in the past?
- What do you do when you get really ticked off at another adult? (If response indicates use of physical violence, ask) Have you ever been arrested for assault?
- Has anyone ever assaulted you, either verbally or physically?

F. Caregiver Personal Characteristics

- Impulse control – refer back to “What do you do when you get really ticked off at another adult?” and observe interactions with family members. Do you see yourself as a “laid-back” person or do you tend to “go off” when you get mad? Do you ever get into trouble because of your reactions?
- Cooperation – Observe response to interviewer and openness to agency involvement.) You may have worked *with other programs in the past. How were they helpful? How were they not helpful?*
- Emotional stability – Observe congruence between affect and content. Observe range of emotional responses. *Do you see yourself as a moody person or are you mostly pretty much the same? Which feeling – happy, sad, angry, or scared – describes how you feel most of the time?*

G. Medical Needs Of Caregivers

- Do you have a doctor (medical provider)? Dentist? When was the last time that you saw the doctor/dentist?
- Do you have any health conditions that impact your ability to care for your children?
- Has your health ever held you back from getting a job or taking care of your children?
- Are there any medications that you are taking?

H. Parent’s Mental Health

- Do you ever feel like you just can’t take it anymore?
- Do you ever have a hard time just getting going in the morning? When you cannot “get going” who takes care of your child?
- Do you have a mental health diagnosis? If so, are you on any medications? Do you take them regularly?

I. Parent Substance Use

- How do you get through a bad day?
- Has your drinking or drug use caused job, school, family, or legal problems?
- Do you ever use prescription drugs in ways other than prescribed?
- Do others in the home abuse alcohol or other drugs?

J. Family Violence

- On a scale of 1-10 where would you rate your relationship with your partner/spouse/significant other? What would bring you closer to a 10?

- All couples argue, how do you resolve conflict in your family? Have the police ever been called to your home? Have you ever been concerned about the safety of your children when you argue with your partner?
- Has your child ever scared you or threatened to physically harm you?
- Questions to ask the child:
- *What happens when there is an argument?*
- *Have you ever seen or heard someone in your family hurt another family member?*
- *Are you ever afraid something is going to happen to you or to your parents?*
- *Do you have a pet—if so have you ever been worried about the safety of your pet?*
- *Has any of your siblings scared you or threatened to physically harm you or any member of the household?*

K. Child Well Being

Child Substance Use

- Are you concerned about your child's use of substances (legal or illegal) or alcohol?
- Have you (the child) ever felt like you should cut back on your drinking or drug use—or felt bad or guilty about it?
- Has your drinking or drug use caused school, family, or legal problems?
- Have you ever felt annoyed by criticism of your drinking or drug use?
- Do you ever think about drinking or using drugs when you are in school?
- Do your peers ever pressure you to drink or use drugs? What do you say?
- Do others in the home use alcohol or other drugs?

Child/Youth Mental Health

- Does your child have any behavioral problems that worry you? If so, please describe your child's behaviors.
- Has your child ever been evaluated for mental health issues by anyone? If so, what was the outcome? What were you told to do to help your child?
- Have you had to miss work or school because of your child's problems?
- Is your child on any medication for emotional or behavioral issues? Do you give your child this medication regularly?
- Questions to Ask the Child/youth
- On a scale of 1-10 how would you describe how happy you are? Scared you are? Confident you are?
- How do you handle stress in your life?
- Do you ever feel so down that you think about "ending it all"?

Child/Youth Educational Issues

- What about your child/youth's school performance makes you proud?
- What is your child's best subject? Where does your child struggle in school?

Questions to ask the child/youth

- Do you ever have problems understanding what your teacher is saying? Do you have any trouble reading the board?
- What is the hardest part of school for you?
- Do you ever skip school? Where do you go when you skip school?

Medical Needs of Child

- Does your child have a doctor (medical provider)? Dentist? When was the last time that your child went to the doctor/dentist?
- Does your child have any health conditions that cause you concern?
- Have any of your children's health issues ever kept you from going to work?
- Are there any medications that your child is taking?
- Do you know if your child is sexually active?

