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Ramsey County Supervisory Guide for FA

2011

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Background: Coaching and Mentoring in the Implementation of a Practice Model

About Practice Models

Increasingly, organizations across the country are recognizing the need to integrate and align their missions, visions, and core practice principles in clear and concise manners that influence practice development and training curricula and serve as focal points for supervision, quality improvement processes, and assessments of outcome data. The product of this integration and alignment is a practice model.

The Ramsey County Comprehensive Assessment Model of Practice is a conceptual map and organizational ideology that includes definitions and explanations regarding how staff partner with families, service providers, and other stakeholders in the delivery of services to achieve positive outcomes for youth and their families.

The values and principles that serve as foundation of the Comprehensive Family Assessment model of practice are highlighted below:

- 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

The Supervisory Role of Coaching and Mentoring

The purpose of coaching staff is twofold:

➔ ***Creating Awareness***

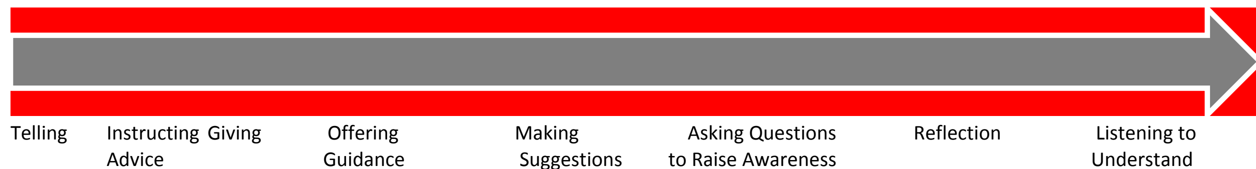
➔ ***Promoting Responsibility***

Creating Awareness

Coaching helps the worker understand what led to his/her decision making, conclusions and what biases may be impacting the work. It helps create self awareness, a level of self analysis and an understanding of how external stimulators (such as peers, community,) may be impacting decision making. By posting questions that ask the worker to critically think about their conclusions in a safe environment…it creates an understanding that can impact the specific case the worker is discussing as well as other cases.

Promoting Responsibility
Coaching helps move the worker from simply "doing what they are told" to actually owning the decisions and the work with the family. It creates a level of motivation within the worker to work effectively with the family—because they own the decisions. If a supervisor creates an environment where workers can come to conclusions on their own, it enhances their professionalism and in the long run helps them develop their professionalism in the field.

Below is a continuum depicting the range of directive-nondirective techniques.[1]



DEVELOPING CRITICAL THINKING

Critical thinking is the intellectually disciplined process of actively and skillfully conceptualizing, applying, analyzing, synthesizing, and/or evaluating information gather from, or generated by, observation, experience, reflection, reasoning, or communication, as a guide to belief and action.[2]

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.

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
- They recognize errors and mistakes as learning opportunities
- They more accurately assess likelihood of attaining hoped-for outcomes

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[1] Developed by Marsha Salus, MSW.

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

- They make valuable contributions at case conferences
- The develop effective plans
- They respect and have empathy for others

Listening and asking questions to guide a worker are key elements of coaching to promote critical thinking. **Coaching involves using nondirective techniques to promote understanding and analysis.** One of the most effective coaching strategies used by supervisors is asking smart, creative and focused questions to get the worker to think about the family in a different way. *NOTE: As workers become accustomed to responding to these questions during the supervisory process, they will most likely begin to use similar kinds of questions when engaging the family.*

There are several kinds of questions used in the coaching process:[3]

- Broad Questions
- Probing Questions
- Questions that ask that the worker look at the situation from a different perspective
- Exception questions
- Scaling Questions
- Miracle Questions

Broad Questions --extremely broad open ended questions are used to get a discussion started. For example, "Tell me about the parents." This allows the worker to respond in many different ways. It allows the worker to tell you what is most significant. In addition, during your discussion you want to continue to ask open-ended questions. For example, "How would you describe their relationship with the child?" versus "What disciplinary techniques do the parents use?" Obviously, the first is broader because it allows for many more types of responses. The second question limits the answers to what was said and it may prevent the worker from telling you what is really important. Sample of broad questions include:

- Say more about that.
- Tell me more.
- And?
- What's behind that?
- You mentioned that … tell me more about that.

Probing Questions-- are used in case discussions to explore the worker's situations. Probing questions bring out information on the table and force the worker to really examine what is

[3] *Stoltzfus, T. (2008) *Coaching Questions: A Coach's guide to Powerful Asking Skills.* Virginia Beach, VA: Tony Stolfus.

going on. Sometimes just the act of exploring and thinking things through in a structured way will bring the solution, without even looking at options. Probing questions are open ended questions. Another type of open ended questions is an indirect question. This is a question in the form of a statement. It usually begins with “Tell me about”, “I’m curious about”, “I’m wondering.” Throughout this document are questions that the supervisor can use to support the clinical consultation process. Below are examples of general probing questions:

- What leads you to conclude that? What data do you have for that? What causes you to say that?
- What is the significance of that? How does this relate to your other concerns?
- How did you arrive at that view? Are you taking into account data that I have not considered?
- What else is important to this discussion?
- What feelings do you have about this?
- Give me a concrete example of that?
- What did you mean when you said ….?
- Give me some background; what led up to this situation?
- What do we know for a fact? What do we sense is true, but have no data for yet? What don’t we know? What do we agree upon and what do we disagree on?

Questions that Examine the Situation from Different Perspectives-- Another important coaching skill is looking at a situation from different angles or perspectives. The following are the areas to explore to create awareness and responsibility.

The Past

- What led up to this?
- Give me some background; how did they get to this place?
- Tell me about some services/interventions the family has used in the past that have been helpful?
- When you have worked with other families who have overcome substance abuse, what made it possible?
- What has the family been doing to make it work?
- When they were following through on the plan, what did it look like?

The Future

- Where do you see this going?
- What do the parents think they need to address the problems in the family?

Patterns

- Have parents been in this place before? Describe what happened?
- Have there been times when the problem could have happened but it didn’t?

Emotions

- How does the family feel about that/
- Describe the emotions this situation brings to the surface in the parents.

The Concrete

- Give me a specific example of that?
- What exactly did you say?
- Tell me exactly what happened?

The Heart of the Matter

- What are the real issues here?
- What makes this significant to you?
- Tell me about the last time you met with the family, how did it go? Who was there, what was said and then what happened?
- You say that almost every time you meet with the Mom she is angry. The last time you met with her and she was angry; can you describe how that contact/visit went from the beginning? And then what happened? How was that contact/visit like other visits? How was it different?
- You said the parents are resistant. What leads you to conclude that? What data do you have for that? What causes you to say that? Tell me what the parents said and did during your interview.
- How does he/she see the problems? How does he/she explain the problems? What is he/she willing to do and what will he/she not do? What resources are there to draw upon -- extended family, neighbors, church, friends?

Exception Finding Questions—are questions that help the worker to understand if there were times that the family was functioning well, and what was happening during that time. Examples of exception questions include:

- What do you think made it different that time?
- If you could repeat the time Mom was really listening to you, what would be happening?
- Tell me what the client says is different for at the times when he doesn't lose control?
- How does the client explain why the problem doesn't happen at those times?
- Tell me about a time when you thought it was going to be hard to get someone from the school to participate in the planning process and you were able to make it happen?
- So that was a time when you thought you wouldn't be able to find a resource for a family and you did. How did you make it happen?

Scaling Questions-- help the worker to assess family's current progress. Examples include:

- How viable do you think the current service plan is with one being it is unlikely that anything will be accomplished and ten being a slam-dunk that all of this is going to happen? What would have to happen to turn this plan into a seven?

- If ten is the most motivated to change and one would be totally resistant to change, where you say the parents are? Well, if you are seeing them as a five, what could you do together to get it to a six?
- You have said that one of your worst fears in working with the whole family together is managing conflict. If ten is connected to excellent skills at managing conflict and one is someone who ends the meeting when conflict begins, where would you rate yourself on a scale of one to ten? If you see yourself as a four, what would it take to get to five?

Miracle Questions- are focused on helping the worker to imagine things going differently (better) with the family. These are often helpful when a worker is stuck and has given up hope that the family can make the required changes in behavior to safely care for their children. Examples include:

- If you had a crystal ball and could see things going the way you want it to go, what would be happening?
- You have a magic wand and you can make any three things happen in your work with the family, what would you pick?

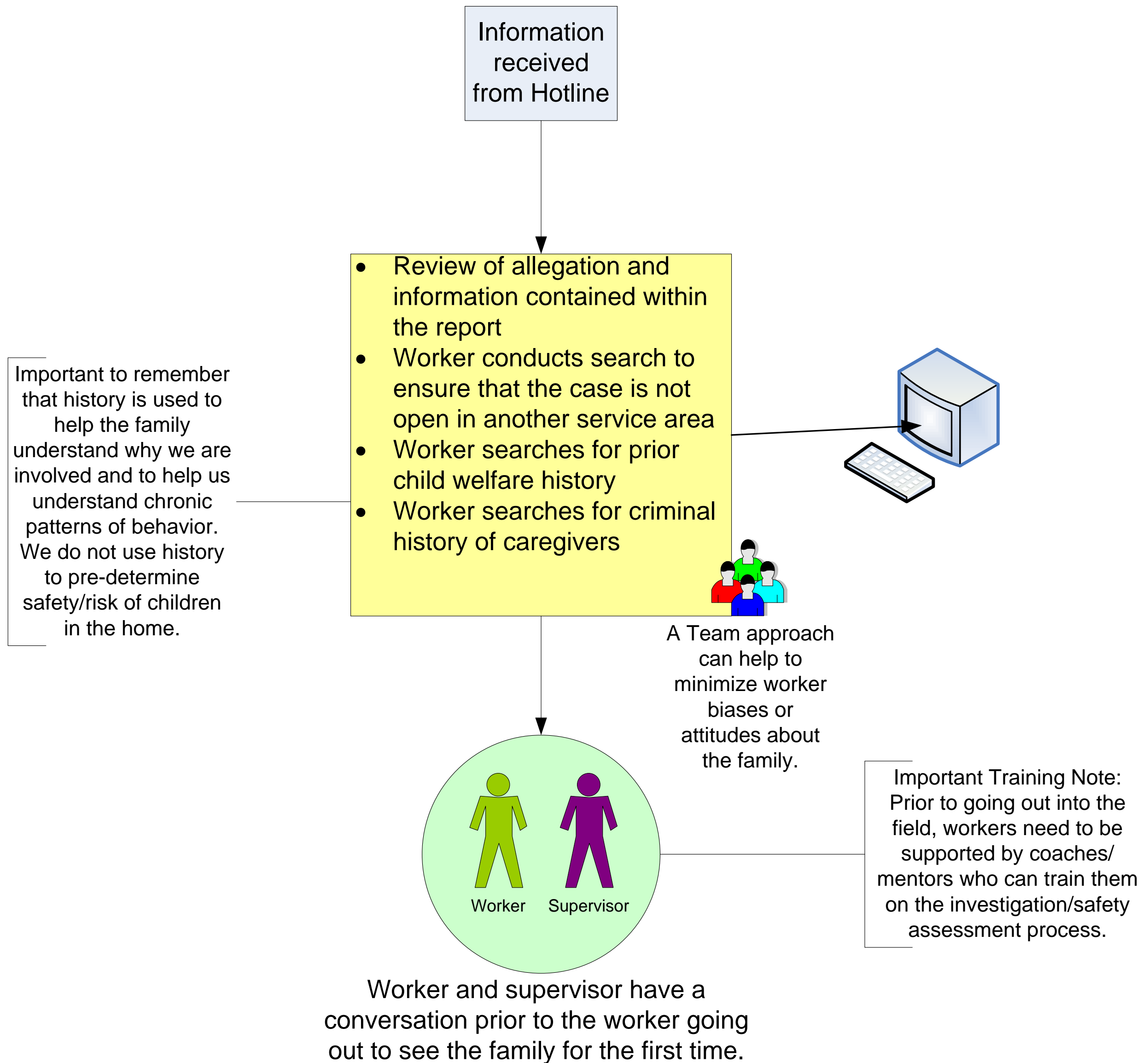
Implementation of the Comprehensive Family Assessment Practice Model in Intake

The following pages depict a visual of the flow of practice case opening to case closure.

