

2012

Michigan 2nd Edition

Pre-Service Institute: MiTEAM Child Welfare Case Practice Model Activity & Handbook

This training handbook encompasses documents and handouts to provide additional information on the following: Engagement, Assessment, Case Planning, and Teaming.

The practice and teaming skills incorporated in this handbook are intended to serve as a guide to child welfare staff on how to work together with children, families, caregivers, internal and external partners to achieve outcomes that focus on safety, child well-being and permanency of children and their families.

September 20, 2012

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Maura D. Corrigan



I am excited to announce the implementation of a Child Welfare Case Practice Model in Michigan - **MiTEAM**. While Michigan has performed admirably in many areas to improve outcomes for children and families, we can do better. I am in full support of the vision of this model and believe it will be the catalyst needed to strengthen our practice.

The MiTEAM model will serve to improve engagement practices and establish a unified approach that helps families, children, youth, and caregivers by:

- Providing for consistency in practice.
- Clarifying roles and expectations for staff.
- Informing policy, training, and quality assurance.
- Explaining how child welfare intervention and services are delivered to children and families.
- Focusing reform efforts by using accepted principles of good social work practice.
- Encouraging family driven solutions.

Strengthening Michigan's family engagement practice is critical to meet federal outcomes in the areas of safety, permanency and well-being of children and families. When families, children, youth and caregivers are engaged in case planning, they are more motivated to make long lasting, sustainable change that improves functioning in all areas.

Michigan is committed to engage and partner with all families in the child welfare system to develop plans for the safety, permanency, and well-being of children. I would like to thank all of you for your time and commitment to this process. I know that together we can make the necessary changes needed to improve the outcomes of Michigan's children and families.

MiTEAM Training Objectives:

Day 1 and Day 2

Day 1: Engagement

1. Understand the reasons for engaging and the Four Core Conditions of Engagement;
2. Improve their self-awareness and communication skills;
3. Know the Skills of Engagement ;
4. Understand the importance of utilizing engagement to “dig deep” when completing Assessments;
5. Understand how to be clear, concrete, and inclusive in Case Planning and Interventions.

Day 2: Teaming & Mentoring

1. Understand the purpose of teaming informally and formally;
2. Gain knowledge on how to prepare for a Team Meeting and the process;
3. Gain techniques to utilize with difficult participants;
4. Understand what makes a good mentor and how these skills can be used with various partners;
5. Understand the importance of utilizing mentoring skills throughout the case to empower families and youth.

MiTEAM Child Welfare Case Practice Model Section

MiTEAM Case Practice Model:

Core Outcomes

MiTEAM has four key competencies that align with the agency's mission, values, and principles. The four key competencies for MiTEAM Case Practice Model are the following: **T**eaming, **E**ngagement, **A**ssessment and **M**entoring. Michigan utilizes the following practice skills to achieve positive outcome for families and children.

Teaming is the collective effort that necessitates a team approach. It is the ability to assemble, become a participant of, or lead a group or groups that provide needed support, services and resources to children or families and that help resolve critical child and family welfare related issues.

Engagement is a series of intentional interventions that work together in an integrated way to promote safety, stability, well-being and permanency for children, youth and families.¹ The goal is for the family to actively participate in strengths-based and solution focused planning that is needs-driven.

It is the ability to successfully establish a relationship with children, parents, and individuals, to work together to help meet the needs of the child or family and resolve child welfare related issues. Interactions are open, transparent, and non-judgmental and relationships are viewed as partnerships.

Assessment is the process that includes information gathering, analysis, and collaborative decision-making that incorporate the family, child, and caregivers in the plan development. Thorough initial and ongoing assessments have a direct effect on better outcomes for children.

It is the ability to utilize engagement skills is to acquire information about significant events and underlying causes that trigger a child and family's need for child welfare related services. Strength-based assessment offers a strategy for empowering children and their families by building on the personal strengths and resources that are frequently overlooked or given minimal attention in more problem oriented approaches to assessment.

Mentoring is a developmental partnership through which one person shares knowledge, skills, information and perspective to foster and empower the personal and professional growth of someone else. The power of mentoring creates a one-of-a-kind opportunity for collaboration, goal achievement and problem-solving. Mentoring is the ability to guide and empower others, it is vital to demonstrate and reinforce desired skills to promote positive outcomes for children, families and practice.

MiTEAM Case Practice Model:

Core Outcomes

The MiTEAM practice model goal is to achieve the following three core outcomes: **Safety**, **Child Well-being** and **Permanency** of children and their families. MiTEAM is our agency's guide of how staff, children, families, stakeholders, and community partner's work together to reach desired outcomes.

Safety: The Department of Human Services (DHS) recognizes that the parent(s)/legal guardian(s) have primary responsibility for keeping their own children safe. However, when safety cannot be maintained in the home, DHS and private agency providers have been entrusted with the authority to intervene on behalf of the child. Our desired outcome is that children are safe from abuse and neglect.

Permanency: The primary goal for the children and families involved with DHS and private agency provider is permanency - a safe, stable home in which to live and grow including a life-long relationship with a nurturing caregiver. When the home is not safe and stable option, the goal is to move children from the uncertainty of foster care to the security of a permanent family. Our desired outcome is to reach permanency by reunification, adoption, and legal guardianship, permanent placement with a fit and willing relative or another planned permanent living arrangement.

Child Well-being: Implementing interventions that provide protective and positive outcomes to ensure that children thrive in safe permanent homes with access to necessary resources for long-term stability. Our desired outcome includes maintaining a child or youth's connectedness to family, supportive relationships, and the community as well as, effectively meeting the physical, mental health and educational needs of a child, youth or young adult.

MiTEAM Case Practice Model: Core Outcomes

Safety

Outcome S1:
Children are, first and foremost, protected from abuse and

Item 1: Timeliness of initiating assessments
Item 2: Repeat maltreatment

Outcome S2:
Children are safely maintained in their homes whenever possible and appropriate.