Additional Possible Questions for Interviewing Children

Gathering Information

1. Open-ended Questions/How to elicit more:
 - Tell me more about that
 - Tell me about a time when...
 - What happened then?
 - Did anything else happen?
 - Was anyone else around?
 - Do you remember when, what were you doing?
 - Has it happened since?
 - How did you feel when.....?
 - I wasn't there so....
 - Even if you think I know, tell me anyway.
 - Even if you think it doesn't matter...
 - You told _____ something happened.....
 - What happens to someone when they get in trouble?

2. Home Life:

- We are going to talk about your day from the time you wake up to the time you go to sleep.
- Where do you sleep? Who puts you to bed? Who sleeps in the room and where?
- Who wakes you up in the morning?
- What do you have for breakfast? What is your favorite food?
- What happens at dinnertime?
- Do you have chores? What happens if you don't do your chores?
- Who stays home with you if you are sick?
- Clothes – Who buys them for you? What was the last time you received something new? What is your favorite outfit? Where do you keep your clothes?
- How do you like living here?
- What do you like best/least about living here?
- What do you do for fun?
- Who is your favorite person in the family? Why?
- Who would you go to if you needed help if someone harmed you or threatened you? Has anyone ever done that?
- Has anyone ever told you not to tell this SW something because you might get removed or hurt?
- Looks like you have a bruise on your knee. How did that happen?
- What happens when someone is really liked by the caretaker?
- What happens when the foster parent/caretaker has to be somewhere without you? Who watches you?
- How do you feel about that?
- Is there anyone you don't like to stay with? Why?
- What happens when the foster parent/caretaker gets mad?
- If you could change something here, what would it be?

3. Education

- Do you go to school? How do you get to school?
- What's your teacher's name? Do you like your teacher?
- What's the easiest thing about school? What's the toughest?
- What happens after school? How do you get home? Do you have to do homework?
- Who helps you?
- Have you missed any school?
- Tell me about your school. What grade? Friends at school? What don't you like about school? What do you do at recess? Recent grades?

4. Medical/Dental/Therapy

- Are you going to counseling? How do you like it? What do you do? Do you think it's helpful?
- Have you been sick recently? Who is your doctor?
- When was the last time you saw a dentist? Who is your dentist?

5. Family/Visits

- Do you have contact with your Mother? Father? Sibs? Others? When was the last time you saw any of them?
- Talked to them on the phone? Do you have phone numbers? Do you want contact? Do you want to write to your family? Do you have private/confidential time with family? (if appropriate)

6. Court

- The next court hearing is....
- Do you wish to attend (current statute requires for any child aged 10 and over)?
- If appropriate, share purpose of the hearing and possible outcomes
- Is there anything you would like me to tell the Judge?
- You have an attorney and someone from his or her office may be visiting you.

7. Safety

- If something happens to you or someone else scares you, hurts you or makes you sad, who would you tell?
- (Brainstorm who they could tell).
- Is there anything that you don't want to tell me or are afraid to tell me?
- Have you told someone else? Who?
- Does anyone else know about it? Who?

Closure

- Do you have any questions? Anything else you want to talk about?
- Discuss what information will be shared with caregiver. Is there anything you would like me to talk about with your foster parents/caregiver?
- Provide business card (if age appropriate) with emergency number listed letting the child know that they have the right to call you anytime.
- Thank child for participation (not for giving information).

Attachment 3 Behaviorally Based Language Examples

SEXUAL ABUSE CASE EXAMPLE

- 11 Y/O CHILD REPORTED TO TEACHER THAT SHE WAS SEXUALLY ABUSED BY HER STEP-FATHER.
- MOM AND STEP FATHER MARRIED FOR 18 YEARS.
- STEP FATHER DENIES THAT HE HARMED HIS DAUGHTER
- MOM INITIALLY STATES THAT SHE DOES NOT BELIEVE HER CHILD
- FOUND AN AUNT WHO BELIEVED CHILD AND WAS WILLING TO CARE FOR CHILD
- AUNT WAS FULLY ALIGNED WITH US IN PROTECTING THE CHILD-AND WOULD NOT ALLOW STEP FATHER ACCESS TO THE CHILD
- SAFETY PLAN WAS FOR CHILD TO GO WITH AUNT
- OTHER CHILDREN WERE ASSESSED TO BE SAFE
- STEP FATHER LEFT THE HOME THE FIRST NIGHT BUT IS NOW BACK AT HOME.

