

In-Home and Out-of-Home

Procedural Operations Manual (POM)



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Background and Overview Of the Use of Practice Models

Increasingly, organizations across the country are recognizing the need to align their missions, visions, and practice principles in clear ways that describe the day to day efforts of social workers as they serve children and families. At the same time, there is a growing urgency to become more evidence based and produce outcomes that demonstrate children are safer, have increased permanency and enhanced well being. **The byproduct of this urgency and alignment is a practice model.**

Core Tenets of our CFSA Model of Practice include:

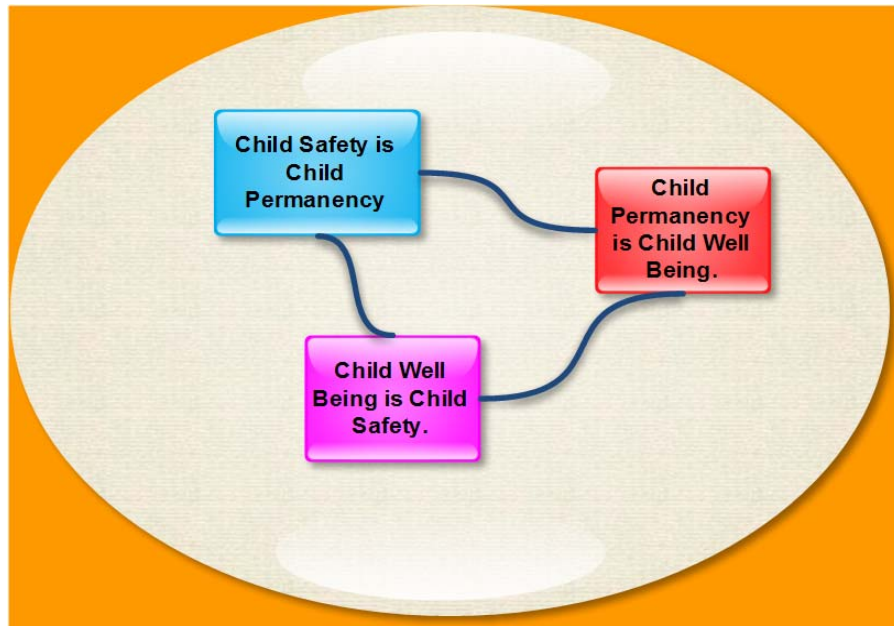
- We understand **effective child welfare practice** and we apply a **child-centered** perspective to address issues of child safety and risk. This is reflected in every intervention, every plan, and every contact.
- We work collaboratively with families and youth as appropriate and other professionals using a **strengths-based and solution-focused** strength focused service delivery approach that is **family-focused and community-connected** to support child safety, wellbeing and permanence.
- We practice **cultural competent and responsive practice** to see the strengths of the individual child. We work to create supportive environments that positively aid child development through appropriate placement within their families or within foster family alternatives.
- We understand how the **continuous quality improvement** of services promotes a child's physical, intellectual, social and emotional development.

The Child and Family Services Agency decided to complement our Core Practice Model with an Operational Manual. This manual integrates the many initiatives of the agency into a cogent and clear flow that describes how families are served from case opening to case closure.

This manual is the result of hundreds of hours of work over the past year. Special recognition must go to our 30+ member team of line workers, supervisors, program managers and administrators from throughout the agency who contributed countless hours in the development of this manual. They engaged in complicated, highly creative and constructive

conversations to design this manual for child welfare services in the District of Columbia. Their time and suggestions and thoughtful guidance are greatly appreciated.

It is important to note that this practice model seeks to more fully integrate the concepts of child safety, permanency and well being in practice than what is reflected in the national conversation. We believe that child Permanency, child safety and child well being CANNOT be separated.



While we often talk about these three goals independently—they are in fact inextricably interwoven. One cannot exist without the other. So while we may have removed a child from an unsafe living environment, and we may have attended to their medical, mental health and educational needs—it is only when a child leaves our system with permanent connections to loving adults that we have achieved safety, permanency and well being.

Disproportionality in Child Welfare

Disproportionality refers to a situation in which a particular racial/ethnic group of children are represented at a higher percentage than other racial/ethnic groups and at a higher percentage than their representation in the general public. *The numbers in child welfare bear out the issue:*

- Families of African American children are more likely to be investigated for emotional maltreatment and neglect, yet, when disadvantaging characteristics (low income, large family size, single-parent homes) are factored in, African American children are actually maltreated at lower rates than white children.

- African American children, who comprised 15% of the U.S. child population in 1999, constituted 45% of the children in substitute care. Conversely, white children, who comprised 60% of the child population, accounted for 36% of children in out-of-home care (U.S. Census Bureau, 2000).
- Of those requiring substitute care, most African American children (56%) are placed in foster care, while most white children (72%) receive in-home services (Annie E. Casey Foundation, 1999; HHS, 2003). African American children remain in foster care for longer periods of time (U.S. Children's Bureau, 1997).
- Five major studies in four states between 1990 and 2003 revealed that white children are four times more likely than African American children to be reunified with their families, and they are

Given that disproportionality is impacted and increases the deeper a child enters the system, every time a social worker makes a decision about child safety and risk, how to control and manage the identified safety threat (in home or out of home), where children should be placed, the frequency and consistency of intentional visitation efforts, reunification, legal guardianship or adoption the decisions impact the disproportionality of children of color in the system and the disparity of outcomes.

reunited more quickly.

- Disproportionate numbers of children who are reunified return to foster care, with "race of the child" identified as one of five strong variables in decision making.¹

We believe that the historical impact of racism, which tore African American and American Indian families apart and limited opportunities for higher education and the accumulation of wealth, is still being deeply felt in our current society. African American and American Indian families deeply, and justifiably, mistrust public systems. When a family's mistrust interacts with the mistrust, cultural misunderstanding or biases of the service provider, true engagement is severely hampered. Service providers are less able to connect with the family, know the family, and understand the family's true strengths and needs. As a result, families are less likely to be motivated to pursue or connect with the services that will best help them.

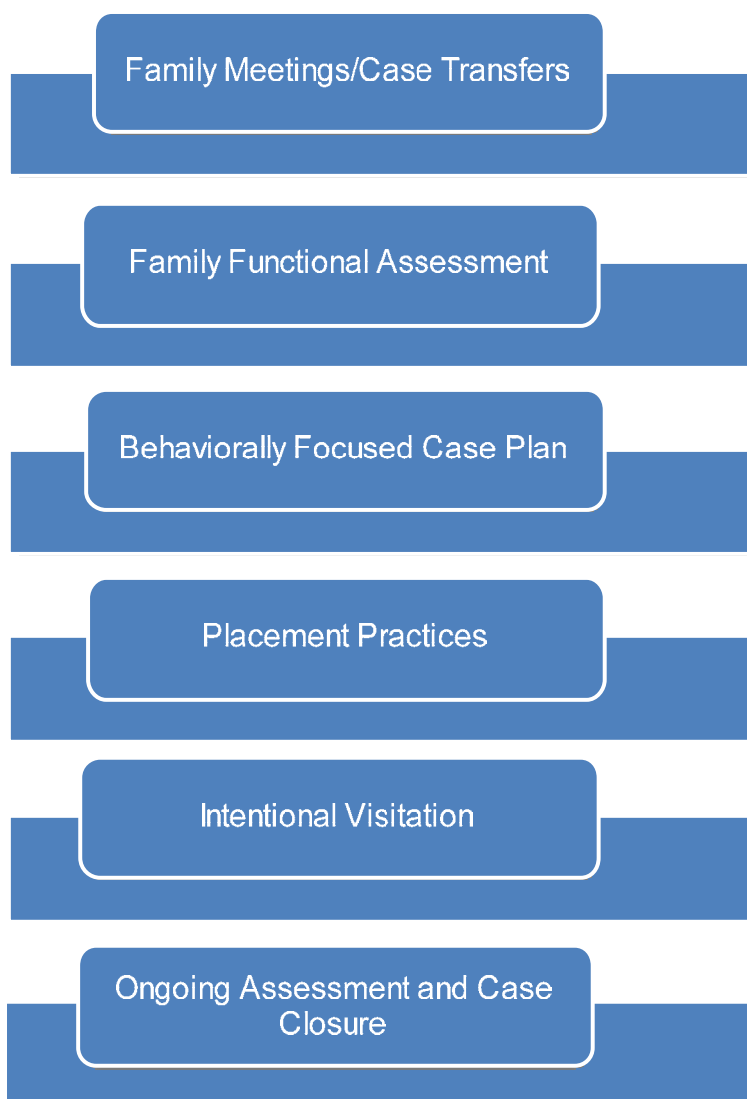
Full implementation of this way of practicing will challenge every child welfare staff member to work to varying degrees, differently than they may have in the past. It requires new and evolved partnerships with birth families, foster families, kin and our community service

¹ Race Matters: The Overrepresentation of African Americans in the Child Welfare System,

partners. It requires thinking differently about the process of visitation, case planning and ongoing assessment. It requires strong teamwork between the various units of the agency, and a willingness to look at biases, and personal values that may get in the way of effectively serving families.

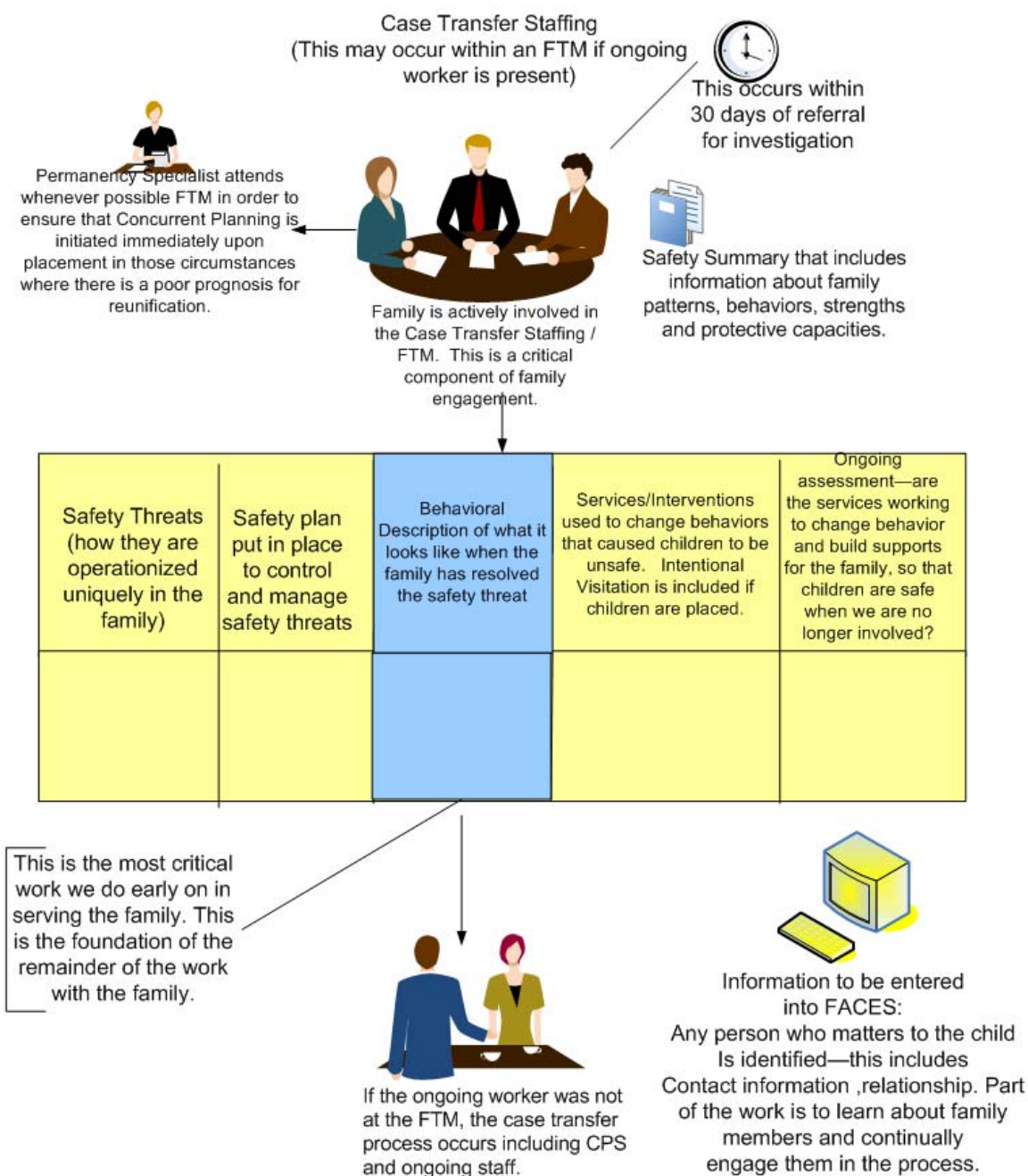
As difficult as this practice change might be to implement, we believe that over time this practice will safely reduce the number of children entering the system as well as improve the care of those that do.

The content of the In Home and Out of Home Practice Model Operation Manual includes:



Each module includes a flow chart depicting the practice and a narrative that more specifically defines the practice of the social worker.

Family Team Meetings/Case Transfer Staffing



Description of Practice Within Family Team Meetings/Transfer Discussions

A transfer discussion occurs whenever a case is transferred from one worker to another. Because it is difficult for families to have their case transferred it is important that this process is thoughtful and considers how to best ensure the effective and respectful flow of information from one worker to another. Often these case transfer discussions are held within a Family Team Meeting—so that families have the opportunity to meet the new worker and the worker and family begin the critical process of relationship development.

BEST PRACTICE “TIPS”

- ✧ This transfer discussion must include a thorough explanation of the safety threats/risks and how these threats/risks show themselves within the family. It must also include a discussion of family strengths, protective capacities and ways that families have been successful in the past.
- ✧ This discussion must also include a description of the way that the safety threats are being controlled and managed. (How we are ensuring that the child is not being harmed or neglected while we are working on changing behaviors). This is the process of safety management—and it occurs as long as we are involved in the family’s life.
- ✧ If the child is placed in out of home care—this initial meeting should consider ways that we could return the child to their home with an in-home safety plan.
- ✧ This discussion must focus on helping every participant understand what the family parenting will look like when the safety threats no longer exist and the risks are reduced.
- ✧ The style of communication should respect and honor for the family; using language that the family understands so that they are not at a disadvantage to participating.
- ✧ If the child is in care due to egregious actions by the caregiver or if because of the nature of the act and history of the family there are significant questions about reunification, immediate discussions on Concurrent Planning will occur. Concurrent planning discussions begin with full disclosure—explaining to the family why it is important to ensure that a child has permanent, safe connections to adults who love them and will take care of their needs. These discussions also include identification of people who care about the child.
- ✧ When we cannot identify kin within these discussions, we engage our Diligent Search unit to ensure we have exhausted all options for kin identification.
- ✧ NOTE: Permanency Planning Specialist must be an active part of the team whenever a child is removed from their homes.

Content Of The Family Team Meetings/Transfer Discussions

Safety Management

Once a child is determined to be unsafe...safety management is required. Safety management occurs throughout the life of a case and must be the primary topic of discussion within the transfer discussions.

For safety management to be effective, it must be a driving force for in home and out of home social workers. Safety Management is dynamic, and the worker must be open to constantly increasing or decreasing the level of effort in safety plans in order to control and manage the identified safety threats.

Safety management refers to something specific that CPS initiates and is maintained until the safety threat no longer exists.

Safety management is not voluntary. If a child is believed to be unsafe there is no choice but for child welfare agency to protect him/her. **If the protection occurs through an in home safety plan, it must be monitored on a continual basis** to ensure that it continues to control and manage the identified safety threats until such time as parent's protective capacities have been enhanced and child safety is no longer a concern.

Clarity About What Must Be Different

Families who have been involved in the child welfare system often tell us that they were unclear what was required of them to have their children return home. 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**. If families do not understand what has to change, they may not focus on the right things and jeopardize being successfully reunited with their children.

During the Family Team Meetings/Transfer Discussions, the chart (below) may be helpful in assisting the participants to understand the following:

- The safety threats and risks described in behavioral terms ;
- The safety plan that has been put in place to control and manage the safety threats;
- How the family will function as parents when the threats are eliminated and risks reduced;
- The interventions and services that will be put in place to meet underlying family needs resulting in behavioral changes ; and
- Ongoing Assessment of Progress—including evaluation of whether or not the right services are in place to support behavioral change.