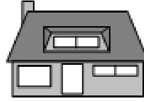
The specific modules in include:

Following the flow charts is a narrative that describes techniques, strategies and the critical thinking required by workers to fully implement Comprehensive Family Assessment.

Review of Information From Hotline and Search for Family History

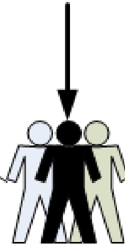


Initial Interaction with the Family and Completion of Safety Assessment



Conversation at the front door should include an introduction by the worker, request to come into the family's home to talk, and an attempt to put the caregiver at ease.

NOTE: Pay attention to how we talk about families-when we are not in their presence. This influences our thinking about families.



Research demonstrates that there is a direct correlation between family engagement and child safety.

Initial Meeting with the Family

The worker should demonstrate respect of the family by the following:

- Asking where the family would like to sit down and talk
- Asking family members how they would like to be addressed
- Seek to ease the family's fears
- Share the purpose of the visit/discussion
- Seek to engage the family in their primary language
- Attend to our language –not using terms that are unfamiliar to the family.

One of the first responsibilities of the worker is to determine the location of the children and if they are in danger.

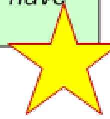
Worker needs to be aware of surroundings—determining how safe it is for family members to talk.

Worker should seek to obtain permission to conduct individual interviews with the children in the family. Pay attention where to interview the children—so that it is safe for them.

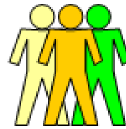
Safety Assessment (cont)

Remember: There can be no specific incident and a child can be unsafe, or there can be an incident and a child can be safe.

*Information gathering is not limited to learning about whether or not an "incident occurred" but a process that involves a **full assessment of child safety** including information about an incident that may have occurred.*



Critical thinking and analysis begins at this stage of the work. Synthesizing through a lot of information, paying attention to the right information.



The **information standard** in safety intervention refers to what should be known about a family in order to fully evaluate the presence of a safety threat and the caregiver's protective capacities. Specific areas that must be assessed include:

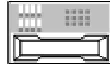
- Behavioral health issues in the family and how they impact the safety of children.
- Parenting skills including how caregiver was parented.
- Disciplinary practices including how caregiver was disciplined.
- Substance use/abuse issues n the family and how they impact the safety of children.
- Housing/environment/and ability to meet children's basic needs.
- Family dynamics/relationships/support system.
- Child functioning /characteristics.
- Medical issues in the family that may impact the safety of children.

See array of strength focused questions in the narrative that can assist in information gathering. The way that questions are posed can engage even the most reluctant caregiver.

In each of these areas the worker is assessing if this domain area is impact child safety. The worker is also looking for **protective capacities**, that can be mobilized immediately to protect the children if needed.

NOTE: Protective capacities are not promises or hopes, they are skills and abilities that the caregiver currently possesses that can be operationalized immediately to keep children safe.

Safety Decision



A conversation with the supervisor occurs on the phone as part of the decision making process.

Workers need to use the SDM Safety Assessment framework to assist in the decision making process. This validated instrument helps to remove the impact of personal bias and guides the determination of child safety. Critical thinking, conversation with the supervisor and use of the tool result in decision if the child is safe.

Examine five criteria in the decision making process: Imminence, Out of control, Vulnerable child, Specific and observable and Severity of harm.

Decision

Safe (No presence of Safety Threat)

Risk

High Risk

Unsafe (There is the presence of a safety threat)

Unsafe

Safety Planning

If a child is determined to be unsafe, the safety plan must be developed BEFORE the worker leaves the home.

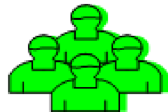
Safety Planning

Safety planning and ongoing oversight refers to something specific that continues along the life of a case.

Examples of safety plans to manage child safety might include:

- Person who harmed the child is officially out of the home or the caregiver who did not harm the child has a protective resource to ensure that the person who harmed the children does not come back into the home

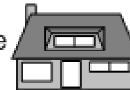
- Caregiver who did not harm the child and the children go somewhere else, and there is an individual in the home to help protect the children



Kin who control and manage safety threats

NOTE: Whenever we are relying on another person (kin for example) to help us protect the children—we must explore their alignment with us in protecting the children and their protective capacities.

- Bring into the home someone who has "eyes on the child" and is committed to protecting the children if the caregivers do not have the protective capacities.



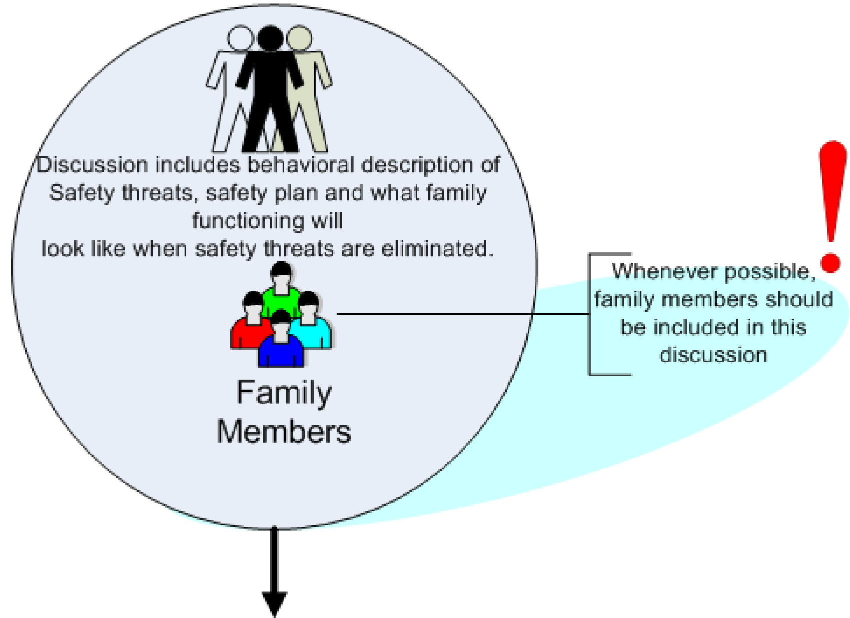
- The child is placed in out of home care (this includes both kinship care and traditional foster care.

The safety plan MUST specify how the safety plan protects the child, the role of each person identified in the safety plan including when the individuals identified within the safety plan must contact the worker.

A Safety Plan is in existence as long as the Safety Threat exists. It is not voluntary and is not **necessarily a temporary plan**.

The safety plan must be implemented and active as long as impending danger threats to child safety exist and caregiver protective capacities are insufficient to assure a child is protected. Safety plans often remain in place for weeks into months and co-exist with the ongoing case (treatment/case) plan.

Case Transfer Discussion (in FA cases this discussion occurs with the supervisor)

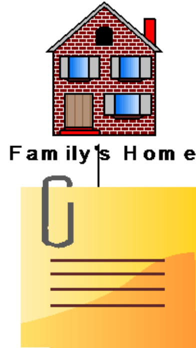


Include discussion of the safety plan and how it is controlling and managing safety threats.

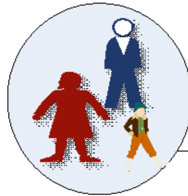
The Chart Below Creates Clarity for Family and Team on Focus of the Work

Safety Threats (Described Behaviorally)	Behavioral Description of what it looks like of the safety threat no longer exists	Interventions to be used to change behaviors/conditions—including Intentional Visitation	Ongoing assessment—are the services working to change behavior?

Family Functional Assessment and Behaviorally Based Case Plan



If the child is in the home as a result of an in home safety plan, the worker must brings the written safety plan and walk through it-ensuring that it continues to manage and control safety threats.



Critical components of family engagement at this point of the process include:

> Finding ways to hear family voice—identify and reinforce family strengths, identify needs and understand the dynamics from the family's perspective.
> Honoring the culture and race and ethnicity of the families we serve. Understanding that the unique cultural, racial and ethnic identities of families is an essential perspective to the work.
> Deliberate conversations about who families are—without pre-conceived notions.

Completion of the Comprehensive Family Functional Assessment with the family helps inform the case plan. Information is also compiled from the larger team—such as education, other family members, medical providers, etc.

The completion of the Functional Assessment is intended to give the worker have a better understanding of the underlying causes of behavior and underlying needs related to child safety and risk. **This allows us to develop a case plan that has optimal chance of meeting needs and changing behaviors of caregivers.**

Referral to providers that describe specific behaviors that need to change—and underlying needs must be met. The content of reports from providers needs to specifically focus on meeting needs and changing behaviors.

Completed in concert with the family and the Family Team. Family is clear about what needs to change in order for children to be safe.

Behaviorally Focused Case Plan To Address Underlying Family Needs That Contribute to Children being unsafe or at risk of future harm

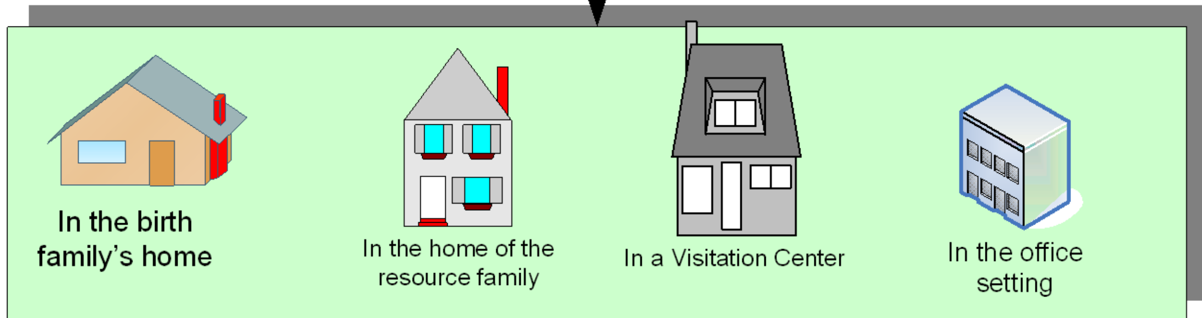
1) restate the safety threats/risks in behavioral language
2) Restates what the family's behaviors look like when the underlying need has been met and the safety threat has been resolved/risks reduced
3) identifies the strengths of the family that can be leveraged to achieve behavioral changes
4) Determines interventions /services used to change behavior and meet family's unmet needs as they relate to child safety and risk.
5) Set timelines for review of the efficacy of the interventions.
6) Also set timelines for reunification and case closure.