Item 3: Services to family to protect child(ren) in home and prevent removal or re-entry into foster care
Item 4: Risk Assessment and safety management

Permanency

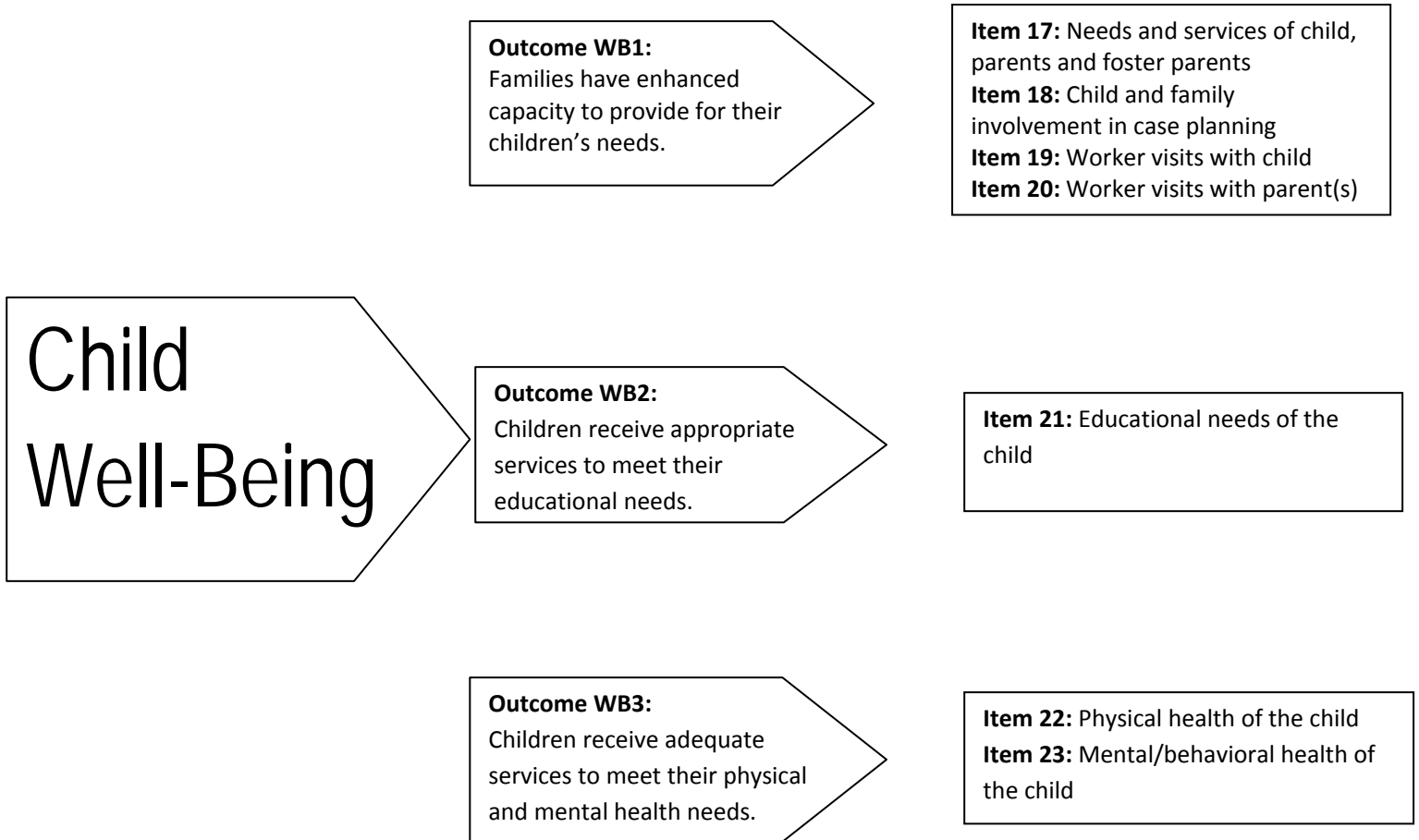
Outcome P1: Children have permanency and stability in their living situations.

Item 5: Foster Care re-entries
Item 6: Stability of foster care placement
Item 7: Permanency goal for child
Item 8: Reunification or transfer of permanent legal and physical custody to a relative
Item 9: Adoption
Item 10: Permanency goal of long term foster care

Outcome P2: The continuity of family relationships and connections is preserved for children

Item 11: Proximity of foster care placement
Item 12: Placement with siblings
Item 13: Visits with parents and siblings in foster care
Item 14: Preservation of connections
Item 15: Relative placement
Item 16: Relationship of child in care with parents

MiTEAM Case Practice Model:
Core Outcomes



Assessing Promising Approaches in Child Welfare

Child and Family Services Review at a Glance

- Congressionally authorized review of state child welfare systems
- The first round of onsite reviews was conducted from 2000 to 2004: administered by the Central and Regional Offices of the Children's Bureau, U.S. Department of Health and Human Services. The second round of reviews will begin in 2007.
- State conducts their own Statewide Assessment with support from the federal government.
- Federal and state teams conduct an onsite review of three sites in the state: the teams examine outcomes for a sample of children and families served by the state child welfare agency.
- States prepare a Program Improvement Plan to develop or enhance policies, training and practice identified as needing improvement.
- Federal penalties apply in states do not make the required improvements.

Child Welfare Outcomes Assessed by the Reviews

- **Safety:** Children are protected from abuse and neglect and are safely maintained in their homes whenever possible and appropriate.
- **Permanency:** Children have permanency and stability in their living situations and continuity in their family relationships and connections.
- **Child and family well-being:** Families are better able to provide for their children's needs, and children are provided services that meet their educational, physical health and mental health needs.

How Performance is Assessed Through the Reviews

- State Child Welfare data are compared with national standards.
- Qualitative information on state performance is collected through reviews of actual case records and interviews with children, families and others.
- State performance is evaluated with regard to how well critical components of the child welfare system function ("systemic factors," such as the agency's responsiveness to the community and the training of child welfare staff.)

More information about the reviews is available at: <http://acf/hhs/gov/programs/cb/cwmonitoring/index/htm#cfsr>.

MiTEAM Leadership Principles for: Supervisors and Managers

Supervisors and Managers are champions in their own right. Their training supports the skill that allows them to be an effective coach. It is the task of the supervisors and managers to model appropriate skills and behaviors that the Case Managers are to use when working with the family. As an effective leader supervisors and managers will utilize coaching techniques and provide the appropriate feedback. Effective communication will result in identifying resources, strengths and needs, thus, moving staff from a learner to mastering the practice skills.

Coaching: Demonstrating practice skills that provide leadership, direction, education and support that will help staff to gain confidence in Teaming, Engaging, Assessing and Mentoring our families, their peers and community partners.