Safety Threats (how they are operationized uniquely in the family)	Safety plan put in place to control and manage safety threats	Behavioral Description of what it looks like when the family has resolved the safety threat	Services/Interventions used to change behaviors that caused children to be unsafe. Intentional Visitation is included if children are placed.	Ongoing assessment—are the services working to change behavior and build supports for the family, so that children are safe when we are no longer involved?

Participants in the Family Team Meeting/ Transfer Discussion

The CPS worker and his/her supervisor, the in home or out of home worker and his/her supervisor, the family, and any individuals the family invites, participate in the meeting. If the child is in out of home care, the foster family and Permanency Planning Specialists should be invited to the meeting in order to support full disclosure and initiation of Concurrent Planning. (Permanency Planning Specialists may not participate in every meeting, as such, when they are not present, it is important that the worker communicate the content of the meeting to the Permanency Planning Unit).

This meeting is a critical opportunity for identification of kin who can support the family. Workers must stress the importance of kin identification and inclusion in the planning and ongoing service delivery process. If a child is in out of home care, inviting kin to the Family Team Meeting provides an opportunity to educate kin on the licensing process—so that if the child is not able to return home we are able to move rapidly to our alternate permanency plan.

Honoring Culture, Race and Ethnicity

One of the benefits of Family Meetings is the ability they provide to learn about the cultural, racial and ethnic background of the family and how their background impacts parenting decisions.

Culture includes race, religion, ethnicity, family values, lifestyle, family composition, customs, values and beliefs. The family itself is the most important source of information about its unique characteristics, historical roots, and cultural values.² Culturally competent workers can help families to have a positive experience in planning and participating in parenting and other family access time by:

- Respecting the client's perspective.
- Listening well enough to learn about people who are different from themselves.
- Avoiding judgment from bias, stereotypes, or cultural myths.

² Berg, I.K. & Kelly, S. (2000). Building Solutions in Child Protective Services. New York: Norton.

- Asking the family to explain the significance culture has for them, especially regarding family traditions, child rearing and discipline practices, spiritual beliefs and traditions.

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

The cornerstones to effective family meetings/transfer discussions include:

- ***Everyone desires respect***
- ***Everyone needs to be heard***
- ***Everyone has strengths***
- ***Judgments can wait***
- ***Partners share power***
- ***Partnership is a process***

The Process of Family Team Meetings/Transfer Discussions

The Family Team Meeting process begins by the child welfare worker talking with the key family members about having a meeting. In order for the family-centered meeting to be effective, it requires the full support and participation of the family and worker.

Sometimes parents/caregivers are reluctant to include other members of their family/community network in a family meeting. This may be because of the desire for privacy, embarrassment, self-protection, safety, damaged relationships, prior abuse, or any number of reasons. Family Meetings are essentially voluntary processes. Participants, including parents, ultimately decide the level of their participation.

While parental wishes concerning who is invited/not invited should be honored and respected, it is also imperative that the child welfare worker uses diligence in expanding the circle of support for the child and family as widely as possible. ***A broad and comprehensive circle of support is more likely to keep the child and family safe.*** Widening the circle involves a great deal of skill in working with resistance. When parents/caregivers are reluctant to hold a family meeting, social workers must seek to understand what this reluctance is about and how the safety and comfort of the parents/caregivers can be achieved.

Being Open and Willing To Consider the Family’s Ideas

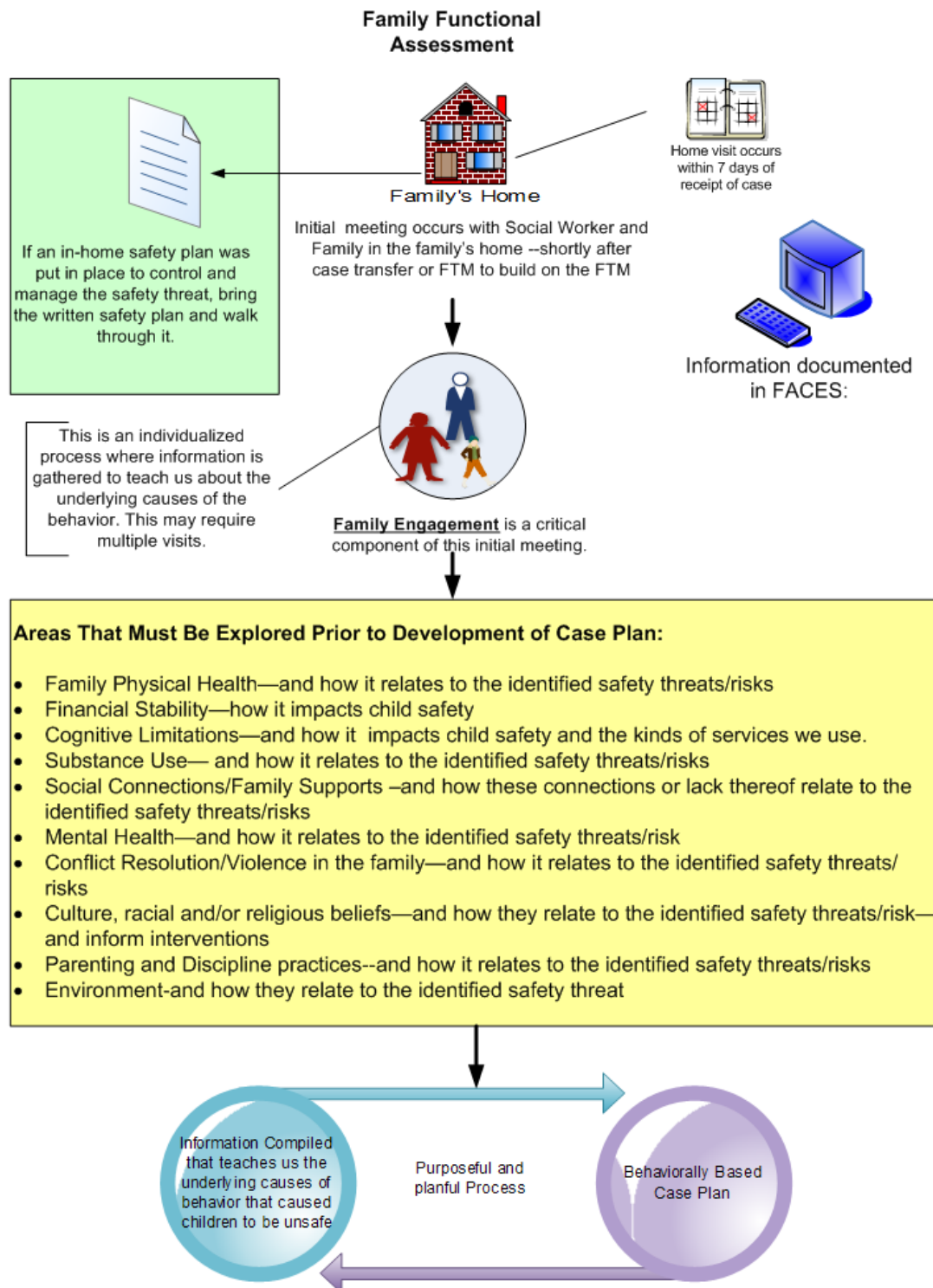
Sometimes the facts of the case determine decisions and actions that need to be taken. If a decision is already made, it is imperative that the meeting not be held for the purpose of making/justifying that

particular decision or simply getting the family to agree with it. Likewise, if there is only one outcome that is potentially acceptable to the agency representative, then it is likely not a good time for a Family Team Meeting. Remember that family-centered practice is all about choice and empowerment. Without choice and the power to make plans and decisions, participants will feel that the meeting is a waste of time—making it a frustrating experience.

Initiation Concurrent Planning Within the Family Team Meeting

If a child has been placed in out of home care, Concurrent Planning is discussed during this initial transfer discussion. The Concurrent Planning discussion is initiated by a thorough disclosure of the need for permanency in the life of a child, allowable timeframes to achieve permanency, and the efforts that the agency will undertake in partnership with the family to help the child return to their home. This is a process of helping the family understand the agency's commitment to children living in permanent loving families. While we communicate that we will rigorously work with the family—to help them learn to safely care for their children, we will also communicate that this process cannot go on indefinitely. We describe to families the importance of identifying kin who care about the child to first serve as a support to them in the process of reunification and who may, if needed, serve as a permanent caregiver for the child. Diligent Search should be used to support the identification and finding family members. These conversations are not made in a threatening manner—but only to ensure that the family fully understands the process.

Family Functional Assessment



Description of Practice When Completing Family Functional Assessment

After the transfer discussion, the first step of the in home or out of home worker is to engage the family in conversations about the underlying issues in the family that may be causing the behavior that resulted in their children being unsafe or at risk of future harm. Once this understanding occurs, it serves as the foundation for the case plan. In the absence of understanding the underlying causes of behavior, case plans become routinized and often lacking in focus or use of services that will not have the greatest impact.

The way the worker engages the family in the case planning process is critical to success. Best practice tips for this phase of the work are highlighted below.

BEST PRACTICE TIPS:

- The intent of the information gathering is to understand the family's functioning enough to know the right intervention/support to provide to the family.
- Gathering information is often dependent upon framing the conversation and then asking questions in way that promotes the emotional safety of participants, allowing family members to answer without feeling judged. We find ways to hear family voice and seek to understand the day to day dynamics of the family from the family's perspective.
- We take an approach that honors the culture and race and ethnicity of the families we serve.
- We engage in deliberate conversations which allow families to describe who they are. We strive to entire into these conversations without pre-conceived notions.
- Team formation and development is foundational to our long term success with families. Workers make a concerted effort to build a family support system (if none exists) and enhance the system (that does exist) so that when we are no longer in the family's life, they are able to function in a way that ensures child safety, permanency and well being.
- Part of strong practice in the assessment process is to continually identify individuals who care about the children in the family.
- Due to the emotional complexity of this work, supervisors/administrators need to create a space where workers can openly and honestly discuss their struggles and the way the family's reaction, behavior and interaction with their children is impacting them.

Focus of the Family Functional Assessment

Understanding the Behavior

One of the primary goals of this phase of the work is to understand the family issues/underlying needs that are impacting the safety of children in the home.

What Do We Mean by Underlying Need of a Family? A need is what drives a behavior. A need is what makes a behavior seem functional for the family—although it can be undesirable and harmful. Behavior can be driven by a variety of needs—which is why it is imperative that we do not have a “standard response” to certain behaviors—but look closely to better understand what is actually behind the behavior. Well intentioned people can actually prescribe certain interventions without fully understanding the issues and underlying causes of the behavior and miss critical opportunities to make a difference. For example, we often assume that caregivers who do not get up and take care of their children need parenting classes or need to learn how to take care of their home, when in fact the underlying issue may be depression or some form of debilitating mental health issue that is impacting caregiver’s energy and will. Underlying family need should not be viewed as a deficit but a driver of behavior. The more we understand what is underneath parenting behavior, the better we can target the best services and interventions to meet this underlying need and ultimately change parental behavior.

One aspect of understanding underlying needs is assessment of the trauma the family system has experienced.³ (See Essentials of Trauma Informed Child Welfare Practice In Attachments) Many families experience trauma; the long term sickness and death of a loved one, significant financial loss, loss of a child at birth, car accidents that result in debilitating conditions, etc. In many instances the family supports function as “trauma membranes or protective environments” surrounding the trauma survivor. In these circumstances, the extended family and community provide extra support, structure and coping to assist the traumatized family member. However, under conditions of chronic family stress where families experience multiple and/or complex trauma, the family may lose the supports to help serve this protective function. Understanding the context in which child welfare children and their families have experienced trauma is important to: (1) adequately assessing their responses; and

³ Children and adolescents who are exposed to traumatic events are helped by numerous child-serving agencies, including health, mental health, education, child welfare, first responder, and criminal justice systems to assist them in their recovery. Service providers need to incorporate a trauma-informed perspective in their practices to enhance the quality of care for these children. This includes making sure that children and adolescents are screened for trauma exposure; that service providers use evidence-informed practices; that resources on trauma are available to providers, survivors, and their families; and that there is a continuity of care across service systems.

(2) staging and sequencing appropriate services to meet families' needs and optimize positive outcomes for children and their families.

It is Imperative to Explore Family Strengths

As highlighted in the CFSA Core Model of Practice:

- ⊕ All families have strengths;
- ⊕ Families are the experts on themselves and their own history;
- ⊕ Families deserve to be treated with dignity and respect;
- ⊕ Families can make well informed decisions about keeping their children safe when supported;
- ⊕ When families are involved in decision making outcomes can improve;
- ⊕ A team is often more capable of creative and high quality decision making than a single individual; and
- ⊕ The family's culture is a source of strengths, and culturally responsive practices honor the family's customs, values and preferences.

A functional assessment seeks to understand history and current behavior and their impact on future child safety. It involves recognizing patterns of parental behavior over time that have contributed to children being unsafe or at risk of future harm.

Family Engagement in the Assessment of Family Functioning









Understanding underlying needs and family strengths is dependent up the quality of family engagement. The chart below is provided as a way to workers to explore the strength of their family engagement practice. This not intended to be critical—but to encourage growth and development of professional skills.

You Have Strong Family Engagement Skills If:	You May Need to Strengthen Your Family Engagement Practices If:
You consistently treat families with genuineness, respect and empathy—regardless of what has happened within their family system.	You believe that approaching families who are unable to appropriately care for their children with genuineness , empathy and respect seems like condoning poor parenting.
You create an environment for families to tell you their story and then you listen attentively.	You feel that you do not have time to listen to broader issues and must focus only on the immediate issue at hand.
You believe that families have strengths that can be used to help them improve their parenting capacity and family functioning.	You still need evidence that some of the most challenging families have strengths that will be helpful in meeting safety, permanency and well-being goals.
You engage families in looking at how their	You are focused on making sure that families

You Have Strong Family Engagement Skills If:	You May Need to Strengthen Your Family Engagement Practices If:
behaviors have caused harm to their children and their family.	take responsibility (accept blame) for their situations.
You ensure that families have meaningful representation and influence at all levels of the system and are provided diverse opportunities to participate in shared decision-making.	You are part of constructing processes where families are absent from decision-making or have only token representation at any level beyond their own case or in any role other than service recipient
You develop an initial working agreement with families about the underlying issues to be addressed and what success (behavioral change) will look like.	You are not clear with families about what needs to change and what success will look like—so families are led to believe success is about completion of a set of tasks.
You ask about the family's goals before insisting on the agency's goals	Your practice is driven by agency-determined goals for the family
You enlist the family in developing the case plan	Most of your plans are prepared in advance of planning meetings with families—and then you go out and ask the family to sign the plan.

Gathering Information About Family Functioning

We suggest that during this phase workers structure their assessment by gathering information in the following areas:

-  Underlying Needs/Issues and Strengths Associated With Caregiver's Day to Day Parenting
-  Underlying Needs/Issues and Strengths Associated with Household Relationships/Family Violence
-  Underlying Needs/Issues and Strengths Associated with Caregiver's Use of Substances
-  Underlying Needs/Issues and Strengths Associated with Caregiver's Mental Health/Coping Skills
-  Underlying Needs/Issues and Strengths Associated with Caregiver's Social Support System/Community Connections
-  Underlying Needs/Issues and Strengths Associated with Caregiver's Management of Resources/Living Conditions/Meeting Basic Needs of Children
-  Underlying Needs/Issues and Strengths Associated with Physical Health
-  Underlying Needs/Issues Strengths Around Child Emotional Safety/Behavior

Use of Strength Focused-Solution Focused Questions is a critical component of the Family Functioning Assessment process.

Please See Addendum for a list of possible Strength-focused/Solution Focused questions to use during the assessment process.

It is important for workers to continually develop and hone their information gathering skills. **Remember assessment generates experience** that either enhances or hinders the quality of the information provided by families as well as the success of the interventions.

Most families are fearful of our involvement in their lives –and understandably so. Imagine the power that we have in their eyes. We can choose to use that power for good or not. The better our assessment of the family, the more likely we are to empower and make a real difference in family's lives through focused and targeted case plans.