If the child is in out of home care—this is the time to discuss concurrent planning and child permanency

Intentional Visitation Practices

Critical thinking to decide where the visits occur and who serves as the parenting coach (monitor).

Team including foster parents and birth parents discusses the focus of the visitation, expectations and activities focused on helping to cagne behavors that caused children to be unsafe.



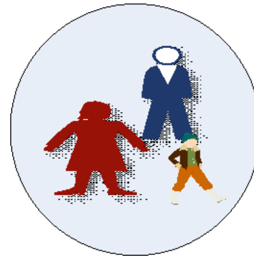
Parents have an active role in planning visitation activities and in assessing progress

Individuals who function as a parenting coaches during visits are committed to helping parents safety care for their children.

Parenting Coaching

Clarity around parenting behaviors that need to change in order for children to be Safe

Visitation planning involving worker, birth family, kin, and resource family.



Visitation Activities focused on learning new protective parenting behaviors—coached by kin and resource family

Assessment
1) Are underlying needs being me and behaviors changing—should we move to unsupervised visits?
2) Do we need to modify visitation activities?
3) Do we need to move to concurrent plan?

Ongoing Assessment

Every contact between the worker and the family, the child, the service providers, team members, case aides, and resource family must intentionally assess whether or not **1)** the in home safety plan is continuing to control and manage safety threats, **2)** services are being effective in meeting underlying needs, changing behaviors and resolving safety threats and reducing risks of future maltreatment **3)** child well being.

1

If the child is at home and safety threats are being controlled through a safety plan, the CSW must continually assess if the safety plan is controlling and managing safety threats. If NOT, immediately re-assess child safety.
If we cannot do this we have to find an alternate place for the child to live.

If the child is in out of home care---this is the time to discuss concurrent planning and child permanency

2

Worker assesses if the interventions/ plan are working to meet family's underlying needs. If they are working—continue services. If NOT….

Team Meeting is called by the worker –to learn from the family how their needs are not being met through the plan and what needs to be different.

Modified Behaviorally Focused Case Plan that better meets family's underlying needs and has optima chance at supporting successful behavioral change.

Ongoing process where we continue to work the plan, in concert with the team and ultimately make the permanency decisions.

3

Assess for Child Well Being ensuring educational, physical and emotional needs are being met.

Module 1: Review of Information

COACHING TIPS FOR SUPERVISORS

Workers need to review as much information as possible before going to see the family. This includes all past involvement in the child welfare.

Understanding the past allegations, the outcome of the past investigation(s)/safety assessment(s) and the impact of services, is imperative in making safety decisions.

Workers should also seek to learn if any of the family members have been involved in any other systems such as mental health, juvenile justice, or if law enforcement has been involved with the family for issues of domestic violence.

While it is crucial to understand history, it is also important that workers take the time to learn about the present circumstances of the family—and NOT pre-judge child safety without completing a thorough investigation/assessment of child safety.

There is a growing body of research about the importance of workers fully understanding family history prior to going out to meet with the family. This information is not used to pre-judge the family or to draw conclusions about the family prior to completion of the assessment process, but to inform the quality of family engagement, the focus of the questions that are asked of the family and generally to enhance the information gathering process.[4]

"It is the responsibility of the supervisor as a case consultant to the worker, to prevent the premature commitment to a position, point of view, judgment and prevent staff from becoming unwilling to consider alternative interpretations based on further information."

Gambrill, 1990
Critical Thinking in Clinical Practice

Prior to going out and seeing the family the worker should consider the following:

- Potential severity of harm to child/children to determine the rapidness of the response.
- Issues that may impact worker safety.
- Need for Law Enforcement involvement.

[4] *The research from Washington University in St. Louis Missouri indicates that a comprehensive understanding of the family issues [if the family has previous history with the child welfare system] is a critical practice in reducing recurrence of maltreatment.*

- Past involvement of the caretakers in the criminal justice system, including incidents of domestic violence in the home.
- Past history of child welfare involvement including:
    - Past referrals to hotline;
    - Severity of past allegations and findings of assessment;
    - Services provided to children and caregivers;
    - Perceived outcomes and effectiveness of those services; and
    - The family's attitudes about child welfare involvement.

It is important to note that workers begin forming the family picture as they proceed with information collection and finalize it at the conclusion of the Investigation/ Assessment. The picture a worker creates of the family is only finalized at the end of the Investigation/Initial Assessment. It is not based on what a worker understands at the onset of the Investigation/Assessment. While this information review is critical part of the information gathering process, it is really just a window to the family story and how the family functions. Understanding comes from a diligent, exerted, and focused approach to information collection.

Help Workers Be Careful of Confirmation Bias

Confirmation bias occurs when we selectively notice or focus upon evidence which tends to support the things we already believe or want to be true while ignoring that evidence which would serve to disconfirm those beliefs or ideas. Confirmation bias plays a stronger role when it comes to those beliefs which are based upon values, prejudice, faith, or tradition rather than on empirical evidence.

Our biases often impact how we arrive at certain conclusions. Biases are troubling because in nearly all instances, they actively keep us from arriving at the truth. It is understandable why confirmation bias can exist in our work. Data which supports our beliefs is simply easier to deal with on a cognitive level — we can see and understand how it fits into the world as we understand it, while contradictory information that just doesn’t “fit” can be set aside for later. Supervisors play a critical role in ensuring that workers do not come to premature conclusions by exploring the decision making process with social workers.

Module 2: Safety Assessment

COACHING TIPS FOR SUPERVISORS

- The nature of the work requires that workers be skilled in rapid family engagement—which is a different skill than building relationship with a family over time.

- Small things such as the way that workers introduce themselves, the way that workers describe the allegation and the tone of voice impact the willingness of the family to allow us in the front door, and into their lives.

- It is critical to remember that family members cannot talk to us if they cannot understand us and we cannot complete an accurate assessment of child safety and risk if we cannot understand what the family members are saying. When working with families who do not speak English we must engage interpreters (either professional interpreters or members of the family's circle of support). Family engagement is required to accurately assess child safety and risk. Research teaches us that there is a direct correlation between family engagement and child safety.[5]

- The way that a worker asks questions directly influences the quality and often quantity of the information provided by the family as well as collateral contacts. ***The process of assessment of child safety is much broader than determining if an incident occurred. It is critical to understand patterns, history, and their way of approaching day to day life.***

- Workers must be able to distinguish between a *protective capacity* that can be immediately mobilized to protect the children and *a strength* which is a characteristic of a family that will be helpful in motivating the family to change—but NOT sufficient to protect.

If the worker has not previously seen the children, one of our first tasks when entering the home is to identify the location of the children and to assess for their immediate need of protection. Once the need for immediate protection has been resolved, the assessment process continues. Again, it is important to emphasize that a safety assessment is only complete when all of the information required to assess child safety has been compiled and analyzed.

Family Engagement Is Imperative

In order to compile accurate information during the investigation/assessment of child safety, it is imperative that workers have the ability to engage families. The more the worker bypasses efforts to engage the family in a partnership for change, the less hopeful and motivated the family becomes. With the pressures of the child welfare system today, it is clear that workers are at risk for trying to "get the job done fast" rather than building a consensus for change with

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[5] Antle, Martin, Barbee &Christensen. Solution Based Casework.   (2002).

the family. Missing early opportunities to engage the family usually results in the worker taking control of the case, trying to draw the family's attention to the seriousness of the problems or a deficit, then trying to secure quick cooperation with what the worker thinks needs to be done. There is considerable evidence now that this effort to speed things up usually results in a lack of engagement and a high potential for the family to resist, either openly or passively. This client resistance to losing control and being forced to accept a negative picture of themselves often confirms the worker's worry that the family doesn't want to change and therefore "the case" is not making adequate progress.

Family Engagement Occurs Through The Following:

- Workers communicate to families (both through our actions and our words) that what they say matters.
  - *Actively listen to the family story and communicate to the family that their perspective and voice is vital if we are to serve their family effectively.*
  - *We ask families where they would like us to sit and what they would like us to call them.*
  - *We behave as a guest in the family's home—a guest with a purpose but a guest nonetheless.*

- Workers practice full disclosure
  - *We let the family know why we are in their homes, what we are learning, the steps of the process and the rationale for any decisions we make.*
  - *We provide for families specific contact information, (worker and supervisor) expectations for calling back, voice mail, and ongoing interaction expectations.*

- Workers honor the family's culture
  - *Entering a family's culture is a process that requires humility—being a student of how culture impacts decision making, parenting and family functioning. Workers must not assume that they view the world through the same lens as the family.*
  - *Because ethnicity is such an integral part of people's makeup and inextricably linked to how families live and interact with one another, social workers cannot afford to overlook or profess ignorance of their client's cultures.*
  - *The first step in developing cultural awareness is to* ***scrutinize our own feelings and beliefs about ethnic groups*** *other than our own. Everyone has some kind of racial and ethnic stereotypes: conscious or unconscious, subtle or obvious. We need to recognize these biases.* ***Lack of understanding of how these biases are impacting their social work practice*** *can create barriers to service deliver and each barrier could represent a lost opportunity to help.*
  - *Seek to learn who matters to the family—who might be able to support the family such as kin in the problem solving process.*

- Workers attend to avoid, to the extent possible, actions that minimize/undermine parents' power.
  - *It is important to remember that invoking authority is easier and requires less skill than engaging families.*
  - *It is the worker's responsibility to look for opportunities to put the family in a position of authority—remembering that they are the experts in how they function.*
  - *People are more disclosing, open, and cooperative if they don't feel threatened and judged.*

"Words are a form of action, capable of influencing change."

The information standard refers to what should be known about a family in order to fully evaluate the presence of a safety threat. The areas of family functioning that require assessment include:

1. Behavioral health issues in the family, how they are managed and how they impact the safety of children in the family;
2. Substance abuse issues in the family, how they are managed and how they impact the safety of children in the family;
3. Child functioning /characteristics for each child in the family;
4. General approach to parenting including how caregiver was parented;
5. Disciplinary practices including how caregiver was disciplined;
6. Housing/environment/and ability to meet children's basic needs;
7. Family dynamics and their support system; and
8. Medical Issues within the family, how they are managed and how they impact child safety.