Modeling: The demonstration of the MiTEAM skills in Case Conference, Field supervision and in daily activities. Modeling is staying visible to staff and actively engaging staff in setting individual goals and objectives that reflect the MiTEAM skills. From the top down, leaders will always model best practice with staff and all external partners.

Feedback: Articulate expectations of Teaming, Engaging, Assessing and Mentoring. Give frequent and effective feedback that is behaviorally specific to skills that promote MiTEAM. Effective feedback is timely, sharing of pertinent information, empathetic, concentrates on strengths and works toward solutions. The supervisor and/or manager will work with the Case Worker to clarify performance expectations and encourages them to take an active role.

MiTEAM Leadership Principles for: Case Mangers

The Case Manager is the first person to utilize the MiTEAM core skills to provide every effort to maintain permanency. The skill of engagement will encourage the families' participation in case planning. Assessing the appropriate needs of the family will enable DHS to make recommendations for services that can benefit the family and assist in reunification. Teaming allows the family to have their supports and service provider's to work together to help recognize their needs and strengths.

Engagement: The ability to successfully establish a relationship with children, parents, and individuals who work together to help resolve the child welfare related issues that brought the youth into care. Effective engagement allows the Case Manager to guide and empower youth and parents during the life of the case.

Assessment is a process rather than a one-time or point in time event. A thorough initial and ongoing assessment has a direct effect on the MiTEAM core outcomes; permanency, safety and child well-being.

Proficient assessments helps children and families recognize and promote strengths they can use to resolve issues, determines the child or family's ability to complete tasks or achieve goals, and ascertains a family's willingness to seek and utilize resources that will support them as they try and resolve their issues.

Teaming: When a Case Manager effectively teams with the youth and family, the needs of the family can be addressed in a safe and supportive environment. The process includes information gathering, analysis, and collaborative decision-making that include the family as partners. Teaming is a collective effort that necessitates a team approach. The ability to assemble, become a participant of, or lead a group or groups that provide needed support, services and resources to children or families and that help resolve critical child and family welfare related issues.

MiTEAM Leadership Principles for: Peer Coach

Peer Coaches are “Practice Champions” that have mastered the four core MiTEAM competencies, Teaming, Engagement, Assessment and Mentoring. On the onset of implementation the Peer Coaches will assist supervisors and managers in the training of the MiTEAM practice model. As an effective Peer Coach they will train, mentor, model, and provide feedback to move staff from observing and practicing to mastery of the MiTEAM skills.

Train: MiTEAM four core skills Teaming, Engagement, Assessment and Mentoring, and Family Teaming Meeting Process.

Model: The basic coaching approach is for the Peer Coach to first model for the Case Worker preparing the family and team for a FTM, facilitating the family's team meeting, and conducting follow-up. The Peer Coach then observes the Case Worker doing the same and provides feedback and guidance to the Case Worker.

Mentoring: The Peer Coach will participate in ongoing opportunities for guidance, leadership, and coaching among peers as it relates to the MiTEAM core skill development. Peer Coach's will have effective communication with the supervisors and managers on observations and FTM Follow-ups.

Feedback: Peer Coaches are expected to give effective behaviorally specific feedback to the case manager, with the case manager's Supervisor in attendance. Effective feedback is timely, sharing of pertinent information, empathetic, concentrates on strengths and works toward solutions. The Peer Coaches will work with the Supervisor and Case Worker to support the elevation of behavioral performance expectations that are required to support the MiTEAM model.

MiTEAM Case Practice Model Goals:

Family Team Meeting

Family Team Meetings are utilized to engage families in safety planning, case planning, service identification and assessing progress. Family Team Meetings are voluntary for the family; they must be offered and encouraged throughout the life of a case. Family Team Meetings is an inquiry-driven learning process; Is conducted by a family's service team; Forms a big picture understanding of the family; Informs family-team decisions; Guides a change process; Achieves necessary conditions for safe case closure.

Strength Based: Means that we will recognize and emphasize the family's strengths. The focus is to identify strengths from the family, supportive groups and communities that will be utilized to solve the problem to crises that brought the child into care.

Child Centered: Promotes and emphasizes the need to actively encourage that safety and health of the child thus, ensuring the well-being of the youth. Promoting the youth's right to make and maintain connections, while, asking questions and searching for answers.

Family Focused: It emphasize family relationships as an important factor in maintaining permanency, identifying strengths and overcoming concerns. The Family Focused skills begin with treating the family with respect and dignity. Having their strengths acknowledged will empower them to participate in services.

MiTEAM Case Practice Model: Family Team Meeting Process

The Family Team Meeting process is flexible and individualized for each family. The purpose of the meeting is to effectively communicate any concerns and work toward a consensus in overcoming any issues. The meeting is governed by the agenda, ground rules and non-negotiable(s).

Pre-meeting Discussion: The Case Worker will inform the family on why the meeting is being called. This will allow for the family and their team members to be ready to fully participate but to provide the family with a forum to share their point of view. During the pre-meeting the family with the Case Worker input will identify the location of the meeting, develop the agenda, ground rules and participants that are to be invited. It is important that all participants are prepared for the meeting, agree to what will be accomplished, and understand the purpose of the meeting.

Meeting: The team will agree to the confidentiality statement, agenda and ground rules. The team highlights the family strengths and utilizes them in supporting the family in making the necessary changes to increase child safety, permanency, and well-being. The Case Worker will promote an atmosphere of safety and transparency. So that all concerns can be addressed and evaluate realistic, measurable and obtainable solutions.

Meeting Documentation: The Case Worker will document action steps/safety plan on *DHS-1105*, as agreed upon by all team members, and distribute to participants at the conclusion of the meeting. Document the meeting in the JJOLT database and in SWSS/SACWIS and service plan.

FAMILY TEAMING MEETING SECTION

Permanency Planning Conference (PPC) and Family Team Meeting (FTM) Comparison Chart

Permanency Planning Conference

Purpose: designed to meet needs for case planning and case management, family may be invited but little family directed decision-making.

Introductions

Introductions are made, focusing on each person's relationship to family. Confidentiality, Informational Sheet and Ground Rules addressed. Purpose of the meeting is explained.

Issue Identification

Family may be asked to provide insight in regards to the caused their involvement with DHS. Case Manager reviews child safety issues identified during assessment.

Situation Assessment

Group identifies family's assets to successfully address identified child safety issues.

Brainstorming

All team members are encouraged to provide ideas to address the concerns related to the purpose of the meeting. Facilitator charts all ideas from all members. All ideas are captured. Criticism is discouraged.