Consider Billy, a 14-year-old boy who has been hospitalized 12 times in the last three years, and is increasingly involved in the juvenile justice system. There have been multiple referrals to the child welfare system that Billy's mother is using substance and this is impacting her parenting. An intake worker is collecting information about the family including Billy's previous hospitalization history, their past involvement in the child welfare system and Billy's current involvement in the juvenile justice system. The worker also gathers information about all of the interventions that have been tried to help the family. As the worker methodically obtains the information, she notices Billy and his Mom's presence in the room literally "shrinking". The intake worker is only collecting information, not "intervening," and yet is it any wonder that by the time Billy and his Mom describes his 11th unsuccessful hospitalization, his fifth court appearance and a string of services and interventions that their sense of hope has shrunk to microscopic level? Assessment generates experience. In this situation while the worker was doing a wonderful job of gathering important historical information, she forgot about the importance of learning how Billy and his Mom made it through all this, their strengths, their dreams and goals for the future. How they have both survived their experiences and is still standing to tell about them! If we better understood these strengths we would be much clearer about how to best serve Billy and his Mom.

In his Collaborative Therapy with Multi-Stressed Families author Bill Madsen describes [the Smith Family's] interaction with two teams of social workers from the state child welfare system. The first team viewed the family as chronically dysfunctional, whereas the second team saw them as having tremendous coping skills and survivors of many family traumas, desperate for help but very suspicious due to a long history of previous negative experiences with helpers. As we reflect on the families' interactions with the two different teams, several important points emerge. "Different observers 'see' different things in a situation. Perception is not a passive process of observation but an active drawing of distinctions."⁴ The distinctions we draw as social workers are profoundly organized by our own history and our own set of cultural

⁴ Collaborative Therapy With Multi-Stressed Families: From Old Problems to New Futures. (1999)

“shoulds and shouldn’ts”. The different views of the [Smith family] were shaped by the context of the social workers’ interactions with the family and the values within which those interactions were interpreted. The first team anticipated the family’s “dysfunction” and described themselves as stiffening up in anticipation of the family’s “craziness.” The second team, whose perspective emphasized the family’s resilience and commitment to one another, had a different reaction. They admired the family’s persistence in continuing to struggle to get their children back, and wanted to help the family have a different experience in their interactions with the team.

Our reactions to families are often communicated in subtle ways and, in turn, invite families reactions to us. The [Smith family] thought the first team of social workers was uneasy around them, and that the workers were critical, “uptight and judgmental.” The family responded with suspiciousness and defensiveness, and a relationship developed that was characterized by mutual mistrust, blaming, and antagonism. As the interaction became more polarized, each party became more entrenched in their negative view of the other.

In contrast, the Smith family felt understood and validated by the second team and responded by sharing more of their life story and became active participants in the process of service planning and service delivery.

Assessment of Child Well Being

The Adoption and Safe Families Act explicitly and legislatively mandates that the outcome of child well-being be actively pursued and regularly assessed. All children involved in the child welfare system must be assessed to ensure that they have their educational, health and behavioral health needs met. The rationale for this assessment is founded on several research studies that indicate that children and youth that come to the attention or care of the child welfare system demonstrate significantly lower levels of well-being than any other subpopulation of children and youth in the United States. Their findings include the following: 53% of all children aged 3 months to 24 months whose families were investigated for maltreatment are classified as high risk for developmental delay or neurological impairment, 38% of all children in the study are classified as having “fewer” social skills than the general population, 30% of all children in the study have low or moderately low scores for daily living skills, substantially lower than the general population.⁵

Comprehensive assessments of child and youth well-being (which is done through observation, formal assessment, interaction with school, mental health and medical professionals, conversations with the family and /or alternate caregivers) in child welfare should include the following:

⁵ Department of Health and Human Services. 2001

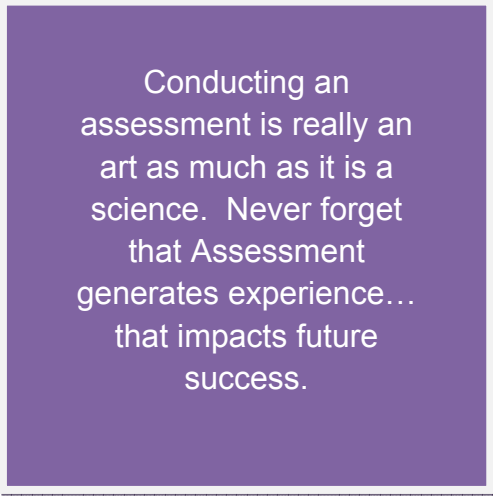
1. Ensure normal development and functioning based on observable characteristics, self- and caregiver-reports, and other sources of information (including school records and other care agencies);
2. Identify child/youth strengths in order to inform service/treatment planning, to reduce identified risks, to monitor the course of service, and to provide outcome scores;
3. Obtain a quick “snapshot” of the child or youth’s general status in order to make referral to specialty care as indicated.

The categories for comprehensive child assessment as indicated within the SDM and supplemented by the Child’s Strengths and Needs Assessment and Educational/Vocational Assessments include the following:

- physical and motor skills;
- intellectual ability and cognitive functioning;
- academic achievement/motivation;
- depending upon their age explore any sexual orientation issues they may be experiencing;⁶
- emotional and social functioning;
- vulnerability/ability to communicate or protect themselves; and
- developmental needs.

In addition, as children age youth assessment should include the following well being areas (as identified in Chafee legislation):

- readiness to live interdependently,
- ability to care for one’s own physical and mental health needs,
- self-advocacy skills,
- future plans for academic achievement,
- life skills achievement,
- employment/career development, and
- quality of personal and community connections.



Conducting an assessment is really an art as much as it is a science. Never forget that Assessment generates experience... that impacts future success.

It is important to remember that during the past decade, lesbian, gay, bisexual, and transgender (LGBT) adolescents have become increasingly visible in our families, communities, and systems of care. A significant number of these youth are in the custody of the CFSA child welfare agency. Quantifying the number of LGBT youth in out of- home care is difficult because many of these youth hide their sexual orientation and gender identity from adults and peers whom they perceive as rejecting or unsupportive. CFSA has made a commitment to ensure that youth have the opportunity to safely discuss their sexual orientation and gender identity

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and to ensure that youth live in environments that do not discriminate against them regardless of their sexual orientation or gender identify.

The comprehensive nature of these child well being assessment areas make it clear that it is not sufficient to ensure child safety and child permanence without focusing the same level of effort on ensuring child well being. Child and youth voice is critical to ensuring a comprehensive and accurate assessment of child well being.

Specialized Assessments

As information is being gathered in the process of family functional assessment, it may be necessary in some instances, to request specialized assessments. These specialized assessments could be for developmental issues that seem to be impacting the child, physical conditions of family members that cause concern, mental health evaluations of the child, youth, and/or parents, or evaluations related to the use of drugs.

Teaming During the Assessment Process

We see today, more than any other point in our history of serving children and families the need to team within and across systems and programs. Research teaches us that children needing child protection increasingly come from families who have multiple needs and problems and that family complexity has demanded more comprehensive assessments and service planning on the part of professionals. In order to achieve the outcomes we desire for children and families CFSA appreciates and emphasizes the need for interdisciplinary communication and collaboration.

Research supports the need to enhance teaming skills on behalf of families. “The different orientations, vocabularies, and working styles of professional staff can pose substantial barriers to effective teamwork if not explicitly addressed. For example, numerous studies suggest that neither child welfare nor substance abuse workers are exactly sure what the others have to offer, and they tend to be wary of one another. Wariness to team not only comes from lack of knowledge, but from differing philosophies around areas such as - who the client is (parent versus child), harm reduction versus the need for total abstinence, and timelines regarding treatment interventions.”⁷

This approach to conducting comprehensive and family focused behavioral assessments requires that workers are consistently developing their critical thinking skills.

Critical Thinking and Analysis During the Functional Assessment Process

Critical thinking is the intellectually disciplined process of actively and skillfully conceptualizing, applying, analyzing, synthesizing, and/or evaluating information gather from, or generated by,

⁷ Young, Gardner and Dennis. Teaming As a Way to Support Families. (1998)

observation, experience, reflection, reasoning, or communication, as a guide to belief and action.⁸ A well cultivated critical thinker:

- 📖 Raises vital questions and problems, formulating them clearly and precisely;
- 📖 Gathers and assesses relevant information;
- 📖 Thinks open-mindedly within alternative systems of thought;
- 📖 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 make valuable contributions at case conferences
- 📖 They develop effective plans with maximum family involvement, which clearly identify specific behavioral changes required to ensure child safety and improved family functioning
- 📖 They respect and have empathy for others
- 📖 They continue to learn and enhance their skills

⁸ Michael Scriven & Richard Paul. (February 2005). National Council for Excellence in Critical Thinking Instructions.

Behaviorally Focused Case Plan

Behaviorally Focused Case Plan

Permanency Planning starts at the point of contact with the family and continues throughout the life of the case

Family and youth is fully involved in all aspects of case plan development—this means that you **do not create a case plan and bring it to the family to sign.**

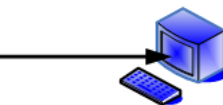
In Home or Out of Home Safety Plan manages safety throughout the life of a case.

When the child has an in home safety plan every visit assesses if the safety plan is still controlling and managing safety threats.

If the child is in out of home care every conversation with the family assesses 1) if we have learned about additional supports so that we can send the child home under an in home safety plan and 2) if the children can be safely reunified based on behavioral changes the family has made that have resolved safety threat.

Behaviorally Focused Case Plan

- 1) Restate the safety threats/risks in behavioral language
- 2) Restates what the family's behaviors look like when 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 and for achieving permanency.



Until the system is changed, use the comment section within the case plan document to define behaviors that need to change in order for children to be safe **AND** ongoing identification of People who care about the children.

Written version of the case plan is provided to the family based on conversation with the family.



Family receives the formal document and signs it.

Description of Practice When Developing a Behaviorally Focused Case Plan

When the information from the family functional assessment is compiled and reviewed through the lens of the safety threats and risks for future maltreatment, it helps focus the interventions. Workers are focused on ensuring that the services put in place have optimal chance at changing behaviors that caused children to be unsafe or at risk of future maltreatment.

Best Practice “Tips” in Developing a Behaviorally Focused Case Plan:

- The case plan is developed in partnership with the family—it cannot be developed in isolation by the staff and then brought to the family. It is the family’s case plan—and needs to be developed, worded and understood by the family and the child (based on age).
- When thinking through the information from the functional assessment to develop a case plan, we remember that the case plan is DIFFERENT than the court report—it is a living document that is continually modified based on new learning.
- The case plan language is about change in behaviors not solely about *compliance* to a set of tasks.
- Following the completion of the case plan, we make targeted referrals to community providers –ensuring that the provider works with the family to change specific behaviors that cause children to be unsafe or at risk of future harm. Providers report back to us on their progress in making these specific behavioral changes.
- If the services are not working—we must change them!
- The plan is crafted through the lens of safety, permanency and well-being. This means that case plans include ongoing identification of people who matter to the children.
- If the family does not make progress we need to continue our pursuit of concurrent planning activities such as background checks, home studies, conversations with the family and alternate permanency options. The permanency specialist will support this process.
- We ensure that our work results in the family being able to safely care for their children WITHOUT our involvement. Our work should result in a “team of supports” for the family that exist long after we are gone.

Linking the Information from the Assessments of Safety and Family Functioning to the Behaviorally Based Case Plan

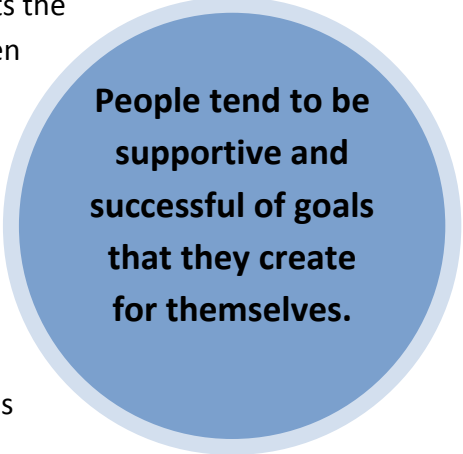
Effective case planning is a natural byproduct of a comprehensive assessment. A strong behaviorally based case plan:

- ☉ Describes in behavioral terms that families can fully understand what needs to change in order for children to be safe, reduce risk and enhance child well being.
- ☉ Identifies specific interventions and actions facilitate or support this behavioral change.
- ☉ Includes an ongoing assessment of whether or not the in-home safety plan continues to manage identified safety threats.
- ☉ Leverages what the family is already doing well (their strengths) to help motivate the family and to encourage them that they can be successful.
- ☉ Should be viewed by the family as achievable and realistic.

The case plan should reflect the “golden thread” that connects the planned services to changing the behavior that caused children to be unsafe and meeting family needs related to child safety and risk.

Family Engagement in Case Planning

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 and own the changes in behaviors necessary for children to be safe. It also negates the opportunity for the team members to actively participate in the planning. Family members should be intricately involved in the process of moving from assessment to the development of the case 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.

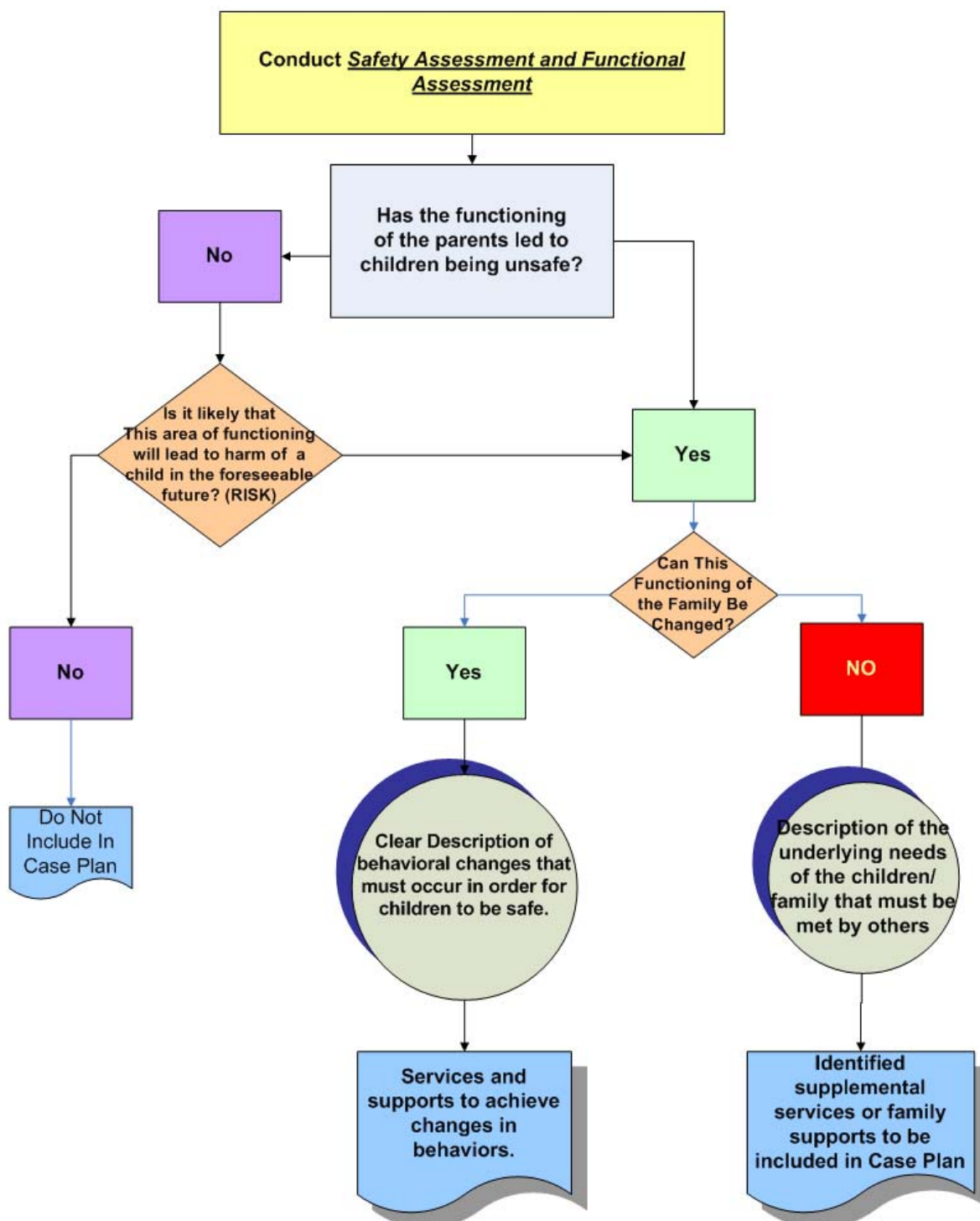


People tend to be supportive and successful of goals that they create for themselves.