CONSIDERATION OF PROTECTIVE CAPACITIES IN THE ASSESSMENT OF CHILD SAFETY

Caregiver protective capacities are personal and parenting characteristics that are specifically and directly associated with protecting one's young. A Protective Capacity points to an inherent family skill and/or resource that can be mobilized to contribute to the ongoing protection of the child.

Consideration of the protective capacities of parents/caregivers is relevant for assessment in that these capacities can help us in determining if children are in an environment where their safety is or can be controlled.

Enhancing diminished caregiver protective capacities should be the primary goal of the caregiver's case plan.

It is important to note that the assessment of protective capacities is different than an identification of the family's positive qualities and strengths. Protective capacities must be relevant and **dynamically involved in keeping children safe on a day to day basis**. The protective capacities must be able to be

deliberately and immediately mobilized. While caregiver's strengths are important as part of understanding the family, being able to motivate the family and being able to promote long term behavioral change –they are NOT sufficient to immediately protect.

There are three kinds of protective capacities that workers need to pay attention to; cognitive, behavioral, and emotional.

Examples of **Cognitive Protective Capacities** include:

- ➔ Caregiver actively plans to protect the child:
    - Parent is realistic in their arrangements for child care.
    - Parent can identify danger around them and actively protects the child from this danger.
- ➔ Caregiver is aligned with the child.
    - Caregiver is highly connected to the child and therefore expects that he/she is to be responsible for the child's safety and well being.
    - Caregiver does not choose other's needs over their child's needs.
- ➔ Caregiver has adequate knowledge to fulfill caregiving responsibilities and tasks.
    - Caregiver knows enough about child development to keep their child safe from household dangers, neighborhood dangers, etc.
    - Caregiver has accurate information about what basic care means for children and provides this basic care.
- ➔ Caregiver perceives reality accurately
    - Caregiver recognizes threatening situations and people and protects their children from these situations and people.
    - Caregiver is able to distinguish threat to child safety.
- ➔ Caregiver has accurate perceptions of the child.
    - Caregiver knows the capacity of children at different ages and does not ask for more from the child than to operate within this capacity.
    - Caregiver appreciates uniqueness and differences of their various children and their various needs.
- ➔ Caregiver understands his/her protective role.
    - Caregiver can explain in their own words what their protective role means, why it is important and can cite examples of how they operationalize their protective role.
- ➔ Caregiver is self aware as a caregiver.
    - Caregiver has in the past raised children with no issues of maltreatment.
    - Caregiver and other reliable people in the child's life can describe various events and experiences where protectiveness was evident.

Behavioral Protective Capacities refer to specific action, activity and performance that is consistent with and results in parenting and protective vigilance. Examples of **Behavioral Protective Capacities** include:

- ➔ Caregiver takes actions to correct problems or challenges.
    - Caregiver does what is necessary when it is necessary as a parent.

- Caregiver takes steps to protect children in the home who are in danger by others—such as taking out a Protective Order, not allowing this person to get near the child again.

➔ Caregiver demonstrates impulse control.
  - Caregiver does not act on urges when acting on this urge places a child in danger.
  - Caregiver who does not behave solely in response to external stimulation.
  - Caregiver who thinks and plans before he/she acts.

➔ Caregiver demonstrates adequate skills to fulfill care giving responsibilities:
  - Caregiver can feed, care for and supervise the children according to their basic needs and consistent does this.
  - Caregiver can maintain shelter that keeps children safe and does so consistently.

➔ Caregiver possesses adequate energy.
  - Caregiver is able to overcome begin tired or emotionally exhausted in order to protect their children.

➔ Caregiver is assertive as a caregiver.
  - Caregiver has a firm conviction about their role and acts on that conviction to protect and care for their child.
  - Caregiver is secure enough with self to ensure that no one else interferes with their caregiving role.

➔ Caregiver emotionally supports the child.
  - Caregiver spends considerable time with their children and this time communicates positive regard for the child.
  - Caregiver takes consistent and frequent action to assure that their children are encouraged and reassured.
  - Caregiver takes an obvious stand on behalf of their children.

Emotional Protective Capacities involves the specific feelings, attitude, identification with the child and motivation that results in parenting and protective vigilance. Two critical issues influence the strength of emotional protective capacity:

- The nature of the attachment between the caregiver and the child
- The caregiver's own emotional strength.

Most caregivers love their children and this love is the motivator to protect their children. This love is demonstrated as a protective capacity when:

- The caregiver's love for the child is unconditional;

- The caregiver realizes that the child cannot produce gratification and self esteem for the caregiver; and
- The quality of the attachment is not diminished when the caregiver discovers that the child cannot meet the caregiver's emotional needs.

Examples of **Emotional Protective Capacities** include:

- ➔ Caregiver is able to meet own emotional needs
    - o Caregiver uses social and personal means to feel happy –these means do not place children in dangerous situations.
    - o Caregivers understand and accept that their feelings and gratification of those feelings are separate from their child.
- ➔ Caregiver is able to emotionally intervene to protect the child.
    - o Caregiver is not consumed with his/her own feelings and anxieties and as such is able to devote energies to their children.
    - o Caregiver is mentally alert and in touch with reality.
- ➔ Caregiver is tolerant as a caregiver.
    - o Caregiver can let things pass and does not over react and place children in harm's way.
- ➔ Caregiver displays concern for the child and the child's experiences and is intent on emotionally protecting the child.
    - o Caregiver is sensitive and feels a strong sense of responsibility for the child—which compels him/her to comfort and reassure.
    - o Caregiver can calm, pacify and appease the child.
    - o Caregiver takes action or physical response that reassures the child and this generates security in the child.
- ➔ Caregiver and child have a strong bond and the caregiver is clear that the number one priority is the well being of the child.
    - o Caregiver organizes life around what is best for the child.
    - o Caregiver's closeness with the child ensures that other relationships do not interfere with caregiving role.
    - o Caregiver can relate to, explain and feel what a child is experiencing—and this translates into protection of the child's emotional safety.
    - o Caregiver relates to the child with expressed positive regard, and reassuring physical touching.

NOTE: These examples demonstrate how a protective capacity is always underscored by action. Unlike a strength which can be a feeling or emotion that exists and can help motivate the parent, a protective capacity means that the parent can and does protect the child from harm.

The chart below depicts the difference between strength and a protective capacity.

Strength	Protective Capacity
Mother says "I love my children" and she can identify the strengths of her children, but this love has not translated into day to day protection of her children.	Mother can identify relatives who can help her when she is stressed, is willing to call these relatives when she is stressed, and has examples of how these relatives have helped her keep the children safe in the past.
Mother says "I want the children to have a better life than I have had".	Mother knows the resources in the community to help her children get food and clothing when the money is tight and can talk specifically about how she has used those resources in the past to get through a tough financial period.
Father reads to the children at night and plays with them.	Father brings children to his parents when Mother has been drinking and he has had to go to work—has done this in the past and his parents have kept the children safe.
Parents like to play games with their children and have fun laughing with them.	Parents understand that their children need to have fun, but they also need fair and consistent boundaries and rules. The family applies these fair rules and boundaries on a day to day basis.

Module 3: Making the Safety Decision

COACHING TIPS FOR SUPERVISORS

- Once the information is compiled, the information is evaluated and a safety decision is made.
- It is imperative that workers do not come to a premature decision about child safety. The safety decision requires critical thinking on the part of the social worker.
- The worker needs to synthesize multiple interviews and draw conclusions from this synthesis.
- Workers must apply the five danger threshold criteria in making the decision about child safety; vulnerable child, out of control situation, severity of harm, imminence and specific and observable situation. If they do not know how to do this well, they may inadvertently identify a situation as a safety threat, when in fact it really is a risk for future maltreatment.

SAFETY DECISION

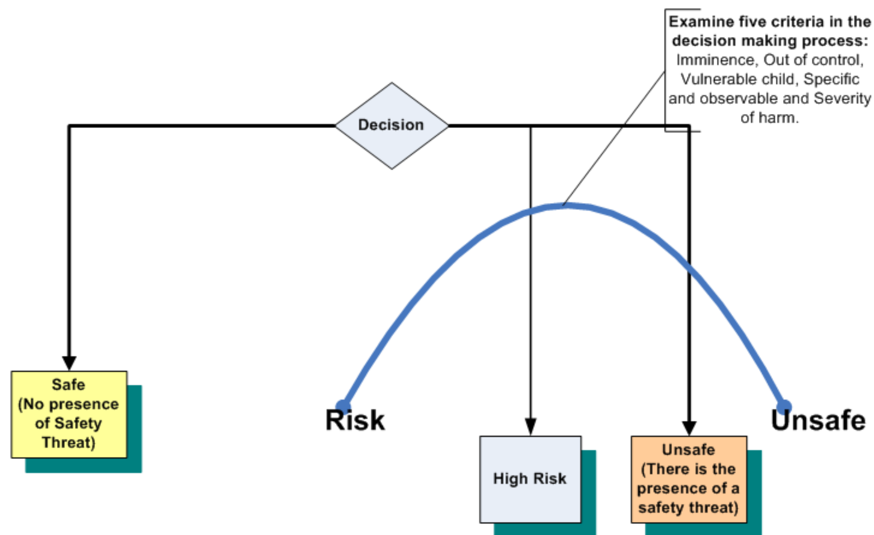
Distinguishing Between at Risk and Unsafe

Often workers struggle with making the decision between a safety threat and a risk. The Comprehensive Assessment model of practice helps the worker to make this distinction through the application of a set of five danger criteria including:

- Is there a vulnerable child?
- Is there a specific and observable situation (not just "gut") that is causing the child to be unsafe?
- Is the situation out of control?
- Is there imminence (a time specific concern about the child being unsafe)?
- Is there severity of harm?

This process of going from information to judgments is critical. There is no ready "prescription" for how these judgments are made; we must train staff to make these essential judgments.

This danger threshold (described more fully below) describe a point at which family functioning and associated caregiver performance becomes perilous enough to produce a threat to child safety. **In order to determine that a child is unsafe each of the five criteria must apply and be met.** If these criteria are met, it means that the family conditions (in the form of behaviors, attitudes, and situation) go beyond being risk factors and have become threatening to child safety. Safety threats are active at a heightened degree and greater level of intensity than risks. (See visual below)



Vulnerable Child

A vulnerable child is one who cannot protect himself; cannot provide for his basic needs; cannot defend himself against a physical aggression; is not alert to and/or cannot get away from a dangerous situation; is physically and/or emotionally (susceptibly) dependent on others.

- Children from birth to six years old are always vulnerable.
- Children who are physically handicapped and therefore unable to remove themselves from danger are vulnerable.
- Children who, because of their physical limitations, are highly dependent on others to meet their basic needs are vulnerable.
- Children who are cognitively limited are vulnerable because of a number of possible limitations: recognizing danger, knowing who can be trusted, meeting their basic needs and seeking protection.
- Provocative children with emotional, mental health, behavioral problems can be such that they irritate and provoke others to act out toward them or to totally avoid them are vulnerable.
- Children who are highly dependent and susceptible to others are vulnerable. These children typically are so influenced by emotional and psychological attachment that they are subject to the whims of those who have power over them.
- Regardless of age, children who are unable to defend themselves against aggression are vulnerable.
- Children who are frail or lack mobility are more defenseless and therefore vulnerable.
- Children who cannot or will not seek help and protection from others are vulnerable.
- Some children have continuing or acute medical problems and needs that make them vulnerable. Children that no one sees (who are hidden) are vulnerable.