BEHAVIOR/CONDITION THAT NEEDS TO BE CHANGED

MOM PROTECTS HER DAUGHTER FROM BEING HARMED BY NOT ALLOWING STEP FATHER ACCESS TO HER.

ACTION STEPS:

- MOM AND DAUGHTER GO TO COUNSELING TOGETHER WHERE DAUGHTER CAN TALK TO MOM ABOUT THE EXPERIENCE IN A SAFE AND PROTECTED ENVIRONMENT
- A SCHEDULE IS CREATED WHERE THE CHILD AND FATHER ARE NOT IN THE HOME AT THE SAME TIME –AUNT WILL SUPERVISE. (*THIS WILL ENABLE CHILD TO SEE BROTHERS IN OWN HOME ENVIRONMENT.*)
- STEP FATHER ATTENDS PARENT DENIERS GROUP
- STEP FATHER DOES NOT SPEND TIME ALONE WITH HIS DAUGHTER

BEHAVIOR/CONDITION THAT NEEDS TO BE CHANGED

- DAUGHTER LEARNS SPECIFIC SKILLS TO HELP PROTECT HERSELF IN THE FUTURE
- DAUGHTER HAS AN IDENTIFIED INDIVIDUAL (AUNT) TO GO TO IF SHE FEELS UNSAFE.
- DAUGHTER IS ABLE TO STATE THAT THE ABUSE WAS NOT HER FAULT.

ACTION STEP:

- DAUGHTER GOES TO SEXUAL ABUSE VICTIM'S SUPPORT GROUP

SUBSTANCE ABUSE CASE EXAMPLE:

- WHAT WE OFTEN SEE WHEN A FAMILY PRESENTS WITH SUBSTANCE ABUSE ISSUES A GOAL THAT LOOKS SOMETHING LIKE THIS:
 - “MOM WILL LIVE A SUBSTANCE FREE LIFESTYLE.”
- WHAT DOES THIS MEAN?
- WHAT REALLY MATTERS IS IF THE CAREGIVER IS USING DRUGS OR DRINKING IS DIRECTLY IMPACTING THE SAFETY OF HIS/HER CHILDREN?
- ARE THEY LEFT UNSUPERVISED? ARE THEY UNFED? ARE INDIVIDUALS CARING FOR THE CHILDREN WHO ARE UNSAFE? ARE THERE PEOPLE IN THE HOME WHO ARE UNSAFE?
- THESE ARE THE THINGS THAT NEED TO CHANGE AND SHOULD BE SPELLED OUT IN THE BEHAVIORAL CHANGE REQUIRED SECTION OF THE CASE PLAN.

SO, FOR A MOM THAT DRINKS DAILY—AND AS A RESULT LEAVES HER YOUNG CHILDREN (AGES 2 AND 5) UNSUPERVISED AND UNFED—AND HER DRINKING HAS RESULTED IN A LACK OF EMPATHY AND ENGAGEMENT WITH HER CHILDREN....

BEHAVIOR/CONDITIONS THAT NEED TO CHANGE TO ADDRESS THE RISKS IDENTIFIED:

- MOM IS AWAKE WHEN HER CHILDREN ARE AWAKE AND SHE ENSURES THAT THEY ARE SAFE.
- CHILDREN ARE FED THREE MEALS PER DAY.
- WHEN CHILDREN ARE HURT OR CRY MOM GOES TO THEM TO ASK THEM IF THEY ARE OK AND COMFORTS THEM.
- THE 5 YEAR OLD IS NOT EXPECTED TO FEED, CHANGE, OR SUPERVISE THE 2 YEAR OLD.

ACTION STEPS TO SUPPORT THE BEHAVIOR CHANGE:

- SOCIAL WORKER SCHEDULES UNPLANNED VISITS WITH MOM TO ENSURE THAT SHE IS AWAKE WHEN CHILDREN ARE AWAKE.
- MOM RECEIVES A SUBSTANCE ABUSE SCREENING/ASSESSMENT TO DETERMINE HER LEVEL OF SUBSTANCE ABUSE. SCREENING RESULTS AND TREATMENT RECOMMENDATIONS WILL BE INCORPORATED INTO SERVICES/ACTION STEPS.
- MOM ACCESS WIC SERVICES AND SUPPORTS. WIC NUTRITIONIST HELPS MOM TO PLAN MEALS FOR CHILDREN.
- MOM IS PROVIDED WITH IN-HOME COUNSELOR TO ASSIST HER IN LEARNING AGE APPROPRIATE EXPECTATIONS FOR HER CHILDREN AND TO HELP HER RESPOND TO CHILDREN’S EMOTIONAL NEEDS.