When Deciding What to Include in a Case Plan

There are times when we learn 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, a mental illness that cannot be controlled through medication or therapy, or a physical disability that is 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 to developing an informal team that can help meet the needs of the child on a daily basis. This team of supports may involve kin, community members or services that can continue without child welfare involvement for a long period of time (such as services to people with disabilities or adult mental health services).

The chart below depicts this kind of decision making:



Making Referrals to Community Providers

It is critical that we receive information from providers that help us to understand if and how behavior is changing.

So when making the referral the following information must be shared:

- ✓ Behavioral Description of the Safety Threats/Risk
- ✓ Safety plan that is in place
- ✓ What needs to change behaviorally to eliminate threat or reduce risk
- ✓ Characteristics of the child that may challenge the parent
- ✓ What information we need back from them:
- ✓ Engagement Level of the parent
- ✓ Concerns that they might have about the parent's ability or progress in learning new skills and changing behavior

It is equally important that the reports from the providers include information about progress in changing behaviors.

It is not sufficient for the reports to simply state that the parent attended, participated and was on time. It is critical that the information from the provider clearly describe progress the parent is developing an understanding of how to parent differently and making in changing behaviors that caused children to be unsafe or at risk of future harm.

Behaviorally Focused Case Plan Examples

The following examples are provided to help show the flow between identified safety threats/risks, questions to engage the families and create effective case plans.

EXAMPLE #1: SEXUAL ABUSE

- 9 y/o child Angela reported to her aunt that she was sexually abused by her step-father. Aunt tried to talk to her sister (Angela's Mom) but Angela's Mom refused to believe that Angela has been harmed by her step father.
- Forensic interview and medical exam indicated sexual abuse has occurred.
- Mom and Step Father have been married for 5 years.
- Step father denies that he harmed his daughter.
- Mom initially states that she does not believe her child. She was in very bad first marriage and feels that this man has been a good provider, a good partner and is loving to her and her children. Mom

has two twin sons (7 y/o) in addition to Angela. The sons speak very warmly of their step father, saying that he is very good to them.

- Step Father left the home the first night but is now back at home.
- Mom is very angry at her sister for reporting the incident to child protection.

Safety Threat Described Behaviorally:

- Step Father sexually abuses daughter repeatedly over the past year. He denies sexual abuse occurred even when confronted with medical exam and forensic report.
- Mom does not believe child was sexually harmed by her husband and will not protect her from future harm.
- Angela is fearful of both her step father and her mother and does not want to be left alone with either of them.

Safety Plan to Control and Manage Safety Threat:

Out of Home Safety Plan. Angela will go to live with her aunt as Mom would not commit to having Step Father out of home or to protect the child from him. Mom did not have protective capacities to protect daughter. Aunt was fully aligned with child protection agency in protecting Angela -and will not allow step father access to the child. Aunt indicates that she has been mistrustful of him for some time. Angela has seemed increasingly quiet and subdued.

Sample Questions to Pose To BETTER Understand Family Issues /Underlying Needs Enough to Develop an Effective Case Plan

Ask Mom:

Under Household Relationships/Family Violence:

- What is the worst thing that can happen if your child is telling the truth?
- What was your last marriage like—how is your current marriage different?
- What are the characteristics you are looking for in a partner?

Under Child Emotional Safety /Behavioral

- What causes you to believe that your child is not telling the truth?
- Has your child ever caused you to believe that she would lie about something like this (based on her past behavior)?

Under Day to Day Parenting

- Can you describe what your relationship with your daughter?
- What are the ways that you feel you protect your daughter?

Case Plan Language: Behavior/Condition That Needs To Be Changed to Remove Safety Threats and Reduce Risks:

1. Mom states to Angela that she believes her daughter and is fully committed to protecting her.
2. Mom protects Angela from being harmed by her step father by never allowing him to be alone with her.
3. Step father will only interact with his step daughter in a way that is safe and healthy—with no sexual overtones, sexual touching or sexually suggestive comments.

Case Plan Services/Action Steps to Change Behavior:

- Mom and daughter go to counseling together where daughter can talk to Mom about the experience in a safe and protected environment
- A schedule is created where the child and father are not in the home at the same time –aunt will supervise. (*This will enable child to see brothers in own home environment.*)
- Step Father attends Sexual Abuse Counseling for Offending Parents group.

Case Plan Addressing Child's Physical, Emotional and Developmental Needs:

- Daughter begins individual counseling to address abuse and traumatization. She needs to understand that this is not her fault as she is blaming herself.
- Daughter learns specific skills (such as self defense skills, has cell phone or emergency beeper) to help protect herself in the future.
- Daughter has an identified individual (aunt) to go to if she ever feels unsafe.
- Daughter goes to sexual abuse victim's support group.

Case Plan Review:

Case plan will be reviewed in 15 days to ensure that all participants have initiated services. Check in with Angela to ensure that she still feels safe in her aunt's home.

NOTE: The worker above made a decision to review this case plan within 15 days to ensure that all were honoring their commitments and to create a sense of urgency about the need to fully protect the child. While policy indicates that case plans are reviewed every 60 days, in most cases a much more frequent review is required to ensure family engagement and that services are meeting needs and addressing behavioral changes.

EXAMPLE #2: LACK OF SUPERVISION

- Mom is 19 years old has 2 children ages 4 and 2.
- Mom uses substances daily and frequently passes out—leaving young children 4 and 2 to play unsupervised.
- Mom indicates that she loves her children but had them very young and has never been confident in being a mother. She admits that she really has no idea what to do. Her mother was not a strong role model—she was a prostitute who is now deceased.
- Mom had a very tough childhood and was in and out of foster care. She had her first child when she was on the run at 15 years old. Second child was born when she was living with friends at 17.
- A boyfriend introduced her to drugs and she admits that she has a very hard time not using.
- Mom did not finish 9th grade but wishes she could have finished school.
- Neighbors have had to intervene and keep children off the road.
- Children are unkempt. Younger child has soiled diapers on for long periods of time.
- Children are often very hungry. 4 year old asks people for food.
- Mom does not appear to have empathy for the children—ignoring them if they cry or if they are hurt. Rarely hugs or comforts children.

Safety Threats/Risks Described Behaviorally

- Safety Threat: Mom is not supervising her 4 and 2 year old children. They are left alone frequently (5-6 times per week) and they play in the yard where there is a busy intersection—they have been in the road on several occasions.
- Safety Threat: Children are often hungry and filthy. Older child asks strangers for food.
- Risk: Mom does not comfort the children –does not respond when they cry or they are hurt.

Safety Plan: Children are placed in foster care. Mom does not have any real connections in the community and needs to go into treatment.

Case Plan Language: Behavior/Condition That Needs To Be Changed to Remove Safety Threats and Reduce Risks

1. Mom is awake when her children are awake and she ensures that they are safe (she knows where they are, what they are doing and that they are playing where they will not get hurt).
2. Children are fed three meals per day and at least two snacks such as apples, banana, etc.)
3. Children are bathed every day and Mom cleans their clothes.
4. Mom changes the diaper of the 2 year old whenever he is soiled or wet.
5. When children are hurt or cry Mom goes to them to ask them if they are OK and comforts them. Comfort can be in the form of a hug, talking to them, asking them what they need.

Sample Questions to Pose During the Family Strengths and Needs Assessment to Understand Family Issues Enough to Make the Right Referrals (worker might choose one or two of these questions in each area)

Ask Mom:

Under Substance Abuse:

- How are you usually feeling when you make the decision to use drugs?
- How do you usually get through a bad day?
- Can you remember the first time you used drugs—what was going on in your life?
- What makes you feel better about yourself and your life situation?
- Do you ever worry that you cannot stop using substances and how this will impact your children?

Under Parenting Skills

- Parenting is not something that you wake up and know how to do...it is hard for all of us. Do you ever get lost as a parent?
- What's it like for you to parent the children? Is it what you expected?
- How do you decide what is appropriate for your children to do? (Such as play alone, eat whole foods, food for your children to eat each day, etc.)
- On a scale of 1-10, where are you at in comparison with where would you like to be as a parent? What would it take you to get to a higher number?
- What is one special way that you show love to your children?
- Who taught you to be a parent? Who is your biggest influence as a parent?
- Has there ever been a time when you were afraid that you will not be able to take care of your children? What did you do?
- What sorts of activities do you and your children do together in your free time?

Under Social Support System

- When you are having a really hard time, who do you call?
- Can you describe the last time that you needed someone...who did you call? Were they there for you?

Case Plan Services/Action Steps to Support the Behavior Change:

- Mom goes into in-patient treatment. Follows up with counselor to support her process of becoming sober.
- Following Mom's release, Mom will consult with WIC counselor. WIC nutritionist helps Mom to plan meals for children.
- Worker will introduce foster parents and Mom within first week of placement.
- Foster Parent will mentor and provide a role model for the Mom. Visits are at Foster Parents home.
- Intentional Visitation practices are aimed at Mom meeting her children's day to day needs. Worker and Mom plan each visit. Mom provides for all meals, diapers, change of clothes and toys/books for visits.

Case Plan Review:

Will occur within 7 days to ensure that foster mom and birth mom are talking to one another while Mom is in treatment.

EXAMPLE #3: PARENTAL VIOLENCE

- There have been 2 reports of Jeremy (13 y/o) and his father getting into physical fights to resolve issues.
- This is not a family that has a long history of involvement in the child welfare system but the pattern of physical altercations and violence between the father and son are escalating over the past three months. The last time the father hit Jeremy he ended up in the emergency room of the hospital with a bloody nose and lacerated cheek (from the father's ring) and a broken finger from his Dad bending it back.
- Jeremy is small for his age—does not look 13 years old. Dad is a very large man who has worked construction most of his life. He is very strong.
- Jeremy admits to not obeying curfew and to telling his dad to “f-off”. He is sick of his Dad blaming him for what is going wrong in the family. He admits that his father has been a good father and that things have only gotten bad the last three months.
- Dad recently lost job and is very down about the prospects of being rehired by his construction firm. He has taken a night shift job as a security guard making very little money. He is worried that they might lose their home.
- Mom works part time but does not make a lot of money. Mom will not intervene in the arguments between her son and husband—believing that Jeremy should have more respect for his father. Mom states that she is not afraid of her husband at all (this was said in private during an individual interview with Mom)—feels that he has been a very good father and husband over the years.
- Dad thinks that Jeremy should “get off his butt” find a job and help the family out. He seems to resent Jeremy for not providing for the family.

Safety Threat/Risks Described Behaviorally

Jeremy's father physically harms Jeremy—causing serious physical injury. This pattern has been increasing over the past three months. Jeremy is too small to defend himself and his Mother does not step into protect.

Safety Plan:

In Home Safety Plan. Jeremy is going to stay at his paternal grandmother who lives down the street every day after school and during the weekend days. He has gone over to her house several times and

Grandma will protect him from his father. She is very frustrated with her son and will not allow him to hurt Jeremy. Jeremy will sleep in his own bed at night and during the weekends.

Case Plan Language: Behavior/Condition That Needs To Be Changed to Remove Safety Threats and Reduce Risks

1. Dad manages his stress by using techniques such as taking a walk, talking to his wife or taking a drive.
2. Jeremy and his father take time out from one another when they are angry or frustrated with one another.
3. Jeremy's mother takes an active role in protecting her son by not allowing the violence to escalate—requiring that Jeremy or her husband leaves the room when he and his father start to argue.

Sample Questions to Pose During the Family Strengths and Needs Assessment to Understand Family Issues Enough to Make the Right Referrals (worker might choose one or two of these questions in each area)

Ask Dad:

Under Household Relationships/Domestic Violence

- I understand that in the past you and your son were very close. What do you think has changed in the past months?
- What is happening inside of you when you argue and have physical altercations with Jeremy?
- How did you use to resolve conflicts with Jeremy?

Under Parenting Skills

- How were you disciplined as a child?
- What is a day in your life as a parent like?
- All kids are frustrating at one point or the other...what is one creative way that you have dealt with your child's frustrating behavior?

Under Mental Health/Coping Skills

- When was the last time that things were really going well with your family?
- Do you ever feel like you just can't take it anymore? When you feel that way, what do you do?
- Do you ever have a hard time just getting going in the morning?
- How do you react to the fact that you child is afraid of you?

Ask Mom:

Under Parenting Skills

- What do you think that your child needs from you as a parent with regard to supervision, protection, support, etc?
- What do you understand your role to be as a parent? Your husband's role?
- Do you feel like you have the right to disagree with your husband when it comes to parenting your children?
- How do you react when your husband and son fight? What do you do?
- Have you ever tried to intervene when your husband and son argue? If so, what happened?

Under Mental Health/Coping Skills

- Your family is going through a tough financial time right now...what is one way that you are coping?
- How do you think that your children are coping with the change in your family's financial situation? What is different for them?

Under Cultural identity

- Your family is Hispanic...what ways have you been able to reach out to members of your Hispanic community to find support during this difficult financial time?

Under Social Support System

- Who do you call when you are having a hard time?
- When your husband and son argue, is there someone in the family you talk to?

Case Plan Services/Action Steps to Change the Behavior:

- Dad will talk to his priest to better understand how to direct his fear and deep concern over the future of his family. Pastoral counseling will focus on helping Dad find other ways to manage his stress.
- Dad and Jeremy will also have sessions together with their priest to better understand how to work out their frustrations with one another.
- Mom will join the Parents of Adolescents support group located at the Hispanic Community Center in their neighborhood, to learn how to better protect and parent her teenage son.

Case Plan Review:

Review within 45 days to determine if classes are being effective in teaching new ways to manage stress and redirect frustration.

CASE EXAMPLE #4: CHILD BEING BULLIED AT SCHOOL

- Randy (9 y/o) was jumped at the beginning of the school year (both before and after school) by several older students and was injured.
- Randy lives with his father—his mother left them three years ago.

- Randy has been part of several fights at school. On one occasion he reported that another youth attacked him after school when he was walking home, and he was attempting defend himself. He indicated that the other student had him in a hold so tight that he became unconscious.
- Randy defends his actions and reports seem to support that his reaction was one of self defense.
- However, he is growing increasingly angry and resentful and is talking about “beating the crap” out of the kids who bully him.
- Randy reported this to his Dad who told him to “buck up and take it like a man”. Dad has been teaching him how to fight and is taunting his son because he says that he is afraid.
- Dad encouraged him to take the bullies out back and “beat the shit out of them”. Dad is starting to belittle his son, calling him a “little pussy” and expecting him to beat up kids who are bigger and older than him. Rather than press charges on the other youth, Dad is verbally blaming his son for not being tough enough. At a school conference he expressed to teachers that his son needs to toughen up and not be such a baby.
- School was very concerned about this issue and reported it to child welfare.

Safety Plan:

Randy is protected before and after school by his neighbor who agrees to give him a ride to and from school. Teachers agree to ensure that he is safe during school by keeping their eyes on him during class transition and lunch time.

Case Plan Language: Behavior/Condition That Needs To Be Changed to Remove Safety Threats and Reduce Risks

1. Dad protects his son, encourages him to be safe and to go to adults when he feels he is being picked on.
2. Randy learns and consistently demonstrates the use of alternate techniques to fighting with peers in school.

Sample Questions to Pose During the Family Strengths and Needs Assessment to Understand Family Issues Enough to Make the Right Referrals (worker might choose one or two of these questions in each area)

Ask Dad:

Under Parenting Skills

- How do you decide what your child should be able to do at what age? In other words, how do you decide what is developmentally appropriate for your child?

- Who parented you? What is the most important thing taught to you by your parents?
- What is one thing that you want to do like your parents? What is one thing that you would like to do differently?
- What is one thing that makes you proud of your son?
- What do you think the most important lesson is for you to teach your son?

Under Social Support System

- It is hard to raise a child alone. Who do you call when you just want to talk about parenting your son?
- What do you do for fun?
- Do you and your son ever do anything for fun? When was the last time you and your son had a good time together?

Under Mental Health/Coping Skills

- Did anyone ever pick on you when you were young? If so, how did you handle it? How did your parents handle it?