Decision

The team reality tests each idea. Team members discuss involvement with family and resources they can offer. The team attempts to come to a consensus. If consensus is not possible, the Case Manager must make a decision within policy.

Safety/ Action Plan

What? Who? When? Is clearly defined. Team develops written plan, which is signed by all participants. Safety Plan developed, as needed.

Recap/ Closing

Facilitator recaps plan and checks for understanding of all members on next steps. Team members thanked for their participation.

Family Team Meeting

Purpose: designed to engage family in case planning, case management, and case closure process, family helps to direct decision making. Family input is highly encouraged throughout all stages of the meeting.

Pre-meeting Discussion: Engagement and Prep-work

Facilitator engages family and prep-work is done with parents regarding purpose of meeting; gathering family's story; asking the family who they want invited to meeting; discussion of non-negotiable(s); asks what family would like to accomplish at the meeting. Family will be asked to suggest ground rules they feel may be necessary in the meeting. Family-friendly meeting time and place is set. Discuss location options (Safety First!). If family's home is ruled out, provide an explanation to the family as to why the home environment is un-conducive for holding the meeting.

Stages of Meeting:

Welcome and Introduction

- Welcome family and team members; family introduces themselves, or meeting facilitator introduces the family (family ritual may be used to start meeting). Roles and responsibilities are explained to the FTM team members.
- Discuss purposes for meeting and FTM philosophy [family may present purpose; consensus of all team members is essential].
- Discuss non-negotiables (policy, procedures and court orders) and confidentiality
- Develop ground rules- agreed upon by all. Some Ground Rules may be developed during prep-meeting.
- Family tells their story of why they have become involved with DHS.
- Define Outcomes for the family-[Outcomes and Behavioral Results desired. Family speaks first, followed by all members
- Explain Charting

Identification of Strengths and Needs/Concerns

- Discuss strengths to achieve outcomes. Family speaks first, followed by all members.
- Discuss concerns and needs related to outcomes. Family speaks first, followed by all members.
- Discuss supports to achieve outcomes. Family speaks first, followed by all members.

Brainstorming Ideas

- Link ideas to Safety /Risk.
- Discuss strengths and supports to assist in reaching goals.

Plan Development

- Develop plan
- Action Steps: what, who is responsible, by when; and Safety Plan: Assess "What can go wrong", and create transitional plan as needed.

Recap and Closing

- Discuss next steps and closing [all come to Agreement]

Permanency Planning Conference (PPC) and Family Team Meeting (FTM) Comparison Chart

Permanency Planning Conference	Family Team Meeting
<p><u>Summary of Differences</u></p> <ul style="list-style-type: none"> • Typically run by a trained Facilitator • Minimal engagement of family prior to staffing, prep work not defined clearly or done consistently • DHS defined purpose for meeting • Content of meeting led mainly by the Case Manager and PPC Facilitator 	<p><u>Summary of Differences</u></p> <ul style="list-style-type: none"> • Name Change: The name change to Family Team Meetings (FTM) was made as it is more family-friendly. Our goal is to increase the engagement and involvement of families; therefore we are creating a format that includes them at every level. • Addition of a pre-meeting discussion: Family is engaged in the entire process. Extensive prep-work is done before meeting. The family defines purpose of meeting with team feedback regarding any non-negotiable(s). Family is empowered to tell their story, share their concerns and strengths, and to assist leading decision making. • Location of FTM's: Family team meetings are conducted at a mutually agreeable and accessible location that maximizes opportunities for family participation. • Facilitator: FTM's may be led by the Case Manager assigned to the case; however there are times that the meetings may be led by another facilitator, as safety dictates. • Additional Types and Timeframes created: Meetings will be held at case planning timeframes that were not required under the PPC model.

Family Team Meeting- Job Aid

Purpose: a family-centered, strength-based, and child centered team-guided approach designed to engage and partner with families in developing plans for the safety, permanency and well-being of their children.

Pre-meeting Discussion: Engage the family in preparing for the Family Team Meeting,

Tasks:

- Explain the purpose of meeting;
- Gathering the family's story;
- Ask the family who they want invited to meeting;
- Discuss non-negotiable(s);
- Ask what the family would like to accomplish at the meeting;
- Ask family to suggest ground rules they feel may be necessary in the meeting;
- Case Worker and Family will develop a family-friendly time for the Family Team Meeting;
- Discusses location options for the Family Team Meeting with the family (Safety First: If family's home is not an option, provide an explanation to the family as to why the home environment is un-conducive for holding the meeting.)

Stages of Meeting Skills:

Welcome and Introduction

- Welcomes family and team members; family & team members introduces themselves, or meeting facilitator introduces the family (family ritual may be used to start meeting). Roles and responsibilities are explained to the Family Team Meeting (FTM) team members;
- Discusses purpose for meeting and [family may present purpose; consensus of all team members is essential];
- Discusses non-negotiable(s) (policy, procedures and court orders) and confidentiality;
- Develops ground rules- agreed upon by all. Some ground rules may be developed during prep-meeting;
- Family tells their story in their own words;
- Defines outcomes with the family;
- Explains Charting.

Identification of Strengths and Needs/Concerns

- Concerns and needs are identified;
- Strengths are identified to achieve outcomes;
- Supports are identified to achieve outcomes.

Brainstorming Ideas

- Links ideas to Safety/Risk;
- Discusses strengths and supports to assist in reaching goals.

Plan Development

- Develops a family centered plan

Family Team Meeting- Job Aid

- Action Steps are clear and measurable. (what, who is responsible, by when; and safety plan addressed: assesses "What can go wrong", and creates transitional plan as needed.)

Recap and Closing

- Discusses next steps;
- Strive to reach a consensus.