Out of Control

Danger exists for children when something in the family and home is out of control. That means that what is happening is not being controlled by anything or anybody within the family network. What is

happening inside the home is not subject to any influence, management or protective adult. Another way of considering this is to recognize that safety doesn't exist solely because there are no threats or danger present in the child's life space. Safety exists because responsible adults control threats or danger when they become apparent.

Severity of Harm
This refers to the conclusion that what is happening in the family is severe enough to result in severe pain, serious injury, disablement, grave or debilitating physical health conditions, acute or grievous suffering, terror, impairment, death

Imminence (A time specific concern that the child will be harmed)
This refers to the belief that family behaviors, conditions or situations will remain active or become active without delay resulting in severe harm to a vulnerable child within the near future or imminently. Imminence is consistent with a degree of certainty or inevitability that danger and severe harm are likely outcomes without intervention.

Observable
This refers to family behaviors, conditions or situations representing a danger to a child that are specific, definite, real, can be seen and understood and are subject to being reported and justified. The connection of these family behaviors, conditions or situations to posing a danger to a child is evidenced in explicit, unambiguous ways. The criterion "observable" does not include suspicion, intuitive or gut feeling, difficulties in worker-family interaction, lack of cooperation, difficulties in obtaining information, or isolated, even provocative information considered exclusive of family behaviors, conditions or situations.

Applying these criteria to the SDM Safety Factors

Applying these danger criteria to **each of the SDM safety factors** will help the worker in determining if a safety threat exists. This is a critically important distinction because if the child is unsafe --- child protective services must intervene with a safety plan.

The SDM safety factors are discussed in detail below[6]:

1) Caregiver's current behavior is violent or out-of-control.
This threat is about violence and or self control. Violence refers to aggression, fighting, brutality, cruelty and hostility.

Self control is about a person's ability to postpone, set aside needs, be dependable, avoid destructive behavior, use good judgment and manage emotions. A caregiver's lack of self control places vulnerable children in jeopardy. This threat includes caregivers who are incapacitated or not controlling their behaviors because of mental health or substance abuse

[6] This information was in part compiled from the American Bar Association Child Safety Monograph. (2009).

issues.

2) Caregiver describes or acts toward child in predominantly negative terms and/or the caregiver has extremely unrealistic expectations for the child's behavior.

This means that as a result of this negative attitude about the child, it can be reasonably expected that the caregiver's behavior will lead to imminent and severe harm to the child.

3) Caregiver has caused serious harm to the child or has made a believable threat to cause serious harm to the child.

This threat refers to times when caregivers are implicitly or explicitly threatening to harm a child. Their emotions and intentions are hostile, menacing, and sufficiently believable to conclude grave concern for immediate and severe consequences to a child.

4) Caregiver refuses access to the child, or there is reason to believe that the family is about to flee, or the child's whereabouts cannot be ascertained.

Several circumstances suggest the presence of this threat. The family who hides the child from CPS, avoids CPS access to the child, overtly rejects all attempts by CPS to enter the home, see a child, or conduct necessary information collection. This is more than simply being "uncooperative" with CPS, this means that there is immediate concern that the family will leave the jurisdiction, or simply refuse any kind of CPS access to the child. In all instances when a family does not allow CPS to see a child, the current status of the child must be considered severe and immediate.

5) Caregiver has not, will not, or cannot provide supervision necessary to protect child from potentially serious harm.

This threat refers to adults (not children) responsibilities for provision of food, clothing, shelter and supervision. Consideration is at the basic level, and the absence of these duties will result in severe consequences to a child.

6) Caregiver is unwilling or unable to meet the child's immediate needs for food, clothing, shelter, and/or medical or mental health care and the lack of these threaten the child.

This threat refers to a circumstance where the resources of the caregiver are routinely going to areas other than meeting the needs of children or that the caregivers lack life management skills to properly use resources for basic needs.

This also refers to situations when the caregivers lack the basic knowledge or skills to meet a child's basic needs or lack of motivation resulting in the caregivers abdicating their role to meet basic needs or failing to adequately perform their parental role. This inability or unwillingness to meet basic needs creates immediate and severe consequences to a vulnerable child.

This threat also refers to the needs of a child, if left unattended (such as a medical condition, mental health condition) that if left unattended, will result in imminent and severe consequences to the child.

7) Caregiver previously harmed or endangered a child and the severity or caregivers response indicate that they child safety is a present concern.

This threat has to do with patterns a caregiver exhibits that emerge inconsistently over time

and when they emerge the harm to the child can be reasonably believed to be severe. Caregivers may minimize what has occurred in the past. These are instances where the protective capacities of the caregivers do not appear to be sustained over time.
In addition, this threat refers to maltreatment that has occurred to other children (not the current children residing in the home) and the caregiver's current r behavior currently is consistent with the behavior that resulted in harm to children in the past.

8) Child is fearful of caregiver or other family or household members or other persons having access to the home.
This threat means that the child's fear must be obvious, extreme, and related to some perceived danger that the child feels or experiences. This threat can also be present with children who are not verbal but their behavior and emotion clearly and vividly demonstrate fear.

9) Physical conditions in the home are hazardous and immediately threaten the child's safety and the caregiver cannot, will not, or is unable to seek outside resources.
This threat refers to conditions in the home that are immediately life threatening or seriously endanger a child's physical health.

10) Child sexual abuse is suspected and circumstances suggest that sexual abuse is an immediate concern.
This threat is a result of a report by a child or another person that a child is being sexually harmed—and that this harm is ongoing or there is a believable threat of it occurring again the near future.

11) Caregiver's drug or alcohol use seriously impacts ability to supervise, protect or care for the child
This threat refers to addictive patterns or behaviors (e.g. addiction to substances) that are uncontrolled and leave the children in potentially severe situations (e.g. failure to supervise or provide other basic care).

Module 4: Safety Planning and Safety Management

COACHING TIPS FOR SUPERVISORS

Safety Management occurs throughout the life of a case.

Safety planning requires that the worker fully understand the safety threats, how they are uniquely operationalized in the family, and how specific interventions control and manage those safety threats.

The worker needs to be able to explain how the safety threat is controlled and managed by the safety threat.

If a child was removed, the supervisor should ensure that the safety threat had to be controlled and managed out of the home—was there any way that it could have been controlled and managed in the home?

Safety Management

Once a child is determined to be unsafe…safety management is required. **Safety Management refers to the ongoing process that the child welfare agency workers take to manage and control safety threats.** Safety management occurs throughout the life of a case.

Safety management assures that the question of child safety and caregiver protective capacity always remains alive. It promotes the point of view that child safety and caregiver protective capacity possess potential for being different, thus requiring different safety management responses.

For safety management to be effective, it must be a living, breathing thing. It is dynamic, being constantly open to increasing or decreasing the level of effort in safety plans in order to meet the safety needs of a child that are apparent.

Safety management is not voluntary. If a child is believed to be unsafe there is no choice but for CPS to protect him. The standards for safety management are: vigilance, promptness, alertness, diligence and timeliness.

Understanding Safety Threats Behaviorally

In order to effectively manage safety the worker must elaboration of the threat in behavioral terms that describe how it exists uniquely within the given family. This elaboration is critical because it establishes the behavior or condition that must be controlled. Who, how, when and where are critical descriptors of any safety threat to children.

Safety Planning

The safety plan is a written arrangement between a family and the agency that establishes how the identified safety threats will be managed. It describes each safety threat behaviorally,

identifies specific safety interventions used to control and manage the identified safety threat; identifies and qualifies individuals involved in the safety plan and describes their level of effort in detail. A safety plan also includes how the worker (and others) will monitor and oversee the plan.

The safety plan is not necessarily a temporary plan. The safety plan must be implemented and active as long as safety threats exist and caregiver protective capacities are insufficient to assure a child is protected. Safety plans often remain in place for weeks into months **and co-exist with the ongoing case plan.** Safety plans are concerned with controlling danger and threats of danger only – not changing family functioning or circumstances. The safety plan manages safety threats while the Program worker proceeds with and carries out planned case plan services focused on changing behaviors that caused children to be unsafe or at risk of future harm.

A Safety Plan Must be Able to Control and Manage Safety Threats

It is important that safety plans make sense and can actually control or manage safety threats. Once it has been determined that the child is unsafe and that caregiver protective capacities are diminished, it makes little sense to expect those same caregivers to be responsible to protect the child. For example, safety plans that expect parents to quit drinking, not to hit their child, or not to leave their child alone when they have repeatedly demonstrated that they are currently incapable of doing so, are not effective safety plans and place the child in danger.

A safety plan must control or manage identified threats, have an immediate effect, be immediately accessible and available and contain safety interventions and actions only, not services designed to effect long-term change. The safety plan must be sufficient to ensure safety.

The safety plan is designed along a continuum of the least to most intrusive intervention.

Safety planning includes in-home, out-of-home or a combination of in-home/out-of-home actions.

<u>An In-Home Safety Plan</u> refers to safety management so that safety interventions, actions and responses assure a child can be kept safe in his own home. In home safety plans include activities and interventions that may occur within the home or outside the home, but contribute to the child remaining home. An in-home safety plan primarily involves the home setting but can also include periods of separation of the child from the home such as a child going to someone else's home on the weekends.

When constructing an in home safety plan it is important to remember that most safety threats are not in operation 24 hours per day, 7 days per week. Often it can be helpful to develop a visual image (weekly calendar below) for those involved in safety planning that depicts when (specifically) during the week someone needs to be working alongside the child welfare agency to control and manage the safety threats—having their "eyes on the child".

<u>Out of Home Safety Plan</u> refers to safety management that primarily depends on separation of a child from his home, separation from the safety threat and separation from caregivers who lack sufficient protective capacities to assure the child will be protected. NOTE: **All placements out of home, whether they are with kin or traditional foster parents are considered out of home safety plans.**

Difference Between a Safety Plan and A Case Plan

One of the ways to ensure that the safety plan controls or manages the identified safety threat is to make a clear distinction between the safety plan and the individualized service plan. The chart below makes the distinction between the two kinds of plans.[7]

THE SAFETY PLAN	THE CASE PLAN
The purpose is to control.	The purpose is to change behaviors or conditions that caused children to be unsafe or at risk of future harm.
The safety plan is put in place immediately upon identifying safety threats.	The case plan is put in place following further assessment about the underlying issues that need to be addressed that contribute to the behavior resulting in children being unsafe.
Activities within the safety plan are dense which means there are a lot of things going on frequently to manage and control child safety.	Activity and services can be spread out occurring intermittently over a long period of time.