Under Education

- Do you ever talk to teachers at school about how your son is doing? If so, when was the last time? Was it helpful? If not, might you consider talking more to Jeremy's teachers about how he is doing in school?

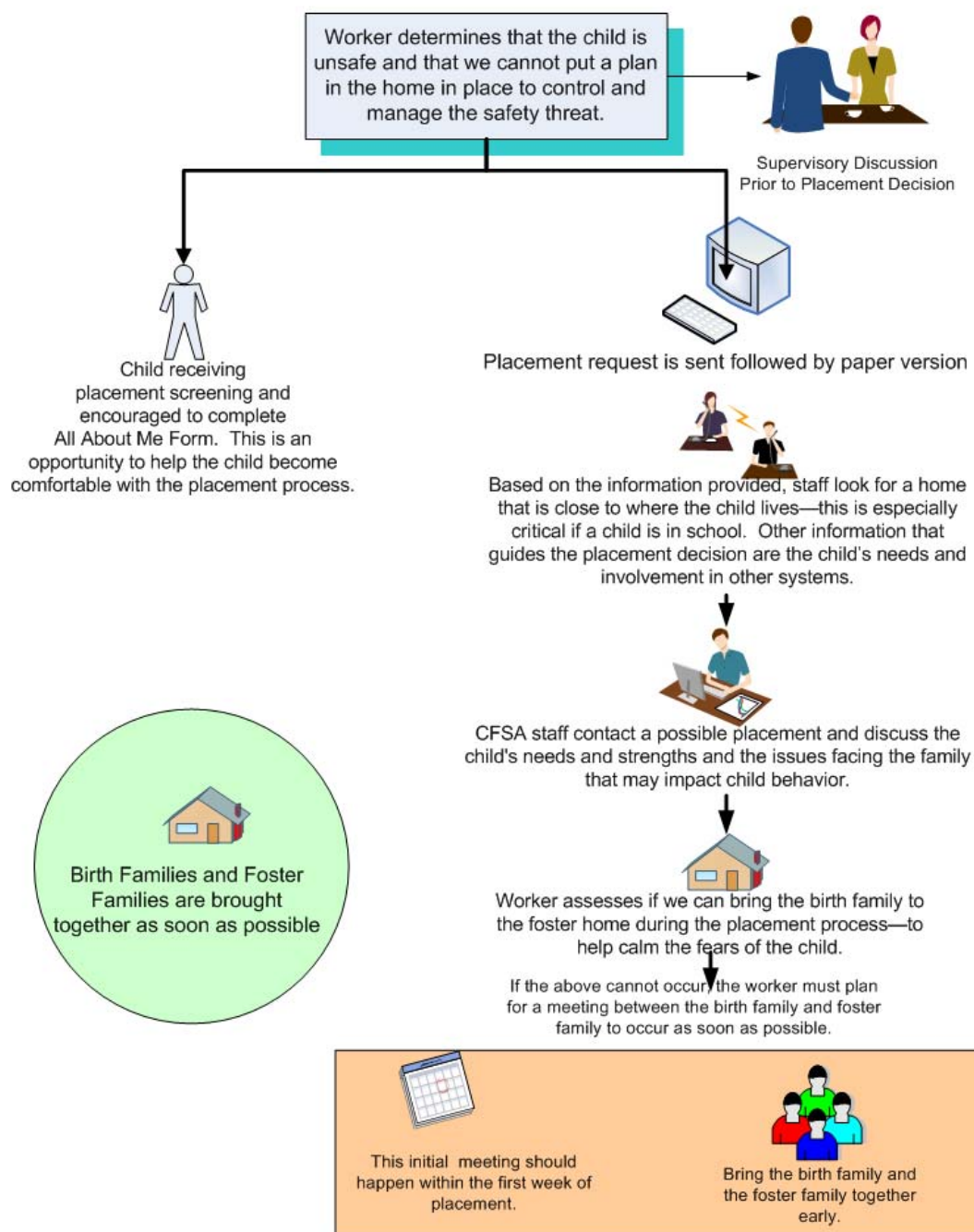
Case Plan Services/Actions Steps to Change Behaviors:

- Randy and his Dad will attend the Hope Center to learn how to avoid conflict/bullying situations and work on strategies and techniques to avoid confrontations.
- Dad will have a facilitated conversation (by school counselor) with the parents of the students are bullying Randy—in an effort to show Randy that he wants to protect him as well as impact the behavior of the older students.
- School personnel will initiate sessions on bullying as part of school curriculum.

Case Plan Review:

Case Plan will be reviewed within 2 weeks to ensure that all family members are active in counseling services—check in to make sure they are finding them valuable.

Placement Practices



Description of Placement Practices

While we will work to avoid placement of children whenever possible, we know that there are times when children must be removed from their home environment in order to ensure their safety. This module is focused on describing practices AFTER the placement.

Best Practice Tips:

- Placement is ALWAYS traumatic to children—and we need to help children address this trauma throughout the entire time they are placed in out of home care.
- Social workers must ensure that children are provided with information about what is happening in their case, ensuring that they understand that what is happening is not their fault and that they have an important voice in determining next steps.
- We must view placement as time limited and temporary. Children need permanent, caring and legal relationships with adults who are committed to them.
- That said, we need to practice full disclosure from the initial point of placement and throughout the entire process, ensuring that every family member understands the need for children to have permanency within a “child’s sense of time”.⁹
- Foster parents and kinship caregivers are partners in our work and as such need to be included in every aspect of case planning and case plan review (ongoing assessment) processes. While we may not have a lot of information about the child at the point of placement, as soon as new information about the child is compiled—this information must be provided to the foster parent/kinship caregiver to help them in their caregiver efforts.
- One of the critical roles of foster parents and kinship caregivers is to help birth parents learn how to safely care for their children. Social workers play a vital role in helping this to happen.
- Social workers must ensure that foster parents and birth families have an opportunity to meet one another as quickly as possible following the initial placement (within 5 days of placement).
- Social workers need to engage everyone associated with the family in the teaming process—helping the birth family to understand that we are trying to create a team to help them be successful.

The form on the following pages is to be used to support the placement process—as well as the sharing of information between the worker and the foster parent/kinship caregiver throughout the life of the case.

⁹ A child’s sense of time is a concept taken from Linda Katz’ work on Concurrent Planning. It means that for children 6 months feels and impacts them MUCH more than adults. Lack of permanent connections for children must be considered within a child development framework.

When the decision is made to place a child, the following needs to be discussed or shared during the placement request/referral process: (See Form in Attachments)

Category of Information	Notes
• Why was this child removed from his/her home?	
• What is the age of the child?	
• <i>If the child is over the age of 12:</i>	
○ Are they gang involved?	
○ What are the child extra-curricular activities?	
○ Any concerns about use of substances?	
• What is the address of the family—where the child is removed from	
• Are there any reasons that we should NOT place the child in his/her neighborhood?	
• What is the gender of the child?	
• What is the youth's sexual orientation or preferred gender identity?	
• What are the things about the child that are delightful? Their strengths?	
• Is the child part of sibling group	
• Are there any child characteristics that the foster family should know about?	
• Any special needs of the child (behavioral, health or emotional needs)	
• Health	
○ Allergies	
○ Medication	
○ Supplies or Equipment the child has	
○ Diagnosed illness	
○ Do you know the child's insurer?	
• Behavioral/Emotional Health	
○ Are there any behaviors that the child exhibits that may result in harm to the child or to others in the home?	
○ Is there a diagnosed Mental Health illness?	
• What school or child care setting does the child attend?	
○ If the child is school age, does he/she have an IEP?	
• Is he/she bused to school or is he/she able to take the metro?	
• Is before school and/or after school care available?	
• Does the social worker have a placement preference?	
• What are the child's feelings about their school experience?	

Category of Information	Notes
<ul style="list-style-type: none"> What are the child feelings about the school that she/he currently attends? 	

Information Sharing With the Foster Families/Kinship Caregivers

Foster Families/Kinship Caregivers must be provided as much information as the worker has about the child and their family at the point of placement. As the ongoing worker learns additional information about the child and his/her family—this information must be shared with the foster family/kinship caregiver. This results in two things, 1) a building of trust between the worker and the foster family/kinship caregiver and, 2) the new information may assist the foster family/kinship caregiver in caring for the child. Public child welfare systems have often erred on the side of sharing too little information with foster families/kinship caregivers. Sometimes this lack of information results in a placement disruption; and it always results in a lack of trust between the foster family and the agency.

Foster families around the country suggest that the lack of honesty on the part of public child welfare systems about the needs of children coming into their homes is the single most troubling reason they no longer “trust the system.” In the CFSA Model of Practice, foster families/kinship caregivers are provided with as much information about the child as is known in order to equip them in being able to care for the child and to work effectively with the child’s family.

Building the Relationship Between Birth Families and Alternate Caregivers

Social workers play a crucial role in developing the birth family-foster family relationship. It requires that child welfare workers communicate to foster families their unwavering conviction that birth parents can grow and safely care for their children. If a worker does not believe this, then they have minimal ability to impart this needed hope and conviction to either the foster family or the birth family.

Much has been written about torn loyalties children face when having to choose (or feeling as if they have to choose) between their families of birth and their foster families. Meaningful relationships between birth families and foster families/kinship caregivers minimize the child’s perception that they must choose. When the child witnesses the birth parents and foster families/kinship caregivers making decisions together about the child’s day to day life, it communicates to the child that many adults are concerned about him/her and that these adults are working together to keep him/her safe.

When sharing initial information about the birth family to the foster family discussions around the strengths of the birth family should be incorporated. The work of Bill O’Hanlon (1999) has

helped to further the social work practice of identifying and using strengths as part of the therapeutic process.

O'Hanlon suggests that active discussion about strengths with a family has the effect of intensifying them. A strengths approach assumes that the birth family has what it needs to identify solutions to its own problems.¹⁰

Often foster families are not helped to understand the birth family's strengths early in the process. This can lead to the foster family drawing conclusions about the birth family that are flawed—and subsequently impact their willingness to work with the birth family.

Many foster families are strong advocates for maintaining a strong parent-child connection and their work reflects this commitment. They understand and appreciate that most birth parents are doing the very best that they can, under very stressful circumstances to make a difference in how they parent their children. Through mentoring and role modeling these enlightened foster parents work with birth families to help children return home safely as rapidly as possible.

The First Meeting

This first meeting between the birth family and the foster family begins as soon as possible, in most cases within 5 days following placement.

The purpose of this meeting is to provide an opportunity for birth families to share information with the foster family about their child's likes and dislikes, needs, medical issues, etc. It also provides an opportunity for the birth family and the foster family to ask questions of one another and begin to think about how they might work together to ensure the emotional safety of the child.

The Initial Meeting is held to:

- ☉ Reinforce the parent's role as "parent" and establish the foster family as part of the team working to support the child and reunify the family.
- ☉ Provide an opportunity for the caregivers and the social worker to obtain information regarding the child from the experts - the parents.
- ☉ Share information that will help the foster family support the child in care.

Often birth families talk about how difficult it is for them to partner with the caregivers of their child. During a recent conversation with a social worker the birth mom said, *"The foster families hold all the power...and the state already thinks that they do a better job than me. What chance do I have? They [the foster parents] have a better house, more money, and there are two of them and one of me. I feel like they are judging me all of the time. Sometimes I think it would be easier if I just gave up...and then I say no, I love my kids and I can be a good Mom to them...it is all just so hard."*

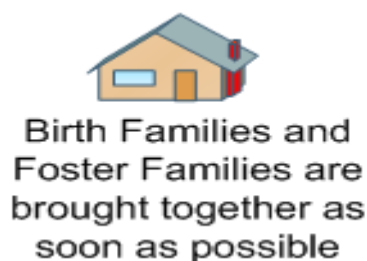
¹⁰ O'Hanlon, Bill. Do One Thing Different. (1999.) Morrow and Company, Inc.

- ☉ Reduce parents' fears about their child's placement and well-being.
- ☉ Reduce the likelihood of placement disruptions.
- ☉ Reassure the child that their parent(s) and foster parents are a "child support team" working together to care for them. (While the child is not present at the initial meeting, they can be made aware that their Mom and/or Dad and the foster parent are meeting to make sure that they take the best care possible of him/her).

If foster families refuse to meet with birth families due to their "fear of the birth family" in most cases this ultimately hurts children in care. Tensions are bound to build the longer the child is in care, with each blaming the other. Children can feel caught and torn by this tension. The University of Illinois Child and Family Research Center published a longitudinal study that showed a strong correlation between birth family-foster family relationship and children achieving permanency outcomes within ASFA timeframes.¹¹

While not a long meeting (the average time for this initial meeting is 30 minutes) it may be some of the most valuable time spent in serving a family when a child is in out of home care. The structure of these meetings follows the general outline below: **(See Tool within Addendum that describes the flow of this initial meeting)**

- Introductions
- Purpose of meeting
- Ground Rules—to make sure that no one gets hurt in the process
- Creating time for the birth parents and foster parents to share something about one another—beginning the relationship building process.
- Development and completion of the "All About Me" (see Attachments) questionnaire—a way to ensure that the foster family understands the needs of the child.



The goal for the development of strong birth family-foster family/kinship caregiver relationships is to ensure that everyone involved in the process views the experience through the eyes of the child... ensuring that children in care experience minimal trauma, and minimal loss of connections to their kin, their culture and their community while in out of home care.

¹¹ University of Illinois Child and Family Research Center. (2003)

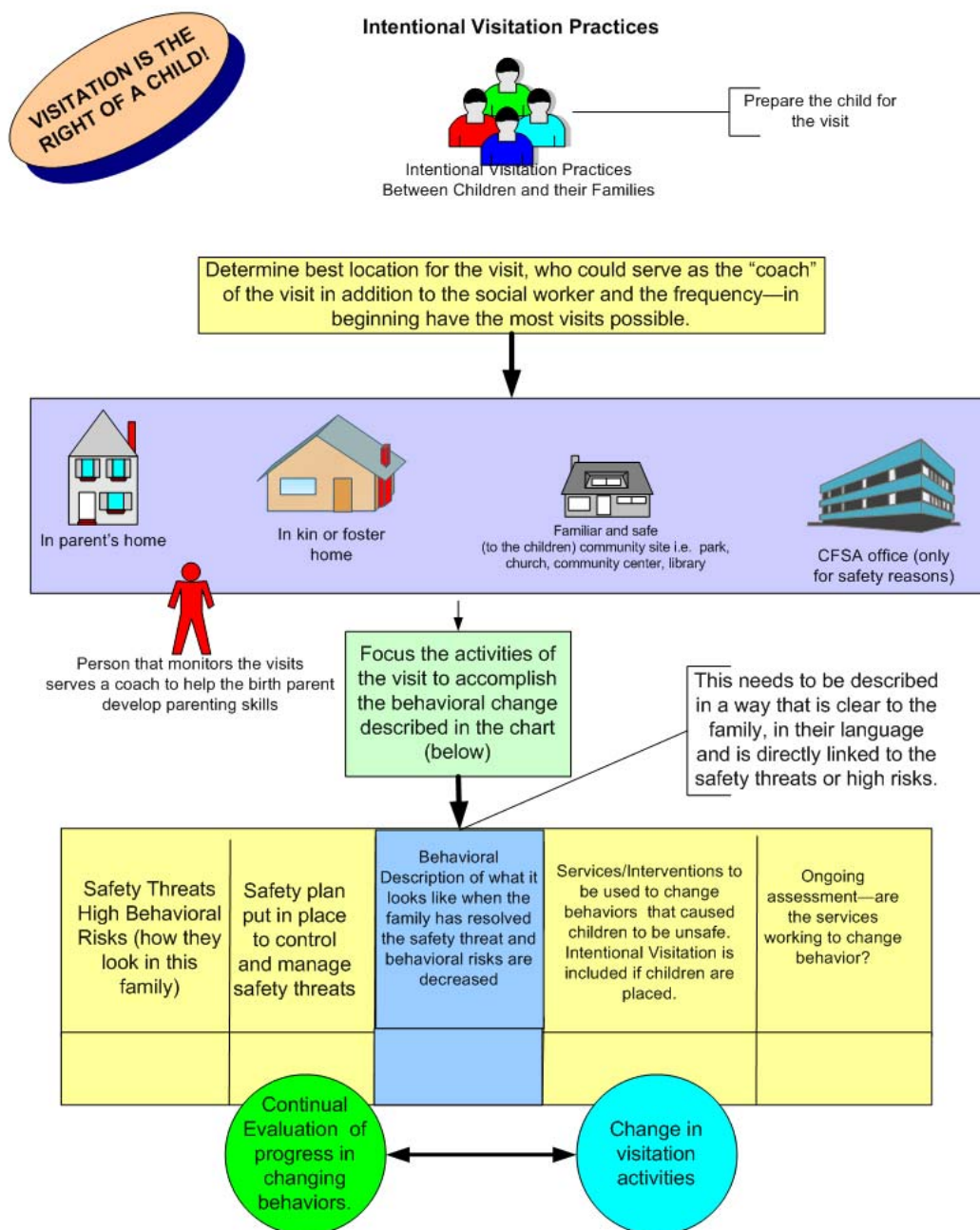
Ensuring the Birth Family Knows Where the Child is Living

As one might imagine, it might be heartbreaking for a child to be placed and for their parents to have no idea where their child is living. In the CFSA model of practice, workers are expected to address this anxiety by making certain that the birth family can actually see where the child is living, and how the child's day to day needs are being met.