Family Team Meetings Types and Timeframes

FTM Type (Event)	Timeframe To Have Meeting
FAMILY PRESERVATION (CPS)	
CPS Case Opening (ISP)	Within 30 calendar days before OR 14 calendar days after CPS case opening.
Updated Service Plan (USP) and Case Closing	For ongoing CPS cases. Within 30 business days prior to USP due date.
Court Intervention	Within 7 business days from the date of the preliminary hearing.
Request by Family	Within two weeks of request being made
FOSTER CARE (FC):	
Case Services Plan Development (ISP)	14 business days prior to Initial Service plan due date
Case Services Plan Reassessment (USP/PWSP)	Within 30 business days prior to Updated Service Plan/Permanent Ward Service Plan due date.
Child in care for 6 months	ASAP after 6 month date but no later than 30 calendar days after.
Change in Permanency Goal	Prior to recommendation of goal change
Placement Preservation/Placement Interruption	
Caseworker request, Foster Parent request and Residential request	Within 3 business days from request of movement.
Mental Health Hospitalization	Within 3 business days prior to discharge from hospital OR within 3 business days after unplanned discharge.
AWOLP	Upon child's return, if child is not returning to last placement OR no later than 3 business days of new placement
Case Closure	Within 30 calendar days prior to case closure OR 1 business day after unplanned court ordered dismissal.
Reunification	Within 14 calendar days after order of reunification.
16 + SEMI-ANNUAL TRANSITION MEETING	
Once a youth turns age 16. DHS-901 must be completed and goals discussed.	Once youth turns 16 and every 6 months thereafter Within 30 calendar days for youth who are 16 or older when they enter care.
90 DAY DISCHARGE	
For any youth 16 or older regarding discharge of ward ship.	Within 90 calendar days before discharge or within 30 calendar days if unplanned court dismissal. Within 3 business days of discovery that YAVFC eligibility requirements are not being met.
REQUESTS BY FAMILY	
Request by family	Within two weeks of request being made

After the Family Team Meeting is held, the event must occur within 45 calendar days or a new Family Team Meeting is necessary to assess action steps/safety plan.

Types of Participant Behaviors

MONOPOLOZING/DOMINATING THE DISCUSSION:

Speaking too often, long or loud, making it difficult for anyone else to participate

- Summarize what the person has said and move to someone else
- Stop the person, thank them for their input and inform that we need to hear from everyone
- Give the person a time limit
- Remind of time limit
- When you know in advance this may be a problem, propose in the ground rules that “everyone monitor air time.” Explain that may mean less talking for some and more for others
- Break eye contact. Stop giving focused attention

NON-PARTICIPATION/WITHHOLDING

Being unable or unwilling to speak up

- Invite person to participate. When they speak be attentive and an active listener
- Recognize and acknowledge that the process and/or discussion can be overwhelming and intimidating
- Understand that some people may not be able to participate due to cognitive/emotional issues
- Recognize that participation is individual. Goal is that each person says everything that he wants to say and is listened to during the meeting
- Ask easy questions (yes, no) or questions that allow person to be the expert or speak with confidence. “Can you tell us about what your child....”
- Determine if the participation is unbalanced due to too many staff or professionals present
- Thank them for participating

THREATS/PHYSICAL ATTACKS

- If there is a threat to other person, determine if the person is fearful. Assess if this is a real threat and what is the next step
- Set ground rules at the beginning and reiterate as needed during meeting
- “Trust your gut” Be self-aware
- Stay calm and confident, monitor your tone of voice—speak calmly

Types of Participant Behaviors

BLAMING OTHERS, ATTACKING, CRITICIZING OR PICKING AN ARGUMENT

- Establish a clear plan for how to make better choices in the future to eliminate further blaming of others
- Describe the behavior in a nonjudgmental manner
- Stop the argument. Ask for and record a statement of each individual's position. Engage other group members in discussing their positions
- Describe the behavior in a nonjudgmental manner
- Redirect, to focus on the issues at hand, resolutions
- Indicate that we are not here to point fingers, but to make the best safe plan for child(ren)
- Ask the person what the group could do to respond to their concern

DENIAL/MINIMIZATION

Being unable to recognize or acknowledge concern or seriousness of problem

- State facts
- State the differences and ask why
- Look for what is in common
- Ask for their perception. Ask clarifying questions to raise their awareness level
- Repeat, clarify purpose, focus. Stress why safety concern is of importance to agency
- Emphasize effects of the caregiver's actions on children. Explain possible consequences

LYING

- Have others share what their experience was regarding the topic
- Acknowledge the disagreement, difference, and inconsistency. Ask the person if they can assist the group to understand why
- Respectfully confront with evidence
- Allow the person to explain, share their feelings
- Don't have to address if not helpful to the process of the meeting

Types of Participant Behaviors

CRYING

- Ask if they need a moment
 - Encourage a family member to comfort, if appropriate
 - Acknowledge feeling and pain
 - Offer tissue
-

HOSTILE/NEGATIVE/ANTAGONISTIC Demeanor

Negative expressions can be either verbal or nonverbal

- Point out the negative pattern
 - Ask if there is any part of the discussion/work being done, which the person feels positive or good about
 - Explore alternative solutions while allowing the individual to state what the worst consequence could be
 - Ask for their opinions about what is needed. Record the opinions. Ask the group to respond
 - Acknowledge the person's point of view. Listen
 - Recognize and acknowledge the anger by a reflective statement, remain calm, soft voice
 - Clarify reason for anger and attempt to deal with underlying reasons
 - Give an opportunity to vent and check for safety of all
 - Make a point of thoroughly paraphrasing the individual's view the first couple of times the person speaks. Stick very close to their exact wording
-

YELLING/SCREAMING

- Value feelings, reframe
 - Let everyone express their feelings to the extent possible—may be loud, animated
 - Stop/pause, silence, breathe and refocus
 - Ask everyone to take a deep breath to regain calm and remind why everyone is here. Restate meeting purpose & goals
 - Speak in calm voice. Don't allow yourself to be pulled in
 - Remind why we are here, what we must accomplish and important that they participate in helpful manner
-

Types of Participant Behaviors

TALKING OFF THE SUBJECT

Being out of synch and appear to be talking irrelevantly

- Try to direct the person or the group to come back to their point
- Explain how the group planned to proceed and let the individual know the group will get to their issues
- Understand that issues being dealt with are emotional and the individual is under a great deal of stress. Ask and answer questions that will assist
- Consider that there may be other things going on—mental health issues, substance abuse etc.