[7] Action for Child Protection.

THE SAFETY PLAN	THE CASE PLAN
The safety plan must have an immediate effect. This means it must work the day it is set in place.	The case plan is expected to have long term effects achieved over time.

As the safety plan is being constructed, it is critical that workers review the plan with their supervisor. We want to make certain that the plan is sufficient to assure safety, that is, the degree of intrusiveness and level of effort represented in the safety plan will be reasonably effective in protecting a child.

Module 5: Case Transfer Meeting

COACHING TIPS FOR SUPERVISORS –ISSUES TO CONSIDER AND QUESTIONS TO POSE

- The worker must full describe 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.

- Use the chart to help the worker "connect the dots" between the safety assessment, safety plan, functional assessment and case plan.

The review of pertinent case documentation during the case transfer meeting is critical for the following reasons:

- Program workers will better understand client's situation—and fully understand the threats of safety.
- Program workers 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 program 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

Ensuring Clarity About the Focus of the Work
Families who have been involved in the child welfare system often tell us that they were unclear what was required of them (especially if their children were in out of home care). According to a study at KIDSRUS Visitation Center in New Haven Connecticut, 85% of the families served over an 18 month period of time did not know specifically what they had to do to get their children back.[8] This lack of clarity often occurs because the child welfare worker is more focused on the tasks that must be completed i.e. attend parenting classes, attend substance abuse treatment, attend domestic violence counseling than the **specific behavior that has to change**.
During the Transfer Meeting the following chart may be helpful in assisting the team to

[8] *Gobbard, Lynn. KidsAreUs Visitation Center. (2007)*

understand the safety threats in behavioral terms, the behaviors or conditions that have to change and ultimately the interventions and services that will be put in place to support these behavioral changes.

This case plan creation (for the most part) occurs in Continuing Services

The Chart Below Creates Clarity for Family and Team on Focus of the Work

Safety Threats (Described Behaviorally)	Behavioral Description of what it looks like of the safety threat no longer exists	Interventions to be used to change behaviors/conditions—including Intentional Visitation	Ongoing assessment—are the services working to change behavior?

Intake Worker Should:

- 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.

Module 6: Comprehensive Family Functional Assessment

COACHING TIPS FOR SUPERVISORS –ISSUES TO CONSIDER AND QUESTIONS TO POSE

- The intent of the functional assessment is NOT to begin a new assessment, but to strive to understand the underlying causes of the behaviors that caused the children to be unsafe or at risk of future harm.
- Supervisors need to ensure that the workers really understand the intent of the functional assessment.
- Once these causes are identified (or the worker has a hunch about the causes) then the case plan services have a greater focus.

Focus Areas in the Comprehensive Functional Assessment Process

This is the opportunity for the worker to align themselves with the family in the process of working to change behaviors or conditions that caused children to be unsafe. Through a process over several meetings the workers should compile information about 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 situatons 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*

In a Comprehensive Family Functional Assessment, the family's strengths and protective factors are also evaluated to identify resources that can support the family's ability to meet its needs and better protect the children. **The Comprehensive Family Functional Assessment incorporates information collected through the assessment of safety and integrates the**

information into a behaviorally focused individualized case plan.

Time perspective is needed in comprehensive family assessment—what led to the current problems as well as the likely impact of both the maltreatment and the response on the child and family.

A comprehensive assessment of family functioning completed early in the process of serving a family, increases the likelihood of that the services utilized will be targeted on addressing the issues that caused children to be unsafe.

Module 7: Behaviorally Based Case Plan

COACHING TIPS FOR SUPERVISORS –ISSUES TO CONSIDER AND QUESTIONS TO POSE

- Can the worker make an explicit link between the behaviors that need to change and the services being provided?
- Did the worker make specific and target referrals to the provider, ensuring that they understand the focus of the intervention and the kinds of reports (verbal and written) that the worker needs from the provider?
- Supervisors need to ensure that the worker fully engages the family in the case planning process.

Effective service planning that reduces safety threats and enhances child well being is a natural byproduct of a comprehensive assessment.

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 material the worker has collected with supervisory oversight and guidance and with the family's involvement. The information gathered should be analyzed, and the results of the assessment should be linked to the development of the service plan. 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.

Collecting and organizing comprehensive assessment information is not an end in itself; it must be used in focused ways in the service plan. The worker should ensure that the family members have an accurate understanding of why their situation was reported to child welfare and the specific behaviors or conditions have to change for their children to be safe.
Family members should be intricately involved in the process of moving from assessment to the development of the service plan. They should help guide the process of determining what interventions could best address their situation, within the context of a shared commitment to making necessary changes. 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.

A Strong Case Plan

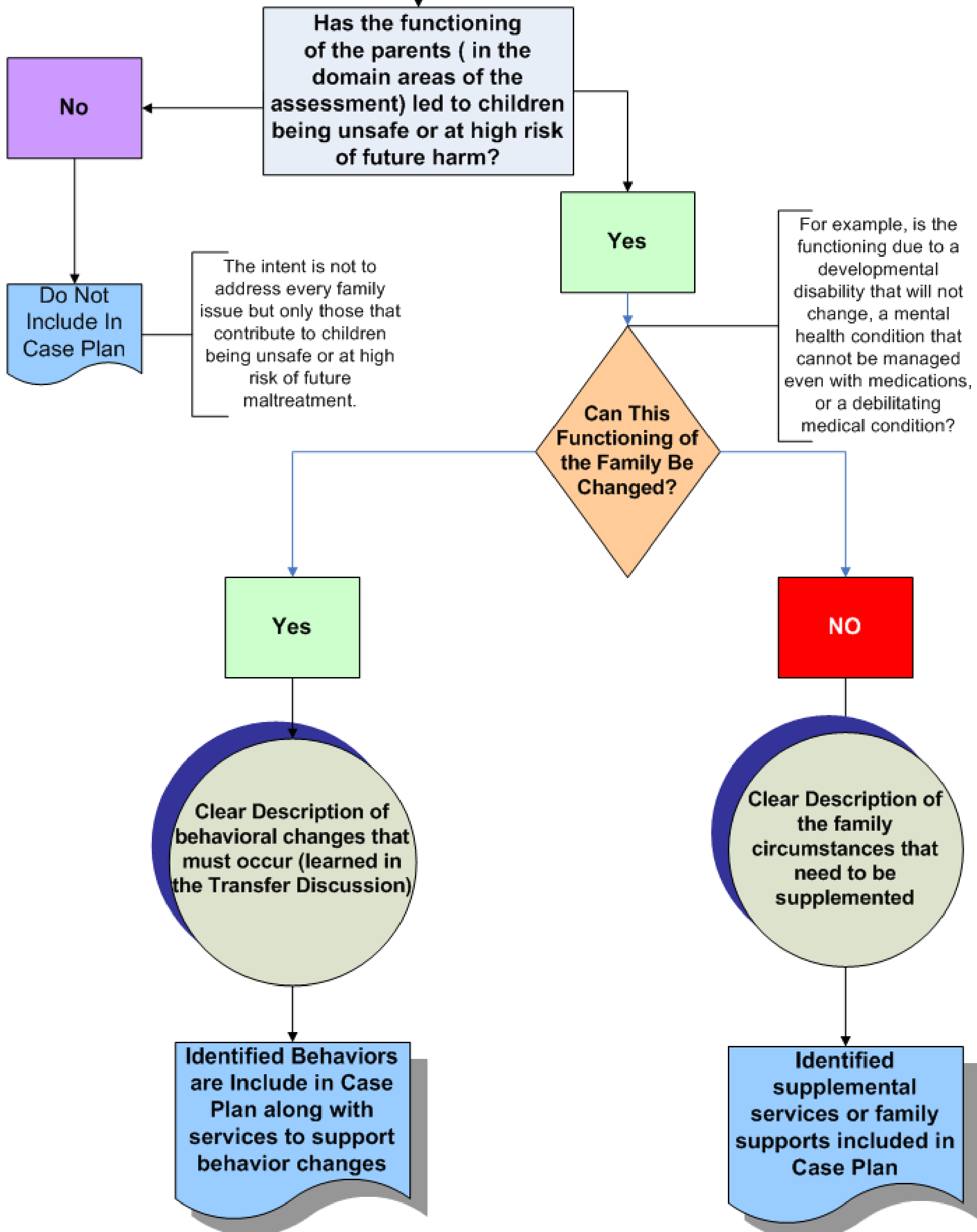
- Is directly linked to the safety assessment.
- Describes in behavioral terms that families can fully understand what needs to change in order for children to be safe or enhance child well being.
- Identifies specific interventions and actions to address and facilitate the changes necessary for children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

When Deciding What to Include in a 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. The chart on the following page provides a flow of the decision making process.

When developing a case plan with the family the worker must make judgments about:

- Based on their understanding of family functioning, determine if the behaviors or conditions that caused the children to be unsafe or at risk of future harm can actually change.
    - If not, determine the most effective means to wrap supports around the children to ensure their safety as long as they are vulnerable.
    - This requires an assessment of the protective capacity of those being asked to protect the children.
- How to prioritize services so that they address the areas of family functioning contributing to child safety issues.
- Which intervention will most effectively change the behaviors or conditions that caused children to be unsafe
- How to use family's strengths as part of the planning process—motivating the family to change behaviors or conditions that caused children to be unsafe.


Conduct Comprehensive Family Assessment to better understand underlying causes of behavior that caused children to be unsafe or at high risk if future maltreatment.
Has the functioning of the parents (in the domain areas of the assessment) led to children being unsafe or at high risk of future harm?
No
Do Not Include In Case Plan
The intent is not to address every family issue but only those that contribute to children being unsafe or at high risk of future maltreatment.
Yes
For example, is the functioning due to a developmental disability that will not change, a mental health condition that cannot be managed even with medications, or a debilitating medical condition?
Can This Functioning of the Family Be Changed?
Yes
NO
Clear Description of behavioral changes that must occur (learned in the Transfer Discussion)
Clear Description of the family circumstances that need to be supplemented
Identified Behaviors are Include in Case Plan along with services to support behavior changes
Identified supplemental services or family supports included in Case Plan

When Making Referrals to Community Providers The Worker Must:

- Share safety threats or risks that exist.
- Share the specific behaviors or conditions that have to change to remove safety threats and reduce risks.
- Be specific about the kinds of information to be included in the reports

Family Team Meetings as Part of the Case Planning Process

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.

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.

Conduct a Family Team Meeting to engage kin in the case planning and to ensure that everyone understands their role.

Module 8: Intentional Visitation Practices

COACHING TIPS FOR SUPERVISORS –ISSUES TO CONSIDER AND QUESTIONS TO POSE

- The planning for the visitation process is as critical as the actual visitation process itself. How did the workers plan for the visit?
- Does the family understand how the visits are connected to behavioral change?
- Does the case aide (or whomever is supervising the visit, understand the purpose?)

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).