Ensuring Foster Families Are an Integral Part of the Family Team

Foster families are to be included as an integral part of the team and as such they are they are invited to all case planning and individualized service plan review meetings. Foster families are caring for the children 24 hours a day, 7 days week. They have a perspective and this perspective needs to be heard. When the foster family is not treated as part of the team, not invited to the case planning sessions and does not receive a copy of the individualized service plan, the effectiveness of their role is minimized.

Intentional Visitation Practices



Description of Intentional Visitation Practice

Visits Between Children and their parents matter! They matter because they help maintain relationships within the birth family, empower birth parents, help birth family members face reality, and allow birth family members to learn and practice new skills and behaviors.

Visits matter because they help children express their feelings and relate better to their parents, calm some of children's separation fears, and give foster children continuing opportunities to see the parents realistically.

Perhaps most important of all, visits matter because continued contact with parents increases the probability that children will go home to their families.¹² Indeed, visits have been called the "heart of reunification".¹³

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.

Best Practice "TIPS"

- Visitation is the right of a child—and needs to be viewed through the lens of the child's experience. It is never acceptable for a visit to be cancelled because either the parent or the child has not "earned" it.
- Visitation should occur as frequently as possible, starting out with a high number of visits in the beginning of the process—in order for this frequency to occur, a team of individuals who know and care about the child must be engaged to support the visitation process.
- Visits should only occur in the office when there are safety concerns.
- Visitation needs to be structured and intentional—providing parents with optimal chances to learn how to parent. Activities during visits need to be focused on changing behaviors that caused children to be unsafe or at high risk of future maltreatment.

¹² DHHS Child and Family Service Reviews. (2006).

¹³ Hess, P. M. & Proch, K. (1992). Visiting: The heart of reunification. In B.A. Pine, R. Warsh, and A. N. Maluccio (Eds.), *Together Again: Family Reunification in Foster Care*. Washington, D.C.: CWLA, 119-139.

- Individuals supervising the visits should coach the parent during the visits as needed on how to safely parent their children.
- We need to understand children's reactions to visits in the context of divided loyalties and their own confusion. REMEMBER: Children's behavior is often their only voice—or way to regain some power in their lives.
- When working with teens whose goal is APPLA, and visits with parents are occurring, although the visits are not necessarily supervised, we still need to ensure that the interaction between child and family is supportive, because youth go home and we need this parent-child interaction to be healthy and supportive.
- As we continue the visits, we need to continually re-assess the frequency and need for supervision—and work toward unsupervised visits, celebrating success and generating hope.
- The goal of the visit is advance behavioral change that is necessary to eliminate safety threats and reduce high risk—NOT to create families without risk.
- Following each visit there is an intentional and focused conversation about how successful the visitation activities were in helping the parent to learn (or improve) parenting behaviors.
- Did what occurred in the visit today, help you to parent your child safely?
- ⊕ If yes, what should we do more of?
- ⊕ If not, what else could we do?
- When the child is in the process of bonding with new permanent caregivers—those visits must also be intentional in developing the parent-child relationships. There is a period of learning about one another and examination of how this child will become part of the new family, and how this evolution to full membership will occur.

The intensity of the coaching is dependent upon family need. Having a visitation “coach” is not an indication of a problem, it is about building ongoing support.

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.

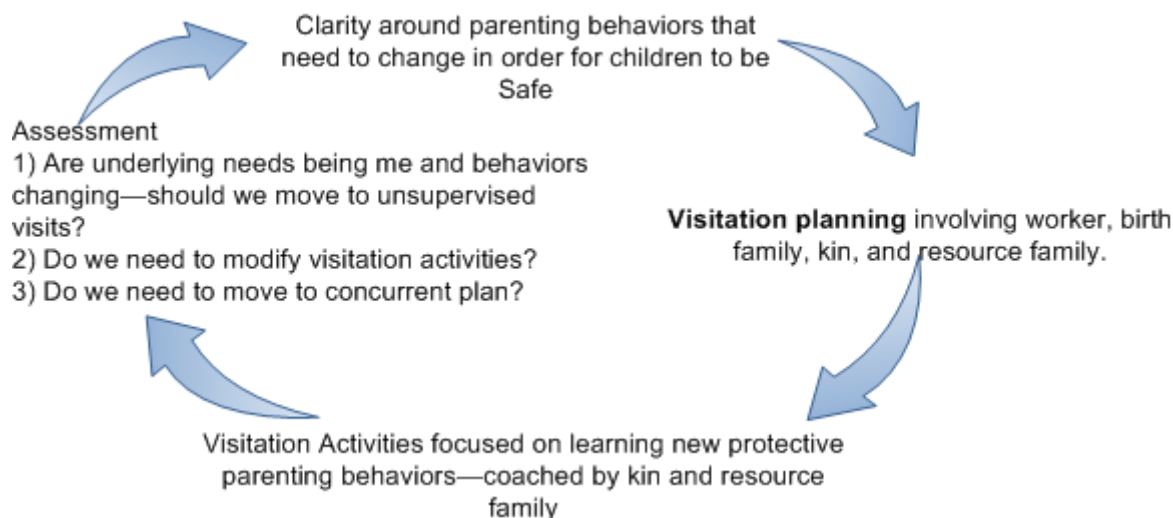
Intensity, Frequency and Focus of Visits

Workers need to use critical thinking skills in order to determine the intensity and focus of the visitation. Workers should refer to the chart on the following page to plan for intentional visitation process—and the individuals providing the coaching need to be fully informed of the information below:

<p>Safety Threats (how they are operationized uniquely in the family)</p>	<p>Safety plan put in place to control and manage safety threats</p>	<p>Behavioral Description of what it looks like when the family has resolved the safety threat</p>	<p>Services/Interventions used to change behaviors that caused children to be unsafe. Intentional Visitation is included if children are placed.</p>	<p>Ongoing assessment—are the services working to change behavior and build supports for the family, so that children are safe when we are no longer involved?</p>
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We need to prepare the parenting coach (person supporting the visits) 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 parenting coach and parents are fully engaged in assessing parent's progress in changing behavior--see below.



Visitations need to occur as frequently as possible.

The frequency of parent-child visits has a lot to do with how children view their parents, how well they adapt to foster care, and how long they are in care.

If the worker does not believe that he/she can find the time to support as much visitation as is necessary, and the case aides are only available at certain times...then the worker needs to look for other individuals within the family who could support the visit and provide coaching to the parents. Family Team Meetings are a wonderful opportunity to identify willing and supportive individuals to serve this role.

A skilled worker understands that the more he/she has involved the family, extended family, informal supports and community providers in the team process, and the more they understand the behaviors and conditions that have to change for children to be safe, and as such the more they can support and fully participate in the process. This shares the workload.

CASE EXAMPLE:

A single Mom of a three, two and one year old had significant issues with use of drugs and alcohol. She did not drink or use drugs in front of the child and she did not leave the children alone to use drugs. What she did do was to leave her children at basically any friend she could

find at home. One of these times, the friend became fed up and contacted child protective services, asking that “CPS come and get these children as she did not know where their Mom was or when she was coming home.”

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

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

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

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

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

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

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

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

Mom became acutely aware that she did not have a pool of friends who could adequately care for her children. Most were involved in the use of substances and did not have the

characteristics of individuals she wanted to care for her children. The worker began to help Mom to build a new support group.

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

Preparing the Person Providing the Visitation Coaching

If supervised visitation is required, the individual supervising the visits should view their role as one of a coach—helping the parent learn new skills.

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, 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.

"It might be easy to judge the birth family as not being good enough, or not trying hard enough...but when I see the kids' eyes light up when they see their Mom; no matter what she has done to them...I know I have to help them find a way back to each other."

Social Worker in Child Welfare

Debriefing the Visit

Following each visit the worker 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.

Debunking the Myth that Parents or Children Must "Earn" Visits

First and foremost, it is profoundly important to remember that visitation is the right of a child—and as such when we take visits away from parents for whatever reason—we may be causing significant harm to the child. The relationship developed by the child with the parent during visitation is one of bonding, dependency, and being nurtured, all of which must be protected for the emotional well-being with the child. It is of extreme importance for a child not to feel abandoned in placement by either the child's parents or by other siblings and for a child to be reassured that no harm has befallen either parent or siblings when separation occurs... Visitation for a child is an opportunity for reconnecting, and reestablishing the parent/child relationship.

Sometimes individuals involved in the visits misinterpret information coming from the visit specifically around child behavior. Children's emotions surrounding interacting with their parents may be (and often is) complex and they need to be understood in the context of trauma, confusion and divided loyalties. A child may be anxious and fearful when with the parent; their time together may be stressful but that does NOT mean that it should not happen—maybe parents and children actually need MORE time together to work through this stress. Vera Fahlberg¹⁴ emphasized in her pioneering work "A Child's Journey Through Placement" that when children are allowed and encouraged to see their parents on a regular basis they have the opportunity to deal with and with help dispel the myth of "fantasy parents". They are encouraged to deal with the reality of whom their parents really are...and who they are not. And they face these realities with the support of their worker and the Resource Parents.

The child may experience loyalty conflicts after having visited with the parent, and may need to reject the foster caregiver upon return to the foster home in order to continue to feel loyal to the parent. If loyalty conflicts contribute to the child's distress, they can reassure the child that it is OK to care for both their family and their foster family.

If the child appears to be fearful and reticent to visit with the parent, the worker should encourage the child to talk about their fears, and reassure the child that the worker will ensure their safety. When this is the case these visits should be supervised.

¹⁴ Fahlberg, Vera M.D. (1991) A Child's Journey Through Placement. Perspectives Press.

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.

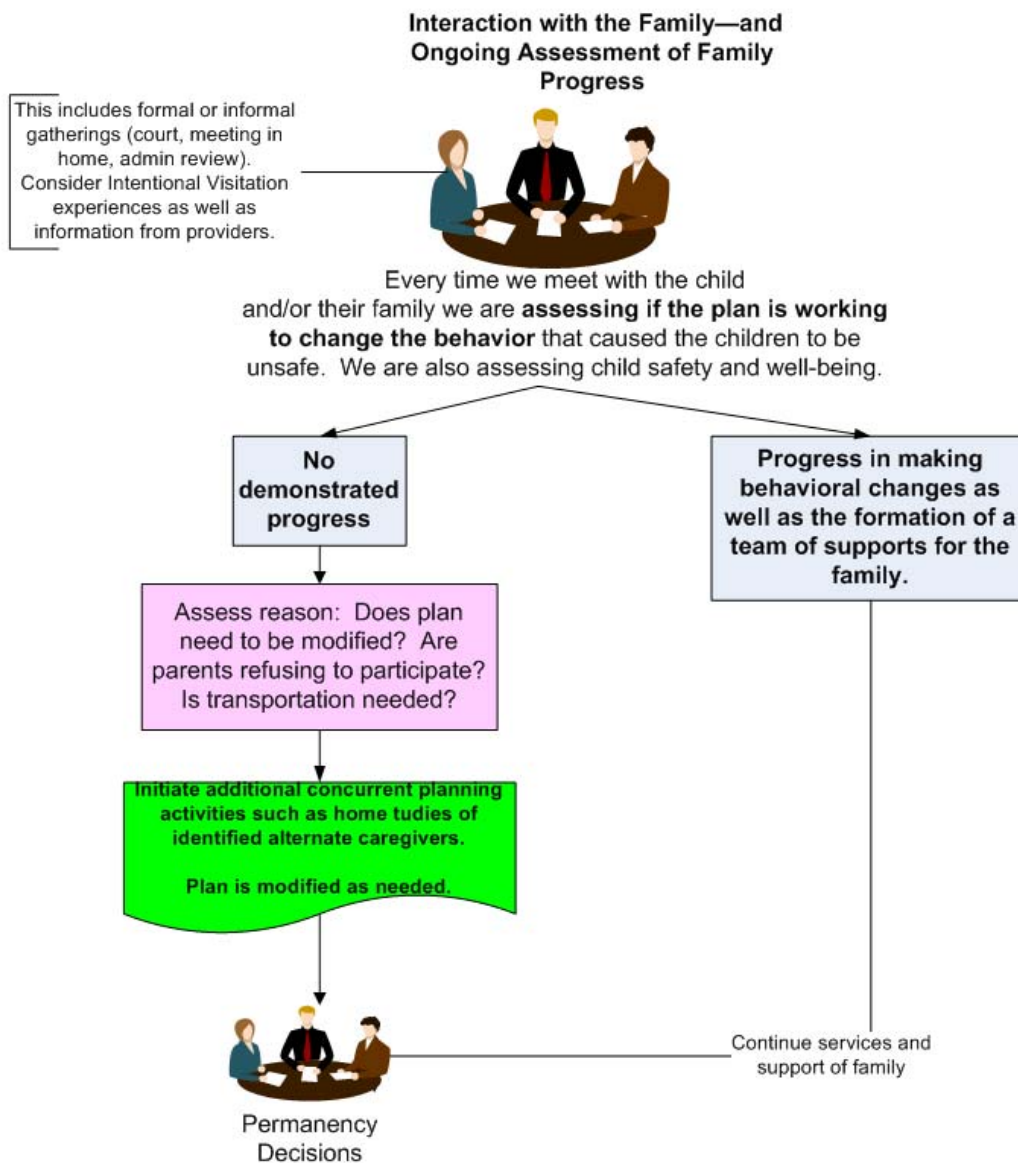
However sometimes this does not occur and then workers need to make concerted efforts to ensure that the sibling bond is not lost. **Regardless of how well parent-child visits are going—siblings need to see one another.**

Some of the activities below are helpful in increasing the frequency of sibling interaction:

- ☺ Educating foster and adoptive parents on the importance of sibling relationships and how to actively facilitate a sibling relationship by helping to maintain contact.
- ☺ Scheduling joint therapy sessions or joint involvement in services.
- ☺ Encouraging shared vacations.
- ☺ Promoting sharing of childcare providers/ babysitters.
- ☺ Scheduling activities together, including special events and cultural celebrations.
- ☺ Using video conferencing when distance creates a barrier for face-to-face visits.
- ☺ Providing current photos of brothers and sisters to each child.
- ☺ Having siblings do life books together.
- ☺ Acknowledging and celebrating each sibling's birthday.
- ☺ Actively encouraging family access during worker visits.
- ☺ Providing flexible visitation locations and schedules.

A Story.... Jessica grew up in care, was an alumna of the system, and was asked to be part of the process of developing new tools for the recruitment and retention of resource families. During one of these meetings we were talking about the Foster Parent Brochure. One of the panels of the brochure discussed the rights of children in care. Frankly it was pretty boring...it said *"Children have the right to three meals a day, they have the right to sleep in a bed, etc"*. When the facilitator of the meeting asked Jessica "what should this panel say?" Jessica did not hesitate for a moment, she said "We should have the right to be told the truth, we should have the right to hear good things about our families as well as the bad things"...and then she said something that caused the room to go very still. *"And we should have the right to grow up together and have the same memories as our brothers and sisters. You placed all five of us in different homes and you did not make sure that we saw one another—hardly ever. When we get together now as adults, it is like we are distant cousins...not brothers and sisters who have stories to tell and family memories that forever bond us. You took that away from us...just as much as you took us away from our Mom."*

Ongoing Assessment



Description of Ongoing Assessment Practices

Ongoing Assessment of progress occurs from the point of case planning through final decisions regarding permanency. Ongoing Assessment involves active interaction with the birth family, providers and others involved with the family—seeking to determine if behaviors that needed to change in order for children to be safe are changing, and if not, what else could be done to assist the family.