HOPELESS/OVERWHELMED

- Let person know that agency wishes to help through this time. Give an opportunity to discuss how they feel about the situation
- Acknowledge difficult situation and assist in identification of support systems
- Review strengths/better times
- Offer support systems to help
- Identify options to reduce stress and improve coping skills

INAPPROPRIATE LANGUAGE

- Monitor group's reaction
- Sometimes "let it go"
- Remind of ground rules and explain that the language may be offensive/condescending
- Consider the context

PASSIVE-AGGRESSIVE BEHAVIOR

- Address solution-seeking questions to that person in hopes he/she will engage
- Ask questions that would prompt the person to own their feelings and direct them appropriately
- Stress importance of everyone's input and participation in decision
- Engage as much as possible in discussion—continue to ask for input, opinions and clarifying points

Types of Participant Behaviors

NONVERBALS AND INDIRECT VERBALS

Provide an "I" message

Recognize incongruent behavior, comments

Comment on what it looks like

INTERRUPTING OTHERS

Cutting off others who are speaking or jumping into a conversation too soon, disrupting the sharing of information and showing disrespect for the other person. Interruptions can be verbal or disruptive, distracting non-verbal communication

Remind of the comfort agreements/ground rules

Stop the interrupter and ask the person to wait while the speaker completes their thought

Be neutral and consistent. Don't allow some to interrupt and not others

Ask if the interrupter would like to write down their thoughts to ensure that they don't lose them and then to share rather than interrupt

HAVING SIDE CONVERSATIONS

Making private comments or carrying on another discussion with their neighbor

Ask the group if they can hear one another

Ask them to stop. Point out how it distracts

Stop the conversation and look at the people talking

Ignore it if it appears to be beneficial or necessary for the family member

Repeat the topic under discussion and ask if everyone can focus on it and have just one conversation at a time

Ask them to share

If staff, in addition to intervening as above, address outside of the meeting

Ask if they can hold it until...

Types of Participant Behaviors

INSERTING PERSONAL AGENDAS

Repetitiously inserting a concern or a disagreement—"Yeah, but..."

- Ask the person what they want the group to do with the information
 - Give the person a time limit
 - Acknowledge the concern and comment
 - Paraphrase or record the point, thank the person and move on
-

REPEATING THE SAME POINT OVER AND OVER

Not being able to let go of something. (This is a variation of inserting a personal agenda)

- Ask if the person can let it go for now
 - Give the person a final time-limited opportunity to make their pitch
 - Acknowledge the importance of the point and the person's passion, advocacy and/or determination
 - Demonstrate that the person has been heard and the point recorded
-

Steps for Working with Resistant People

“Resistance is a predictable and natural emotional reaction to feeling forced to change and to face difficult issues. Resistance occurs as a response to feeling vulnerable, out of control and threatened by change.”

Step 1: Recognize the cues.

Identify the form of resistance. Also, identify the emotions you feel in reaction to the form of resistance. Be aware of the nonverbal messages and the messages heard in the person's voice. Trust your own feelings and accept them as a cue to the possibility that you are encountering resistance.

Step 2: Manage your emotions and reactions.

Examine your emotions and select ways you can manage them effectively. For example, remind yourself resistance is a normal response to the process of change. Do not take the expression of resistance personally. Identify the positive intent or the benefit to the person for experiencing the resistance.

Step 3: Reflect the form of resistance you observe and allow silence.

Use reflection to state in a neutral way the form of resistance you are seeing and hearing. Make your statement succinct and genuine. Use “I messages” such as, “When I ask about the effect of your drinking on the children, I notice you change the subject.” **Then fall silent and allow this reflection to “echo” for them.**

Step 4: Use active listening and empathic reflection to help them discuss their vulnerability.

Now is the time to be quiet and help the person more clearly discuss their feelings of vulnerability or their concerns about control. Use your empathy, active listening, attending, reframing, and clarification; which will enable the person to explore their vulnerability. For example, “If it were true that your drinking has had a negative effect on your child, what would that mean to you?” Help them and you understand some of the feelings of vulnerability and losses being experienced.

Family Teaming Meeting Preparation Sample Questions

The following are sample questions that may be used during the preparation discussion.

These are not steps; they are just some possible questions you might want to use.

To the parent: (possible other team members)

- What would you like to have happen as a result of this meeting?
- What do you see as family strengths? What do you need?
- What are your child's strengths? What does your child need?
- Describe what success is for your family. What would you be doing differently to achieve success?
- Can you think about what you would like team members to know about your family story, including how you got involved with the agency?
- Who are the people who care about you....your family...you children?
- Who would you want to be at your Team Meeting/
- If we invited all the people who care about your family to come to a meeting, what would be some good things that might come from their participation?
- Where would be the best place for the meeting?
- What are some of your concerns that you would like to address?
- Considering we are bringing together a lot of folks, what are some of your concerns?
- What is the family doing at this time that may help the family achieve its goal?
- Can you identify strengths now (written them down in preparation for presenting them at the meeting)?
- Can you be prepared to discuss the needs of the family?
- Do you have any concerns about your participation on the team?

Common Questions from Youth Job Aid

What is a Team Meeting?

It is a meeting that helps make decisions and a case plan about what is going to happen to you. People who are supportive of you are invited to attend and help make important decisions about things such as entering foster care, placement in foster care and issues about your family.

Who is going to be there?

Multiple people who have an impact in your life may be invited. People such as your parents, relatives, teachers, therapists, friends, case workers and DHS employees will attend the meeting. You may request to have people at the meeting you find supportive. Please make sure your caseworker knows who you would like to attend the meeting.

Why am I going?

You have been invited to a Team Meeting to help make a major decision about your life. Depending on your situation, decisions may be made on where you will live, who will take care of you or how you and your family can be supported.

Why should I go?

Attending the Team Meeting will help give you a voice on your future. You will have an opportunity to share your feelings and experiences to help make a good decision. You are the expert of your life, so attending will help others understand your wishes, concerns and goals.

Do I have to attend?

Your participation is voluntary, but highly encouraged. This is YOUR future and you are important.

What should I bring and what should I wear?

Bring an open mind and lots of questions! Paper and pen will be available to you at the meeting. You may dress casual. This is a casual meeting, so come as you are!

Where is the meeting?

Meetings are held in a variety of locations throughout the County. Locations include churches, community agencies and DHS offices. You will be told where to attend the meeting.

Will I have voice? Will people listen to me?

Everyone at the meeting will be given an opportunity to speak at the meeting. Ground rules are given before the meeting. A facilitator is also there, supporting the meeting to assure EVERYONE has a chance to speak their mind, feelings and ideas. If you do not feel you are being heard or are being misunderstood, please make sure to let the facilitator know.

What if I am too scared to speak?

If you are too scared to speak, for whatever reason, please make sure to share these feelings with your DHS caseworker. You may schedule a private meeting with them, call them or email them. You may also write a note to your caseworker during the Team Meeting, letting them know you are uncomfortable. You have the right to have your feelings heard and feel safe.