FAMILY VIOLENCE CASE EXAMPLE

- THERE HAVE BEEN 2 REPORTS OF JEREMY (15 Y/O) AND HIS FATHER GETTING INTO VERBAL ARGUMENTS THAT THEN TURN INTO PHYSICAL ALTERCATIONS.

BEHAVIOR/CONDITIONS THAT NEED TO CHANGE REQUIRED TO ADDRESS THE RISKS IDENTIFIED:

- JOSEPH AND HIS FATHER RESOLVE ISSUES WITHOUT VERBAL OR PHYSICAL VIOLENCE.

SERVICES/ACTION STEPS:

- ANGER MANAGEMENT CLASSES: BOTH JOSEPH AND HIS FATHER WILL ATTEND ANGER MANAGEMENT CLASSES TO LEARN SKILLS THAT STOP THE VERBAL INTERACTIONS THAT HAVE, IN THE PAST LED TO PHYSICAL CONFRONTATIONS.
- REVIEW WITHIN 45 DAYS TO DETERMINE IF CLASSES ARE BEING EFFECTIVE.

CHILD BEING HARMED AT SCHOOL CASE EXAMPLE

- RANDY (9 Y/O) WAS JUMPED AT THE BEGINNING OF THE SCHOOL YEAR BY SEVERAL STUDENTS AND WAS INJURED.
- RANDY HAS GOTTEN INTO SEVERAL FIGHTS. ON ONE OCCASION HE REPORTED THAT ANOTHER YOUTH ATTACKED HIM AND HE WAS ATTEMPTING DEFEND HIMSELF. HE INDICATED THAT THE OTHER STUDENT HAD HIM IN A HOLD SO TIGHT THAT HE BECAME UNCONSCIOUS.
- RANDY DEFENDS HIS ACTIONS AND REPORTS SEEM TO SUPPORT THAT HIS REACTION WAS ONE OF SELF DEFENSE.
- HOWEVER, HE IS GROWING INCREASINGLY ANGRY AND RESENTFUL AND IS TALKING ABOUT "BEATING THE CRAP" OUT OF THE KIDS WHO BULLY HIM.
- RANDY REPORTED THIS TO HIS PARENTS WHO TOLD HIM TO "BUCK UP AND TAKE IT LIKE A MAN"
- PARENTS ENCOURAGED HIM TO TAKE THE BULLIES OUT BACK AND "BEAT THE SHIT OUT OF THEM".

BEHAVIORAL/CONDITIONS THAT NEED TO CHANGE:

- RANDY IS SAFE IN THE SCHOOL ENVIRONMENT.
- DAD AND MOM PROVIDE RANDY WITH SPECIFIC ALTERNATIVES TO FIGHTING IN SCHOOL

ACTIONS STEPS/SERVICES:

- RANDY AND HIS PARENTS WILL ATTEND THE HOPE CENTER TO LEARN HOW TO AVOID CONFLICT/BULLYING SITUATIONS AND WORK ON STRATEGIES AND TECHNIQUES TO AVOID CONFRONTATIONS
- SCHOOL PERSONNEL WILL ACTIVELY HELP TO KEEP RANDY SAFE BY KNOWING WHERE HE IS DURING SCHOOL HOURS.
- RANDY'S MOTHER WILL ENSURE THAT RANDY GETS TO SCHOOL SAFELY.

- RANDY'S HISTORY TEACHER AGREES TO MAKE SURE THAT RANDY GETS HOME SAFELY AS RANDY'S PARENT WORK AND ARE NOT AVAILABLE AT THAT TIME.
- RANDY WILL SEEK OUT IDENTIFIED SCHOOL PERSONNEL TO AVOID VIOLENT SITUATIONS