Best Practice Tips

- As part of ongoing assessment, we are continually assessing for child safety—whether the child is in their own home (under an in home safety plan) or in out of home care. This ongoing process augments the formal assessment of child safety that occurs when there is any change in the family dynamics, prior to unsupervised visitation, when we are considering sending the children home, prior to case closure.
- Specifically, if the child is at home under an in-home safety plan, every time we visit the family we must ensure that the safety plan is still controlling and managing safety threats.
- Every time we visit the family we are learning about progress –and families are active part of assessing progress.
- Ongoing assessment means that we are continually assessing if we have the right services in place to help families change behaviors that caused children to be unsafe or at risk—it is NOT simply about assessing family compliance to a set of tasks.
- Intentional Visitation provides an excellent opportunity to assess behavioral change.
- Ongoing assessment requires that the family sees the worker as an ally and is willing to talk about both progress and barriers to progress. If we have not engaged the family we may miss opportunities to learn how to best help them.
- If progress is not occurring in a timeframe that honors a child’s sense of time, we must actively pursue additional concurrent planning activities such as home studies, conversations with identified alternate caregivers, conversations with birth parents and the children. Social workers must be transparent and remind birth parents about the child’s need for permanent, loving families.
- Part of the ongoing work is to ensure that we are identifying individuals who matters to the child/youth. We must ensure that no young person leaves the agency without people who care about them and have a lifelong connection to them.
- As part of ongoing assessment we ensure that the family has developed an array of supportive people that will be there for the family when we are no longer involved. We actively engage these individuals in the work.
- As time goes on children’s needs change and people’s willingness to provide support for the children and family evolve. We need to make certain that our ongoing assessment takes this into consideration.

- There are times when parents are at a point in their lives when they do not want to parent their children on a full time basis. This parental ambivalence needs to be explored in a way that makes it safe for parents to tell the truth about their feelings –without fear of being judged.
- Ongoing assessment means that we are paying close attention to the well being of children we are serving; their emotional needs, their educational needs, their physical needs all must be continually assessed and as we identify needs we must meet them.

Ongoing Assessment of How the Safety Plan is Controlling and Managing the Safety Threats

When safety threats are identified, the threat must be controlled and managed throughout the life of the case until caregiver's behaviors change, and children are no longer determined to be unsafe. Ongoing assessment of the Safety Plan means continually assessing if all parties involved in the safety plan are doing what they agreed to do, when they agreed to do it; thus controlling the safety threat. If the safety plan is no longer working to control and manage the safety threats the plan must be re-constructed. NOTE: In addition, workers must be transparent with families about our need for ongoing assessment of child safety—and our need to talk to children in private to understand the child's perspective of feeling safe in the home. These discussions with the child occur regardless of where the child is living.

Case plans provide the basis for understanding when the work is completed so that CPS involvement is no longer required.

Assessment of Whether We Have the Right Services in Place

The Adoption and Safe Families Act of 1997 (ASFA) provided very tight timeframes for achieving permanency for children. As such, time cannot be lost providing services that have little to no chance of addressing the concerns in the family.

Case planning is focused on 1) meeting underlying needs that result in behaviors that harm children, 2) changing behaviors and 3) increasing parental support system so that children will be safe when we are no longer involved. All services must be related to change in these areas. Interventions are precisely and intentionally focused on assisting parents/caregivers to identify, understand and change issues related to child safety.

Further, case plans are focused, time limited, behaviorally specific, attainable, relevant, and understandable to all and agreed to by the parent(s). Case plans provide the basis for

understanding when the work is completed so that child welfare PS involvement is no longer required. Conversely, they provide the basis for deciding that sufficient change has not occurred so that alternate permanency goals may be justified and pursued.

When a worker understands the causes of the behavior, it becomes much easier to craft a plan that has optimal chance at being successful for the family. However, at the point that the plan is created, the worker may simply not have the information necessary to fully understand the most effective interventions. This is why it is critical to view the case plan as a hypothesis. It is our best thinking at the time, of the mix and match of interventions in order to meet underlying needs and change behaviors. **Once services begin to be delivered, workers begin to understand families better, families trust workers more, and providers have an opportunity to get to know families, the *right interventions* may become clearer to everyone.** When this occurs, it is critical that workers immediately seek to modify the plan. While this may involve court, we have a moral and ethical responsibility to provide interventions that stand the best chance of meeting underlying needs and changing behaviors that caused children to be unsafe.



Assessment of Behavioral Change

Ongoing assessment of progress in making behavioral changes required, is based in part on talking with and observing the family, talking with other key case participants (extended family, providers), and review of progress reports from service providers. It is very important that the family be an active part in the ongoing assessment process. Rather than sitting in a room and

having others determine if they were compliant....the CFSA ongoing assessment process encourages families to have an active role in determining if behaviors are changing.

There are several strategies that can facilitate discussion about progress include using scaling questions or temperature questions (for example, comparing on a scale of 1-10 how the service to date has helped the family understand their behaviors and what needs to change.)¹⁵

Workers should not assume that they know what is impacting family participation in services or their view of the services. See the example below:

A Mom was required by the case plan to have weekly urine testing. During these urine screenings, it was required that the Mom be observed. The Mom refused to take the tests. Initially it appeared that Mom refused to take the tests because she was using substances. The worker, rather than immediately jumping to that conclusion spent time with Mom trying to understand her decision not to have her urine screened. The Mom slowly and tearfully shared that she had been sexually abused as a child (this information was not known to anyone in the system) and that having someone watch her take a urine screen seemed like she was being re-victimized.

Sometimes new information provides new insight into existing needs. In the example above, a parent revealed a history of child trauma thus indicating a need to cope with the effects of these experiences. There are also times when family circumstances change, such as a parent moving back into the home or a grandparent moving out, etc. There may be times when we thought that parenting classes would benefit parents, only to learn that the parents do not learn well in a group setting. The case plan needs to be changed to reflect this new information.

While there is no expectation that behaviors all change within a short period of time, there is an expectation that team members see growth in understanding of how their behaviors have harmed their children, and some progress in the development of protective capacities that will eventually allow them to care for their children safely. It is a good idea to revisit the chart below to remind all team members involved in the ongoing assessment process the purpose of the interventions.

¹⁵ Comprehensive Family Assessment Guide. Schene, Pat. (2005).

Safety Threats (how they are operationized uniquely in the family)	Safety plan put in place to control and manage safety threats	Behavioral Description of what it looks like when the family has resolved the safety threat	Services/Interventions used to change behaviors that caused children to be unsafe. Intentional Visitation is included if children are placed.	Ongoing assessment—are the services working to change behavior and build supports for the family, so that children are safe when we are no longer involved?

Whenever there is consideration of moving to the alternate permanency plan, the permanency planning specialist who should have been an active part of the team throughout the process-- is an active member of this team discussion. Workers rely on the supports and assistance that the permanency planning specialist can provide in ensuring timely permanency for children.

Assessment of Parental Ambivalence as Part of the Ongoing Assessment Process

Reunifying children with their birth parents is a primary goal of the child welfare system. The focus of the case plan is on meeting parent's underlying needs and ultimately changing parenting behaviors so that children can return home. This is OUR goal. There are times however, when this is not the parent's goal. There are times when they exhibit significant ambivalence regarding providing full time care for their children. One of the responsibilities of the worker as part of ongoing assessment is to try to understand what the parent is thinking and how this is impacting involvement in services.

For some parents it is not that they do not want to care for their children, it is that they do not think that they would do a good job (or at least a good job at that point in time).

Maritza, a parent served by the child welfare agency, indicated that while she loved her child she could not care for him until she stopped using drugs and she was not ready to stop. She knew that the best thing for her son was for her to sign over legal guardianship to her sister. "While this was shameful and while I was filled with guilt I simply was not able to get off the drugs and care for my baby. I did not understand myself how I could choose drugs over my baby, but I did. At this point in my life I was burning every bridge I had, using to live and living to use. I did a lot of damage to me and to my family and the more demoralized I became, the harder it was for me to reach out for help. Bottom line, I had to get into a relationship with me that was good and positive and get Kathy intact before I could safely care for my child."

For others they simply do not want the full time responsibility for caring for a child, maybe they are too young, too scared or too wounded. It is up to the Social Worker to listen to what the parent is saying (both verbally and through his/her actions) about their willingness and or ability to parent. While it may be nearly impossible for a parent to tell us directly that they do

not want to parent their child (often due to societal norms) they will tell us through their actions.

Ongoing Assessment of Child Well Being

Ongoing assessment of child well being is a foundational component of serving children involved in the child welfare system. While the term “child well being” may seem so broad to have little meaning, in the child welfare system the term has been somewhat narrowed, focusing on three primary areas; ensuring medical/behavioral health needs of children are being met, ensuring educational needs are being met including striving to develop educational continuity and ensuring developmental issues are being attended to. This means that every time the worker is interacting with the child or in contact with his parents, foster parents/kinship caregivers, medical providers or educators, he/she is ensuring that child’s needs are being met. Any deterioration in health, behavioral health, academic progression or developmental growth must be attended to. Because children who have experienced abuse or neglect are much more likely to experience physical, behavioral health or academic issues, workers must pay attention to child well being and seek to intervene before the childhood trauma has lasting impact on the child.

Initiation of Additional Concurrent Planning Actions as Part of the Ongoing Assessment Process

Concurrent rather than sequential planning efforts to more quickly move children from the uncertainty of foster care to the security of a permanent family. Conducting frequent and regular case reviews of children's status and family progress toward reaching safety, permanency and well-being goals. Effective implementation of concurrent planning requires that all components of the CFSA model of practice be implemented as highlighted below:

- ➔ Ensuring that families understand clearly what has to change in order for their children to be safe in their care. ***(Occurs in the Family Team Meeting/Transfer Discussion)***
- ➔ Full disclosure of information to birth families early in the planning process regarding the importance of their regular involvement in planning for the return of the child, their rights and responsibilities, and the legal consequences if they are unable to safely make the changes necessary for their child's return. ***(This occurs during initially within the Family Team Meeting process and is repeated throughout our involvement with the family).***
- ➔ Aggressive search for absent fathers, non-custodial parents, and kin occurs initially and throughout the placement process. ***(This begins in the Safety Assessment and continues through the process of serving the child. By finding and engaging these individuals early***

in the process, we can impact disproportionality and disparate outcomes of children and families of color.)

- ➔ Assessment of how the family and child function in key areas (mental health, use of substances, family violence, day to day parenting, etc.) and the underlying causes of this functioning and the underlying needs of the family and child. ***This occurs in the Family Functional Assessment.***
- ➔ Frequent and planful visitation between the child and the birth parents—focused on helping parents learn effective parenting behaviors. ***(See Intentional Visitation Practices).***
- ➔ Provision of focused, intensive services to the birth family to meet underlying needs and make the behavioral changes identified. ***(This is represented in the Behaviorally Based Case Planning process).***
- ➔ Provision of services to the child to address behavioral, physical or educational health of the child. ***(This is represented in the Behaviorally Based Case Planning process).***
- ➔ Ongoing assessment of family success in achieving behavioral changes that may result in an initiation of Concurrent Planning. ***(This is part of the Ongoing Assessment process).***
- ➔ Appropriate use of family meetings, targeted case review to support early involvement of families in case planning and decision making. ***(This is part of the Ongoing Assessment process).***
- ➔ Exploring parental ambivalence carefully counseling parents about relinquishment options and any possibilities of open or cooperative adoption arrangements. ***(This is part of the Ongoing Assessment process).***
- ➔ A respect for the sense of time of young children because separations and relationship disruptions in the early months and years of life interfere with the younger child's initial capacity to learn how to trust and form secure attachments with adults. ***(This is part of the Ongoing Assessment process).***
- ➔ Developing a practice atmosphere where staff can be comfortable working in the “gray” – the plan is not set until it is clear which plan is needed, but options for contingency plans are established early on.¹⁶

If each of these practices occur—when we make the decision to formally pursue the alternative permanent plan, the family who cares about the child will have been identified, they will have gone through background checks and home studies, conversations with the birth family will have occurred and the alternate family and the child will have spent time together. The transition to the alternate permanency option will be able to occur rapidly.

¹⁶ Adapted from Concurrent Permanency Planning Handouts. (1999). National Resource Center for Permanency Planning at the Hunter College School of Social Work of the City University of New York.

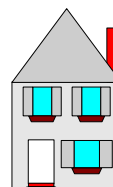
Permanency Planning

Permanency is advanced in these key decision points.....

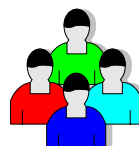
Hotline: Through identification of people who care about the family



CPS: Through identifying people connected to the family who can 1) participate in an in home safety plan—so children do not have to be removed and/or 2) can serve as caregivers for the children.

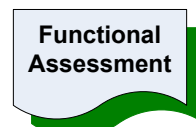


Transfer Discussions: Through communicating and documenting family connections and engaging these people in the family's life.



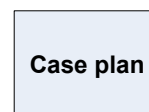
Also, by ensuring that the safety threat is understood, and behavioral changes are clearly defined, the focus of services is clear.

Family Functional Assessment: Through exploration and understanding underlying causes of behavior and family's strengths, we make referrals to services that have the greatest potential to change behavior that caused children to be unsafe.



Because this is co-crafted with the family—there is enhanced awareness, urgency and joint decision making on how to make things better.

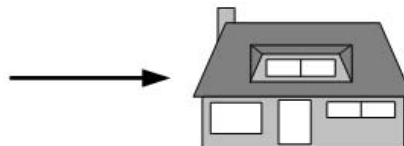
Behaviorally Focused Case Plan:
Through making clear statements about what families need to do to keep their children safe and providing services to help them get there.



Through rigorous attention to identifying engaging and building lifelong connections.

Permanency is advanced in these key decision points.....

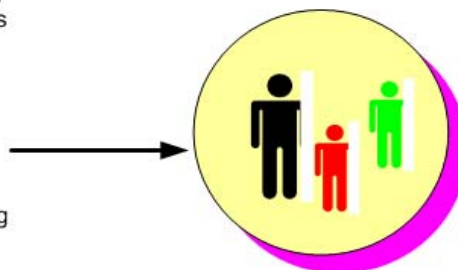
Placement: Through keeping children in their community, culture and with kin



Intentional Visitation: Through constructing visitation activities in places that help parents learn new behaviors to safely care for their children.

Through ensuring brothers and sisters stay connected to one another.

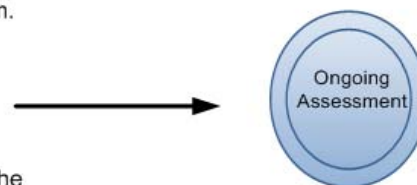
Through engaging family members in helping teach parents and at the same build deeper relationships with the children.



Ongoing Assessment: Through assessing progress with the family not doing it for them.

Through modifying services if they are not working.

Through making the decision to pursue the concurrent plan—that was developed with the family.



Addendum

References

CPS Investigation Practice Operational Manual

Differential Response Practice Operational Manual

Office of Youth Empowerment Practice Operational Manual

Transfer Meeting Planning Chart



<i>Behavioral Description of Safety Threat/High Risk</i>	<i>Safety Plan to Control and Manage Safety Threat</i>	<i>Behavioral Description of what it will look like when the safety threat is resolved or risk reduced.</i>	<i>Interventions used to meet underlying needs and change behavior</i>	<i>Ongoing Assessment—Are the interventions working to meet underlying need and change behaviors?</i>

Possible Questions to Engage Caregivers During the Functional Assessment Process

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

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

A. Family Telling Their Story

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

B. Day To Day Parenting

General Approach to Parenting

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

Discipline

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

Developmental Stimulation

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

C. Management of Resources/ Living Conditions/Meeting Children's Basic Needs

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

D. Social Supports and Community Connections

- When you need help with something are there family members or friends you turn to? What about your neighbors?
- How supportive is your family? Can you rely on them?
- Is finding adequate child care a major concern for you?

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

E. Caregiver History

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

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

F. Physical Health

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

G. Mental Health

- Do you ever feel like you just can't take it anymore?