Common Questions from Youth

Job Aid

The Team Meeting is designed to make everyone feel as comfortable as possible, but it is understandable if some issues are difficult to express. We encourage you to reach out to someone to share your feelings and make certain you are heard and your needs are met. Remember, if you don't speak your problem will not be solved.

What is the Facilitators role in the meeting?

A facilitator is assigned to conduct each meeting. The facilitator's role is to make sure everyone has a chance to speak, that everyone feels comfortable, and that the group stays focused on making any recommendation(s) to develop a case plan.

Am I in trouble? Do I need to have a lawyer?

No, you are not in trouble. This is a meeting to help you and your family make important decisions, not to discipline, punish, criticize, etc. You do not need to bring a lawyer. This meeting is not a court hearing and they do not making any court orders. However, as a youth in foster care you do have a Guardian Ad Litem (GAL), an attorney, which you may request to attend the meeting on your behalf. Remember, you did not place yourself in foster care and being in foster care is no

ENGAGEMENT SECTION

Skills for Engagement

Being Genuine

(Being yourself — not “faking it.”)

- “For Real”...open...honest...real people in real encounters
 - “Freely and deeply express yourself without facades, without being phony.”
 - You are “not thinking and feeling one thing and saying something different.” You are being “authentic.”
 - “Genuineness does not require that we **ALWAYS** share our feelings **IT DOES** require that whatever we express is real and genuine and non- incongruent, impulsive, insincere, dishonest or phony.”
-

Showing Empathy

(Putting yourself in someone else’s shoes)

- EMPATHY = the capacity to show an awareness of, and to some extent feel what the member is trying to express, verbally or non-verbally.
-

Showing Respect

(Seeing individuals’ strengths as well as problems, i.e. seeing the “whole” person --- not just the reason s/he became involved with child welfare.

- Make no assumption about race, ethnic origin, marital status, religion
 - Do not address a person by his/ her first name unless specifically asked to
 - Do not call the person by his/ her illness (an alcoholic, a diabetic, a crack addict)
 - Do not invade another’s personal space
 - Do not interrupt without good reason
 - Do not refer to a parent or a child in the third person
 - Ask or recommend **Don’t** tell
-

Being Competent.

- When you do all the above and follow through with what you say, then you show others that you are

MiTEAM

Engagement

Job Aid

Purpose of Engagement: The skill vital to successfully establishing a relationship with children, parents, and individuals that work together to help meet a child or family's needs to resolve child welfare related issues.

Engagement: MiTEAM Practice Model

The ability to successfully establish a relationship with children, parents, and individuals, to work together to help meet the needs of the child or family and resolve child welfare related issues.

Four Core Skills of Engagement:

Empathy: The ability to understand and share the feelings of another.

Skills of Empathy:

- Reflects on the effects of one's actions on families
- Focusing on the parents affective state without losing perspective or taking on the parents emotions
- Identify underlying emotions and behaviors and exploring the meaning and personal significance of those emotions and behaviors
- Remain objective and not overwhelmed by your own emotions

Respect: A feeling of deep admiration for someone or something elicited by their abilities, qualities, or achievements.

Skills of Respect:

- Values family self-determination
- Appreciates the "expertise/authority" of the family
- Uses language that "humanizes" the family and individuals, with diminished emphasis on hierarchies and labels

Genuineness: Truly what something is said to be; authentic true - real - authentic - sincere - honest - veritable

Skills of Genuineness:

- Uses a conversational tone rather than "clinical"
- Elicit information about a person's familial beliefs and values
- Being yourself (without artificial behaviors) by balancing this with your professional role
- Making sure your non-verbal behavior (voice, tone) and verbal responses match or are congruent

Competency: is the ability of an individual to perform a job properly. A competency is a set of defined behaviors that provide a structured guide enabling the identification, evaluation and development of the behaviors in individual employees.

Skills of Competency:

- Attributes all intent, plan, and strategies to the identified problem, not to the identified individual
- Explains the process of creating a supportive team around the family and youth and how the team works to develop plans
- Creates a content/environment that helps families and individuals "envision their preferred futures and draw on their resources to address the problems that stand between them and their futures"
- Be honest, persistent, consistent and follow through

21 Not Knowing Skills

The purpose of using the Skills for Not Knowing is to have the customer recognize, identify and address their problems, strengths and solutions. Though you may actually know some of the things the customer needs, the best way to help them is to allow them to help themselves. Thus, you are **Leading from One Step Behind**. This is not one of the Skills for Not Knowing; it is the premise for the skills. Remember, the customer is the expert of their own life. Do not forget the **21 Not Knowing Skills** are not designed to work with each customer. Just as with a bouquet of flowers, you choose, pick or arrange which one ones work best for each individual customer. There is no standard and/or set arrangement.

SKILL 1: LISTENING

Who and What is important to the customer? As you listen attentively to the customer you are focusing on the very things they identify as important. This keeps you focused on them and not what you are going to say next.

SKILL 2: FORMULATING QUESTIONS

Formulate your next question from the clients last or an earlier answer. This process is not easy but with practice, it will become easier.

SKILL 3: GETTING DETAILS

For the purposes of being a thorough child welfare worker, you need to get as much detail about your customer. With getting details you want to get as specific as possible. This is extremely important during your initial period of working with your customer. You want to ask questions that require a detailed answer. If the customer likes to use "don't know" you can ask them to share with you what they do know about the situation.

SKILL 4: ECHOING CUSTOMER'S KEY WORDS

You will notice as a worker that when you interact with your customer there are certain words that they will repeat. Some of them may be swear words but those are not the ones we want to focus on. When you echo you are doing just like an echo, repeating the keywords the customer has spoken.

SKILL 5: OPEN QUESTIONS

Very simply put, an open question is one that can not only be answered with a one-word answer. Yes and no, alone, are not responses you for an open question. An open question is designed to elicit a more detailed, complete, answer.

SKILL 6 & 7: SUMMARIZING & PARAPHRASING

Summarizing and Paraphrasing are similar but definitely not the same. **Summarizing** is restating the customer's words in a compact manner. There is no interpretation of the meaning of what they said, simply a summation of what they said. **Paraphrasing** is summarizing what the customer has said, but putting it into your own words or the way you understand what they said. You interpret the meaning.