Intentional Visitation is an evolved, individualize and planful approach to visitation that integrates coaching of parents into the visitation process. Workers need to develop visitation plans within a structure that allows for coaching of parents to build parenting skills.

Planning For Visits: Where Visits Should Occur

In planning for a visit, the worker has to make sure that the environment is safe for everyone involved—this means that if a family has a history of violence to others, we pay special attention to the location and who is involved in the visit. We may need to have a more secure environment if the safety assessment (that can occur at any point along the path of serving the family) identified that the parents are going to run away with the child.

We also have to fully understand what the parent needs to learn and the best environment for that learning to take place—if for example, a parent needs to learn how to supervise their children in the home—we need to create a place where they can learn and then practice that skill.

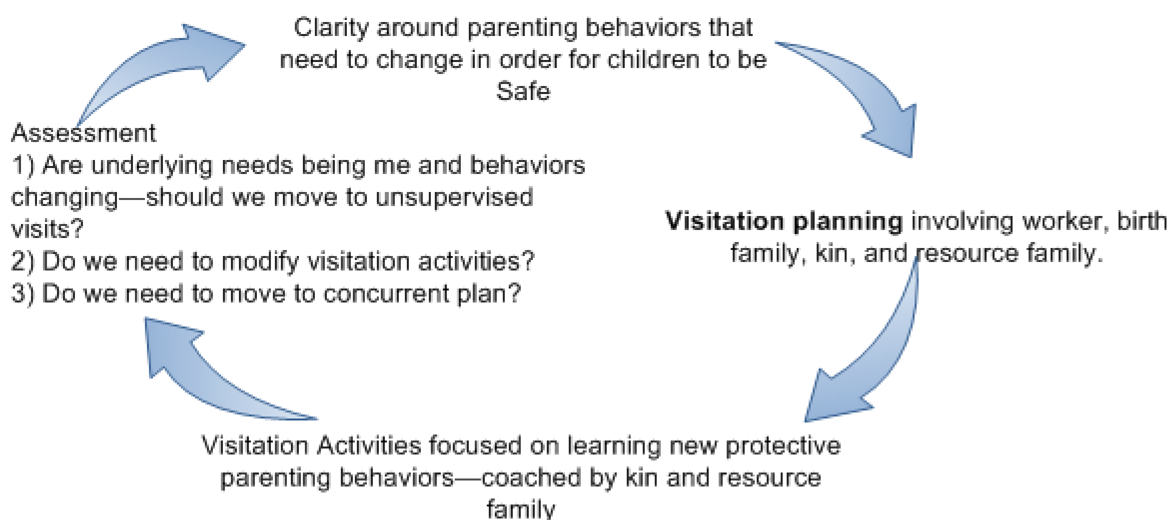
We also have to consider the needs of the child.

- A newborn will need to have diapers changed, bottles cleaned, bottles filled, etc. and the space needs to account for that.
- If the child is 11, the child will need interaction and focused attention and we need a place where that can occur more easily.
- If the child has special medical needs for example if a child is on a g-tube, you would want to have the visit in the resource family home as the medical equipment is very challenging to transport.
- If sexual abuse is suspected, visits need to occur in a place where the child feels safe—not where they may have been victimized.

Planning for Visits: Intensity, frequency and focus of the parenting coaching

We need to prepare the parenting coach to ensure that:

- They fully understands the safety threats/risks and what they uniquely look like within the family.
    - The chart above should be provided and the focus of the visitation should be fully understood so that the parenting coach understands what behaviors need to change and how the visit advances those changes.
- The activities are clearly linked to the behavioral change we are trying to achieve—and the parents understand the link.
- The coach and parents are fully engaged in assessing parent's progress in changing behavior--see below.



Visitations need to occur as frequently as possible.

Preparing the Person Providing the Coaching
If monitoring is required, we need to find a way to have the same individual to function as a coach to ensure consistency.

It is critical that the individuals providing the coaching are supportive of the parent in learning how to parent. This can be challenging if the alternate caregiver is conflicted about the child returning to their parents. For example, there are times when kinship caregivers have their own emotions and reactions to the family involvement in the child welfare system and may actually be angry at the parent for this involvement. This can play out in visits between children and their parents. Or alternately, the converse parents may have strong and angry feelings about their kin, and they are unwilling initially to learn from them. This is an ongoing process and it is part of the workers job to enhance the relationship between members of the kinship network. REMEMBER—the family's kin are going to be there to help keep the children safe long after we leave. A critical bi-product of Intentional Visitation is to build a network of supports for the family –this is part of our family team building role.

Debriefing the Visit
Following each visit the CSW or the person providing the coaching/monitoring should ask 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*

The planning for the next visit is informed by parental responses.

Sibling Visitation
When children have to be removed from their homes, the best hope is that all of the siblings are placed in the same home. This should be the goal whenever possible.
However sometimes this does not occur and then workers need to make concerted efforts to ensure that the sibling bond is not lost. **Regardless of how well parent-child visits are going—siblings need to see one another.**

Module 9: Ongoing Assessment and Case Closure

COACHING TIPS FOR SUPERVISORS –ISSUES TO CONSIDER AND QUESTIONS TO POSE

- Every time the worker meets with the family, one of the tasks is to assess whether or not the services are in fact helping to change behaviors.

- If they are not, it may be that they are simply not the right services—and need to be changed.

Workers must develop a Mindset of "Continuous or Ongoing Assessment"—evaluating the family's progress in changing behaviors that caused children to be unsafe need to be part of the ongoing assessment of progress. 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. This also helps a worker determine if it is time to initiate Concurrent Planning activities.

Strategies that can facilitate discussion about progress include using scaling questions, timelines, "temperature gauge" charts (measuring progress toward changing behaviors that caused children to be unsafe or at risk of future harm), and other behaviorally oriented graphics.

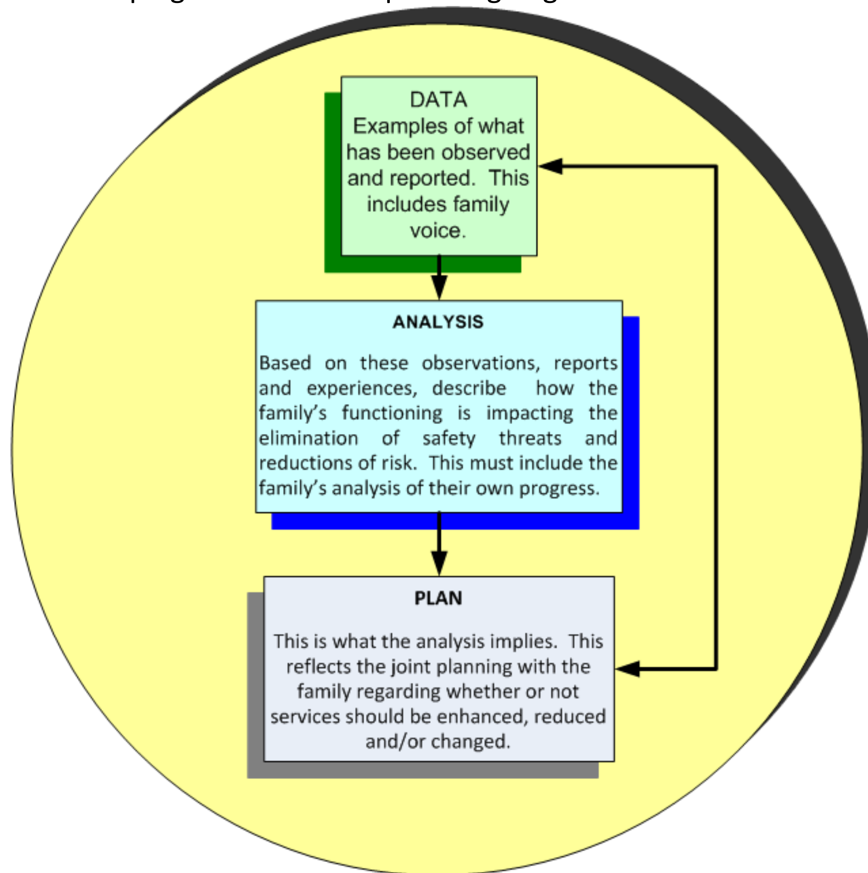
For periodic reassessment of progress to occur, it is important that service providers provide timely, specific reports on progress that address changes in behaviors or conditions that caused children to be unsafe.

Case Plan review 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.

Case Documentation is a part of the work of every social worker in the agency. The visual on the following page is an example of the D.A.P. approach of case notes –Data, Analysis and

Planning which is in keeping with the concept of ongoing assessment.



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:

Assess these issues:

- Have any of 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)?

- What kinship resources continue to be available, 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.

Appendix

Clinical Supervisory Tool

This tool provides a structure for supervisors to assess and support family centered practice in their staff. Three critical areas of family centered practice are addressed; family engagement, critical thinking and intentional visitation practices.

*Name of Supervisor:*______________________________

*Name of Worker:*_________________________________

*Date of Supervision:*______________________________

<table>
<tr><th>Practice Area</th><th>Open Ended Questions to Promote Critical Thinking</th></tr>
<tr><td>
Family Engagement

Consider how the worker:
• Talks about the family during case consultation
• Represents the perspectives of the family
• Writes about the family in case notes and assessment documentation
• Practices Full Disclosure and Transparency
  ▪ The worker helps the family understand safety threats or risks identified in the assessment process.
  ▪ The worker helps the family understand the assessment and case planning process.
  ▪ The worker helps the family understand the Concurrent Planning Process.
  ▪ The worker clarifies agency expectations and discusses the client's expectations.