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

H. Parent Substance Use

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

I. Household Relationships/Family Violence

- On a scale of 1-10 where would you rate your relationship with your partner/spouse/significant other? What would bring you closer to a 10?
- All couples argue, how do you resolve conflict in your family? Have the police ever been called to your home? Have you ever been concerned about the safety of your children when you argue with your partner?
- Has your child ever scared you or threatened to physically harm you?
- Questions to ask the child:
 - *What happens when there is an argument?*
 - *Have you ever seen or heard someone in your family hurt another family member?*
 - *Are you ever afraid something is going to happen to you or to your parents?*
 - *Do you have a pet—if so have you ever been worried about the safety of your pet?*
 - *Has any of your siblings scared you or threatened to physically harm you or any member of the household?*

The Essential Elements of Trauma-Informed Child Welfare Practice

Child Welfare Trauma Training Toolkit: The Essential Elements | March 2008
The National Child Traumatic Stress Network
www.NCTSN.org

1. Maximize the child's sense of safety.

Why it's essential

After traumatic events are over, a child may continue to experience insecurity, both physically and emotionally. A sense of safety is critical for physical and emotional growth and functioning, appetite, digestion, and sleep. Both physical and psychological safety are important, at home and within service settings. If children or their caregivers are living in an unsafe setting, this needs to be addressed immediately. Workers need to provide a psychologically safe setting for children and families while inquiring about emotionally painful and difficult experiences and symptoms. Workers must explain clearly the limits of confidentiality and how certain information must be shared with other appropriate authorities.

2. Assist children in reducing overwhelming emotion.

Why it's essential

Trauma can result in such intense fear, anger, shame, and helplessness that the child feels overwhelmed by his or her emotions. This overwhelming emotion may delay the development of age-appropriate self-regulation. Emotions experienced prior to language development may be very real for the child but difficult to express or communicate verbally. Trauma may be "stored" in the body in the form of physical tension or health complaints.

3. Help children make new meaning of their trauma history and current experiences.

Why it's essential

Child trauma can result in serious misunderstandings about safety, personal responsibility, and self-concept. It can disorganize and distort the connections between thoughts, feelings, and behaviors, and disrupt the encoding and processing of memory. Traumatic experiences may be difficult for children to communicate, thereby undermining their confidence and the social support they might receive from others. School age and older children need to do more than just recall or repetitively replay trauma details; they need help developing a coherent understanding of their traumatic experience. The child needs to feel safe enough to face emotional experiences, begin to make sense out of what happened to him/her, and express this to others.

4. Address the impact of trauma and subsequent changes in the child's behavior, development, and relationships.

Why it's essential

Traumatic events can affect many aspects of the child's life beyond the initial trauma response and may create new or secondary problems. These effects may be adaptive in the short-term but can, in the long-term, become counterproductive and interfere with a child's recovery. These effects can include difficulties in school and relationships or health-related problems (e.g., weight gain) and substance abuse. Other consequences of trauma—or secondary adversities—can also include changes in the family system precipitated by a traumatic event. It may be important to address these issues along with, or before, traumafocused treatment. Problems in these areas may be so extreme, pronounced, or troublesome that they mask other underlying traumatic stress symptoms.

5. Coordinate services with other agencies.

Why it's essential

Traumatized children and their families are often involved with multiple service systems, including law enforcement, child welfare, the courts, schools, primary care, and mental health. Service providers working with traumatized children should endeavor to develop common protocols and frameworks for documenting trauma history, exchanging information, coordinating assessments, and planning and delivering care. In contrast to a fragmented approach, cross-system coordination views the child as a whole person. When different systems have many different and potentially competing priorities, there is risk that children and their families will receive mixed or confusing messages—or simply fall through the cracks.

6. Utilize comprehensive assessment of the child's trauma experiences and their impact on the child's development and behavior to guide services.

Why it's essential

Millions of children experience some sort of trauma every year. Short-term effects might include behavioral difficulties or emotional and health problems. Long-term effects might include depression, anxiety disorders, PTSD, delinquency, substance abuse and relationship problems. Trauma-specific standardized clinical measures identify the types and severity of symptoms the child is experiencing. A thorough assessment identifies potential risk behaviors (i.e., danger to self, danger to others) and aims to determine interventions that will ultimately reduce risk. Assessment also tells us why a child may be reacting in a particular way and the behavior's connection to his/her experiences of trauma. Proper assessment provides input for the development of treatment goals with measurable objectives designed to reduce the negative effects of trauma.

7. Support and promote positive and stable relationships in the life of the child.

Why it's essential

Children form and maintain relationships to important figures in their lives through bonding and attachment. Being separated from an attachment figure, particularly under traumatic and uncertain circumstances, can be very stressful for a child. Within the child welfare system, the risk of separation from parents, siblings, and other important figures in a child's life is common (i.e., removal from home, multiple foster home placements, changes in school and/or community). Establishing permanency for children in the child welfare system is critical if children are to form and maintain positive attachments. Child welfare workers can play a huge role in encouraging and promoting the positive relationships in a child's life and minimizing the extent to which these relationships are disrupted by constant changes in placement. If a parent or caregiver is not available following a traumatic event, it is important for child welfare workers to understand that it may be necessary to engage other familiar and positive figures, such as teachers, neighbors, siblings, and/or relatives, to help provide comfort and consistency for the child. Depending on the age of a child, friends may also play an important role in supporting a child who has been exposed to trauma. Promoting these positive relationships is a well-respected child welfare best practice and is also critical to a child's sense of safety and well-being, particularly during a stressful time.

8. Provide support and guidance to the child's family and caregivers.

Why it's essential

Children experience their world in the context of family relationships. Parents, kin, and other caregivers are the full-time and long-term supports for their children, and they will typically be involved in the child's life longer than will the child welfare or mental health professional. In many cases, the family system is experiencing traumatic stress along with the child. Promoting resilience and improving coping skills among family members helps them deal with traumatic events and also prepares them for future challenges. Finally, family members are critical participants in service planning and delivery within systems of care. Resource families have some of the most challenging and emotionally draining roles in the entire child welfare system. They must be prepared to welcome a new child into their home at any hour of the day or night, manage a wide array of emotions and behaviors, and cope with agency regulations, policies, and paperwork. They are also expected to provide mentoring support and aid to birth families while at the same time attaching to the children and youth in their care. They must prepare simultaneously for the child's reunification with his/her family or for the possibility of making a lifelong commitment to the child through adoption or legal custodianship.

Relatives caring for children and youth face many of the same challenges that other resource parents face and several that are unique. Unlike foster families who are not related to the young people they care for, relatives may not have been seeking this role at this time in their lives. However, they have stepped up to the challenge in order to be there in a time of need or crisis in their family. Thus, they are often dealing with their own conflicting emotions and experiences of trauma and crisis. Meeting the needs of the children they love, responding to the requirements of the agency and courts, and sorting out their own feelings about the children's parents and the situation that brought them to their home, can be overwhelming at times.

9. Manage professional and personal stress.

Why it's essential

Child welfare is a high-risk profession, and child welfare workers are confronted every day—both directly and indirectly—with danger and trauma. Threats may come in from violent or angry family members. On top of this, hearing about the victimization and abuse of children can be very disturbing for the empathic child welfare worker and can result in feelings of helplessness, anger, and hopelessness. Those who are parents themselves or who have their own histories of childhood trauma might be at particular risk for the negative effects of secondary traumatic stress. Some professionals struggle with maintaining appropriate boundaries and with a sense of overwhelming personal responsibility. These challenges can be intensified in resource-strapped agencies, where there is little professional or personal support available. It is critical to address professional or personal stress because, if left unaddressed, it can result in burnout and undermine work performance, to the detriment of the children and families served. Signs of burnout might include avoidance of certain clients, missed appointments, tardiness, and lack of motivation.

Awareness and a plan that provides positive coping strategies are critical to preventing the potential risk of secondary traumatic stress to staff and to program success. Child welfare workers must have a thorough understanding of the impact of trauma on the child victims and families served. They also need to have an understanding of the impact this trauma may have on them. Staff can be stressed by hearing detailed reports of trauma from children on a daily basis and from having to deal with the powerful emotional responses and the impact of abuse and violence on the child. Dealing with a community system with limited resources that is not always responsive to the needs of these children can also be stressful to staff. The trauma suffered by these children can result in serious and chronic emotional and behavioral problems. Feeling frustrated when trying to deal with a complicated, often

CFSA Placement Request Information Form



CATEGORY OF INFORMATION	NOTES
Why was this child removed from his/her home?	
What is the age of the child?	
<i>If the child is over the age of 12:</i>	
Are they gang involved?	
What are the child extra-curricular activities?	
What is the gender of the child?	
Any concerns about use of substances?	
Home/Community	
What is the address of the family—where the child is removed from	
Are there any reasons that we should NOT place the child in his/her neighborhood?	
Is the child part of sibling group	
Child Characteristics	
What are the things about the child that are delightful? Their strengths?	
Any special needs of the child (behavioral, health or emotional needs)	
Child Health	
Allergies	
Medication(s)	
Supplies or Equipment the child has	
Diagnosed illness	
Child's Insurer?	
Behavioral/Emotional Health	
Are there any behaviors that the child exhibits that may result in harm to the child or to others in the home?	
Is there a diagnosed Mental Health illness?	
Education	
What school or child care setting does the child attend?	
If the child is school age, does he/she have an IEP?	
Is he/she bused to school or is he/she able to take the metro?	

CATEGORY OF INFORMATION	NOTES
Is before school and/or after school care available?	
Does the social worker have a placement preference?	
Other?	

All About Me Form

My favorite books/stories/movies are:

I like to be alone when:

I love to eat... (favorite kinds of foods)

I hate to eat....

What I really do well is.....

At night before going to bed my favorite thing to do is....

The thing that scares me most about foster care is....

Things I like about my family are....

What I like about school is.....

What scares me about school is.....

One thing that you need to know about me that I am afraid to talk about is...



More than anything I hope.....

Initial Meeting Between Birth Families and Foster Families

1. Help the parents to begin to establish an open relationship with each other;

This meeting sets the stage for open communication between birth families and foster families. It is the job of the social worker to help the Birth Family and the Foster Family address the natural tension that often exists and to help the adults involved in the life of the child, work together for the benefit of the child.

Together the social worker, Birth and Family should decide how to conduct themselves and agree on rules for contact.

- ☞ Time and days for calls and visits should be agreed upon*
- ☞ All adults should talk positively to the child about the other adults and about the child(ren)*
- ☞ Blame or judgment does not result in relationship building—when/if it starts to occur, the worker needs to redirect the conversation.*

2. Ensure that both parents understand that the social worker supports the relationship between the Birth Family and the Foster Family
3. When in doubt TALK ABOUT THE CHILDREN and help each parents understand they will be sharing the parenting of the child(ren);

- ☞ Shared parenting occurs when two or more adults have joint responsibility for care, nurturing and decision making for the same child(ren). It requires planning, good communication and cooperation among all parties for shared parent to work*

4. Understand the meeting is to share information about the child(ren) and allow the parent(s) to be the expert about their child(ren);

- ☞ This is the time to show respect for the Birth Family by acknowledging the information they have about their child is information that no one else has about their child. This could be as simple as what is the child(ren's) bedtime routine, favorite snack or food, allergies, last doctor's appointments, family rituals, school information, etc.*

- ☞ This is also a time for the Foster Family to ask the Birth Family about any concerns they have or about observations of the child(ren's) behavior, habits, etc. It may also be a time to ask questions about the child(ren's) name, who they were named after, things they want the Foster Family to notice about the child(ren), etc.*

5. Understand the meeting is not to discuss why the children(ren) were removed.

TIPS TO ENCOURAGE CONVERSATION

Ask Each Person To Finish The Following Sentence:

One thing that I want you to know about me (Foster Family and Birth Family each share)

Birth Family: (choose from these areas based on the age of the child)

- ➡ My children like the following food:
- ➡ My child's favorite toy is:
- ➡ My child's favorite story is:
- ➡ My child likes the following music:
- ➡ Please make sure my child stays in contact with:
- ➡ My child's favorite thing to do is:
- ➡ Is there anything else you would like to know about my child?

Foster Family:

- ➡ In our family we have ____ children.
- ➡ My favorite thing to cook is:
- ➡ We wanted to be foster parents because:
- ➡ Our favorite thing to do as a family is:
- ➡ What else would you like to know about my family?
- ➡ Is there anything else you would like to tell me about your children?

Information About LGBT Youth

Self-Awareness of Sexual Orientation and Gender Identity

Sexual orientation is an enduring emotional, romantic, sexual, and affectional attraction to others that is shaped at an early age (American Psychological Association, n.d.). Although there are many theories about the origin of sexual orientation, most scientists agree that it is probably the result of a complex interaction of environmental, cognitive, and biological factors.

Sexual orientation exists on a continuum from exclusively homosexual (attraction to same-sex people) to exclusively heterosexual (attraction to opposite-sex people), and includes varied expressions of bisexuality (attraction to same-sex and opposite-sex people).

Many youth realize that they are lesbian, gay, or bisexual long before they become sexually active, some by age 5 (Ryan & Diaz, 2005). Contrary to common misconceptions, adolescents do not need to have a sexual relationship with an opposite-sex (or same-sex) partner to understand their sexual orientation. Likewise, many young people do not identify themselves as lesbian or gay even though they are attracted to people of the same gender. Moreover, no reliable method of determining whether a young person is lesbian, gay, or bisexual simply from his or her appearance or behavior exists.

Gender identity is distinct from sexual orientation and refers to a person's internal identification or self-image as male or female. Every person has a gender identity. Most people's gender identity—their understanding of themselves as male or female—is consistent with their anatomical sex. For a transgender person, however, there is a conflict between the two; the individual's internal identification as male or female differs from his or her anatomical sex. Gender identity is also established at an early age, generally by age 3.

Gender roles or *sex roles* are social and cultural expectations and beliefs about appropriate male or female behavior. Children generally internalize expectations related to gender roles between ages 3 and 7. Adults often expect children to adhere to culturally defined gender roles and may subtly or overtly sanction children who exhibit behavior contrary to these expectations.

Increasingly, young people who identify as transgender do so during adolescence. Many youth who later identify as transgender report feeling that they were in the wrong body as a young child. This incongruence may cause significant distress, particularly when adults do not understand the child's concerns and try to force the child to comply with the cultural expectations associated with his or her birth gender. Children who understand that the gender messages they get from parents or adults are different from what they feel internally learn to hide these feelings to avoid disapproval or punitive reactions from adults.

Some lesbian, gay, and bisexual individuals exhibit gender-nonconforming behaviors, whereas others fully conform to cultural and social expectations of masculinity and femininity. Regardless of their sexual orientation or gender identity, however, youth who are visibly gender nonconforming are often perceived to be gay or lesbian. Thus, gender nonconformity may fuel anti-gay harassment and

abuse, even when the victims are heterosexual. For example, among 8% of students who were harassed and victimized in school because they were perceived to be gay in the Seattle Teen Health Survey (Reis & Saewyc, 1999), 6% were heterosexual. Regardless of their sexual orientation, youth who were victimized because others thought they were gay had the same serious negative outcomes, including significantly higher rates of attempted suicide.

Definition of Terms/Acronyms:

Concurrent Planning is defined as working actively towards reunification while at the same time working to identify and have in place an alternative permanency option. Concurrent rather than sequential planning efforts to more quickly move children from the uncertainty of foster care to the security of a permanent family.

Family Team Meeting—often referred to as a FTM within this practice operation manuals is a gathering of people involved in the family's life who are working together to help ensure children are cared for safely.

Family/Kin: These terms are broadly used throughout this practice model to include blood and adoptive relatives, tribal connection, step-families, unrelated persons who have an emotionally significant relationship. Youth and family are considered best and uniquely qualified to identify who fits this definition.

Permanency:

- Never having to leave home in the first place—protecting the child through the use of an in-home safety plan and working with the parents to develop protective capacities.
- Reunification from out of home care-by rigorous and intentional efforts to teach caregivers how to safely parent their children.
- Adoption or Legal Guardianship—that is supported so that the alternate permanent caregivers can be successful in raising their new family member.

Risk is when the family dynamics are such that without intervention the child will most likely be unsafe in the foreseeable future.

Safe is when there is no identified safety threat to a child in the home.

Safety Management is a dynamic process where the worker constantly assesses and requires the level of effort in safety plans in order to control and manage the identified safety threats.

Unsafe is when there is an identified safety threat and no adult in the home can control or manage this threat.