Social work requires entering the culture of another human being and trying to understand behavior in the context of this culture.
• Some workers do this very well…and others hold biases against certain races, ethnic groups or socio economic statuses. How have you addressed this?
</td><td>
▪ Tell me about the family.
▪ Give me some background; how did they get to this place?
▪ Tell me about your meeting with the family how did it go? Who was there, what was said and what happened?
▪ If the caregivers were here right now what how would they describe their situation? What would they say they need to do to assure their child is safe?
▪ Tell me about the family's connections, resources, protective capacities, resiliencies.
▪ If the family was 100% successful in addressing the safety factors what would be different?
▪ If ten is the most motivated to change and one would be totally resistant to change, where you say the caregivers are? Well, if you are seeing them as a five, what would it take to get them to a six?
▪ How do you feel about the family and their situation?
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<tr><td>
<u>Information Review</u>

▪ Family patterns—is this a family who has been involved with the agency in the past? Similar referral? What did the agency do in the past to assist the family?
▪ Is the worker who served the family in the past still with the agency? Talk to him/her.
▪ Also learn if there has been law enforcement involvement in the past.
</td><td>
▪ Tell me about the family's history with child welfare services.
▪ What was the severity of the past allegations?
▪ What services were provided to the children/family? What were the outcomes of the services?
▪ How does the family's previous involvement with child protective services affect your feelings/view of the current family situation?
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Practice Area	Open Ended Questions to Promote Critical Thinking
▪ Safety Issues (for worker or family members)	
<u>Safety Assessment.</u> ▪ Comprehensive nature of the information compilation in the following areas: ○ Behavioral Health Issues of the family ○ Caregiving/Discipline practices ○ Substance Use/Abuse issues of the family ○ Housing/Environment/Physical Needs ○ Family Interactions ○ Child Functioning/Characteristics ○ Social Support System ○ Caregiver History of Abuse/Neglect ○ How the caregiver communicates ○ Caregiver's Day to Day Lifeskills/Functioning ○ Caregiver Employment/Financial Status ○ Caregiver Use of Community Resources	▪ Tell me about the caregivers' relationship with their children. How do the caregivers view the children? How do the caregivers describe their children? What is the most positive thing that the caregivers told you about their child? What can he/she do that makes you most proud? What do the caregivers think that their child needs from them as caregivers with regard to supervision, meals, helping with homework, helping to get dressed, etc? What are the caregivers' expectations of their children? Tell me about their disciplinary practices. Tell me about the time the caregivers spend with their children. What do they do together as a family? What would they like to do together? ▪ Given everything that is going on in the family how do they make it work? ▪ Tell me how family members interact with each other, talk to each other, meet each other's needs. How do they resolve conflict in their family? On a scale of 1-10, one being distant or extremely conflictual and 10 being an respectful, supportive, loving relationship, where would the adults rate their relationship with their partner/spouse/significant other? ▪ What are some of the concerns in the family that are affecting the safety to the child? ▪ You mentioned the caregivers' use of substances. Tell me more about that. What does the caregiver use? How often? How does it impact the functioning of the caregiver? Is the caregiver aware of how their substance use affects their care of their children? How does it impact on the safety to the child? ▪ Tell me about the home environment. Describe how the home looked. What was positive about the home environment? What concerned you most about the home environment? How does that impact on the safety to the child(ren)? ▪ Tell me about the child. How is he/she doing in academically? Tell me about his/her peer relationships. How is the child's physical health? Tell me about

Practice Area	Open Ended Questions to Promote Critical Thinking
	how he is at home. How does he interact with his caregivers, siblings? Tell me about the developmental status of the child? How about mental health issues? Are the needs of the child being met? Do any of these factors impact on the child's safety? ▪ Tell me about the family's support system. Who do they turn to for emotional support? Who do they turn to for information and advice? Who do they turn to for concrete assistance? How do the family members describe their relationships with others outside the home? What are the family's connections in the community? For example, are they involved in church or synagogue? ▪ How does the family meet its financial needs? Tell me about employment. What is their income? From where? Is it enough to meet their basic needs? Where does the family live? How do they budget? Do the caregivers ever have concerns about their house or your neighborhood being safe for them or their children? Do any of these factors impact on the safety to the child? ▪ Tell me about the adults in the home. Do they work? How is their physical health? How is their mental health? Do either of the caregivers have a mental health diagnosis? If so, are they on any medications? Are they able to control their behavior/emotions? What do they do for fun? How do they respond to stress? How did/do they respond to you and other service providers? Describe their motivation to change.
Safety Decision Making. ▪ Application of danger threshold ▪ Ensure that workers biases do not impact decision making ▪ Clear understanding of how the safety threats and risks are operationalized in the family—specific behavioral descriptions.	▪ What leads you to conclude that? What data do you have for that? What causes you to say that? ▪ You may be right. I'd like to understand more. What leads you to believe? ▪ What is the significance of that? How does this relate to the other safety threats?

Practice Area	Open Ended Questions to Promote Critical Thinking
	▪ How did you arrive at that view? Are you taking into account data that I have not considered? ▪ What do we know for a fact? What do we sense is true, but have no data for yet? What don't we know? ▪ Are there family conditions in the form of behaviors, emotions, attitudes, intent, situations, operating in isolation or together that create a current, immediate and significant threat to child safety? ▪ Are these conditions/situations unrestrained, unmanaged, without limits or monitoring, not subject to influence and are out of the family's control? ▪ Describe the possible impact to the child from the family conditions/situations that are out of control? ▪ What led you to conclude that there is a certainty about the occurrence in the immediate or near future? ▪ Tell me why you view the child as vulnerable. ▪ If the safety threat was "lack of supervision" What did that look like? Is this pattern of behavior and not an "incident"? ▪ If the safety threat is simply defined as "substance abuse, mental illness or domestic violence"…What are the specific behaviors that caused the children to be unsafe?
<u>Safety Planning.</u> ▪ The safety plan must specifically manage and control the identified safety threats (Who, when, where, how) ▪ The people in the family who are supporting the safety plan must agree with us that the children are unsafe and need protection ▪ In home safety plans must be monitored by worker…	▪ How are the safety threats operationalized in the family? ▪ What are the protective capacities of the caregivers and how can they be used in the safety plan to assure the child's protection in the least intrusive manner? ▪ Are there interventions that can specifically control and manage safety threats and maintain the child in the home?
<u>Case Transfer Meeting :</u> ▪ Clear and specific description of the behaviors or conditions of the caregiver's that have to	▪ Based on our understanding of the family, the safety threats and risks present in the family, and how those safety threats translate into specific caregiver behaviors

Practice Area	Open Ended Questions to Promote Critical Thinking
change in order to eliminate the safety threat or reduce the risk. This should be a collaborative process (whenever possible) between the CPI worker and the Family Services or Foster Care worker and the family. ▪ Family participation in the case transfer meeting.** **If the family is part of the transfer meeting it is an excellent vehicle for creating a common vision for the remainder of the work. If the family is not involved, it is at least important for the worker to spend time with the family helping them to understand why the specific behavioral changes must occur.	what must be communicated verbally and in writing to the supervisor or Program staff? ▪ Behaviorally describe the safety threats. ▪ How is the safety plan that was put in place managing or controlling the identified safety threats? What are 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?
Functional Assessment ▪ The Family Functional Assessment should be focus on understanding the causes of the safety threats/risks identified during the safety assessment. ▪ The worker draw a clear link between intervening in a specific domain area and changing behaviors that resulted in safety threats/risks. Sometimes functional assessments can simply look like additional information gathering –instead of seeking to understand the causal nature of the safety threats/risks.	▪ What does the caregiver/child/family believe is causing or contributing to the behaviors or conditions posing a risk or safety threat to the child? ▪ How does what we know about family functioning in each domain area help us understand the causal nature of the behavior? *Kinship Supports* ▪ Tell me about the family's support system. Who do they turn to for emotional support or assistance? ▪ Who do they consider family/kin? ▪ Is the family close to anyone in their church or community? *Housing/Food Basic Needs* ▪ How does the family meet its financial needs? ▪ Do the caregiver sever have concerns about their house or their neighborhood being safe for them or their children? *Medical Issues* ▪ Tell me about the physical health of the caregivers, children. ▪ Has the caregiver's health ever held them back from getting a job or taking care of their

Practice Area	Open Ended Questions to Promote Critical Thinking
	children? *Caregiver Mental Health* ▪ Tell me about the caregiver's mental health? ▪ What does the caregiver do when they are having a hard day? ▪ In what ways (if any) does the caregiver's mental health issues impair their parenting decisions and the ability to meet their child/s needs? *Caregiver Substance Abuse* ▪ You mentioned the caregivers' use of substances. Tell me more about that. ▪ How does it impact the functioning of the caregiver? ▪ Is the caregiver aware of how their substance use affects their care of their children? *Family Violence* ▪ How do family members get along? ▪ If the worker indicates that the caregiver disclosed domestic violence you may ask, when was the last incident? How often do the incidents occur? ▪ Have the incidents increased in severity and frequency? ▪ Tell me about the whereabouts and involvement of the children? *Day to Day Parenting Skills* ▪ Tell me about the caregivers' relationship with their children. How do the caregivers view/describe their children? ▪ What do the caregivers think that their child needs from them as caregivers with regard to supervision, meals, helping with homework, helping to get dressed, etc? What are the caregivers' expectations of their children? ▪ Tell me about their disciplinary practices. ▪ On a scale of 1-10, where would the

Practice Area	Open Ended Questions to Promote Critical Thinking
	caregiver place themselves at in comparison with where would he/she would like to be as a parent? ▪ Who raised the caregiver? How were they disciplined as children? ▪ What are some things the caregiver would like to do that are the same as his/her parents, what are some things that he/she would like to do differently?
Behaviorally Based Case Planning and Intentional Visitation Practices	▪ Tell me about the behaviors or conditions that need to change to reduce the risk or assure safety. If they miss something, What about…. ▪ If the behavioral description of what needs to change is stated in negative terms, what will be different in the caregiver's behavior if they stop, refrain from…? ▪ If the behavioral description of what needs to change is stated in general terms, how will we know that there is enhanced family functioning? Or what will the first thing the family will say is different in their family? ▪ If the behavioral description of what needs to change indicates a service, what will be different in their behavior when they finish the service? Or what behavior change are we hoping to accomplish by providing this service? ▪ If the family was here right now what would they say would be most helpful to them in changing? ▪ Tell me about the family's culture. What resources in the community would be most beneficial given the family's culture? *Referrals* ▪ In reviewing the referral for service the supervisor may ask: What does the service provider need to know to assure the most targeted service? ▪ What specifically do we need to know from the service provider to help us make decisions regarding safety, risk, permanence, and well being? How often do we need contact/reports from service providers? What form of reports will be most helpful? ▪ Are the interventions specifically focused

Practice Area	Open Ended Questions to Promote Critical Thinking
	on changing behaviors or conditions that caused children to be unsafe or at risk of future maltreatment? *Intentional Visitation* ▪ Tell me about the activities planned for the visit. ▪ Are the activities planned for the visitation obviously linked to addressing the change in behaviors or conditions that caused children to be unsafe or at risk of future harm? • For example are parenting behaviors such cooking meals, putting the child to bed at night, feeding the child, disciplining the child and other parenting behaviors being practiced in the visitation? ▪ What other activities may be helpful? ▪ What else do the caregivers think they could do or what they need to help them learn the skills to safely parent their children? ▪ Where are the visits taking place? What's the rationale for the location? Where else could we locate the visit to allow for privacy and natural interaction? • Has the worker encouraged birth family-resource family relationship?
Ongoing Assessment	▪ What will we see, hear, experience which will tell us that behavior change is occurring? ▪ Tell me what you've observed in the caregiver's and child's behavior, the interaction in the family, the and the home environment during your visits that demonstrates progress toward risk reduction, elimination of safety threats, and development of protective capacities? ▪ What specifically has changed in the family that tells us that safety can be managed by a combination of family protective factors and less restrictive agency safety interventions? ▪ What specifically has changed in the family which tells us that the threats to safety and the relevant risk factors can be managed by the

Practice Area	Open Ended Questions to Promote Critical Thinking
	family without additional protective factors offered by the agency? ▪ What do the caregivers say has changed? ▪ What do community providers report has changed in the individual/family that will help assure safety? ▪ What do the community providers report still needs to change to assure child safety? ▪ Are the services provided meeting the needs of family? Do they need to change in frequency or duration?

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