21 Not Knowing Skills

SKILL 8 & 9: NON-VERBAL BEHAVIORS (CUSTOMER/WORKER) & NOTICING PROCESS

The **Non-verbal behavior** we are referring to is Body Language. Body Language says a lot about a person. It shows if a person is confident, scared, uncomfortable, inviting, etc. We have to pay attention to the customer's body language when we talk with them but our own body language is important as well. The customer is observing us just as we are observing them. The **Noticing Process** is when you pay close attention to what the customer says and what they do. What you want to ask yourself is, do they contradict themselves. Is the customer telling you about an experience they had that was traumatizing to them, but they are laughing? You want to summarize and paraphrase what the customer is expressing so that you can get clarity on what the customer really means versus what you are observing.

SKILL 10: NOTICING HINTS OF POSSIBILITY

This skill is similar to "The Noticing Process". The difference is that for this particular skill you are trying to notice any solution talk the customer is saying. Solution talk involves any talk about a better future, successful past events and any steps they have already taken toward gaining a solution.

SKILL 11: THE USE OF SILENCE

It can be very difficult to be silent. Silence makes many of us uncomfortable. When talking with our customers, sometimes instead of allowing a moment of silence to pass we will jump in with a question or a comment. The truth is some of the most valuable information you will gather will come out of those moments of silence.

SKILL 12 & 13: COMPLIMENTING (Direct & Indirect Compliments)

When we are complementing our customer we need to be genuine. Phony compliments are not hard to pick up on. Identify a strength that the customer has and start there. There are two types of compliments; **direct compliments** are statements to the customer about something they have done well. **Indirect compliments** are questions that imply the customer has done something well.

SKILL 14: AFFIRMING CUSTOMER'S PERCEPTION

The purpose of **affirming** our **customer's perception** about their feelings, beliefs, experience's is so that they know in some way that you can relate to what they are saying. No one likes to talk with anyone who just does not understand them. Try to avoid "I would feel the same way" type of response. It's not about you.

SKILL 15 : EXPLORING CUSTOMER MEANINGS

When we look at **Exploring Customer Meanings** we want them to think things through and draw their own conclusion as to why things are or what they mean. As the worker you don't want to give the customer solutions or resolve their thoughts for them because the customer may view you as being in a role of authority. They may ask you what you think or to interpret the reason for some of their issues. This skill is for you to know how to refer the customer to rely on themselves for their own interpretation.

21 Not Knowing Skills

SKILL 16 & 17: NATURAL EMPATHY & SELF DISCLOSING

Seeing as that you are in the field of human services there is an assumption that your heart must be in this job. An assumption, however, is not a guarantee. Many people have to **learn** how to be empathetic with customers and their struggles. As the child welfare worker, you want to try to put yourself in your customer's shoes, in their shoes specifically, not "how you would deal with the situation if it happened to you".

This is how you use **Empathy**. Sometimes you will come across customers who are having or have experienced something that you have also experienced. You may share your experience with them believing it will help them to understand that you know what they are going through and can therefore relate and that if you made it, they can to.

This is **Self-Disclosing**. Sharing is okay at times but sometimes it is best not to share your personal experiences, beliefs and ideals. Remember, we are being customer focused. If we spend too much time talking about ourselves the customer is not going to feel like they are being heard or valued.

SKILL 18: NORMALIZING

Though normal is a relative term, having this type of revelation can make you feel like you can get through it. Another thing it does is validate you. Normalizing lets you know that people do have similar experiences and that if someone else managed to get through it, it gives you hope that you can too.

SKILL 19: RETURNING THE FOCUS TO THE CLIENT

There are going to be times when a customer has a hard time identifying and taking responsibility for their actions or the situations they are in. Blaming is an issue you will have to know how to identify and address. You can do this by returning the focus back to the customer. Talk with them about their role in the problem regardless of what everyone else may have done. This is to help them take ownership.

SKILL 20: RELATIONSHIP QUESTIONS

There will be times when you will not be able to get your customer to truly see the areas they need help in or recognize their strengths. That's when you can use relation questions. Ask the customer to explain how someone they care about views them. Or what kind of strengths does their mother or father says that they have? What will your friend see to let them know you have stopped drinking?

SKILL 21: AMPLIFYING SOLUTION TALK

You've done it? You have helped your customer begin to see that there is indeed a light at the end of the tunnel. They are not focusing so much on the problem but they are beginning to talk about the solutions to the problem. You want to encourage them to continue talking solution talk and in more detail. Therefore, you **amplify** the customer's solution talking.

Keys to Engagement

Keys to Engaging Families



Engagement Skills:

KEYS TO ENGAGING FAMILIES:

- ↔ Listen for needs, interests, and concerns
- ↔ Assist family members in identifying connections and strengths
- ↔ Demonstrate warmth, empathy, and genuineness as a foundation for engaging family members around concern for child safety and building parental capacity
- ↔ Use active listening skills
- ↔ Tune into self and others (empathy)

KEYS TO ENGAGING FAMILIES:

- ↔ Define terms of working together with the family using full disclosure
- ↔ Manage the use of power and authority
- ↔ Provide concrete and clear information to support the change process
- ↔ Motivate and support participation
- ↔ Assist families in making their own case for change

Keys to Engagement

EMPATHY	PARTIALIZING	PAST SUCCESS QUESTIONS
<p>Empathy is tuning in to the way the other person sees and feels about her experience and communicating to her both your attempt to understand and your compassion.</p> <p>Example(s): <i>Worker:</i> Megi has been in foster care nearly six months and she needs to be someplace where she can grow up. <i>Mother:</i> I know she needs a home for good. I am trying! You try kicking this habit. It is, like, so hard! <i>Worker:</i> I know it's been tough for you. <i>Mother:</i> Do you? Do you? <i>Worker:</i> (pause) You have always told me that, even during the worst of times, you keep Megi in your heart and she is your reason to keep trying to kick your habit.</p>	<p>Partializing is helping clients deal with one problem at a time or breaking down complex problems.</p> <p>Example(s): <i>Mother:</i> I can't believe you guys want me to do all this stuff right away! <i>Worker:</i> Well, let's go over it to see the different parts—it's probably not as much as you might be thinking. First, we need to be sure that Leroy is never left alone. So, let's go over the plan for that again. What are your plans? <i>Mother:</i> I'll take him over to this new day care on my way to work every day. <i>Worker:</i> OK. And how about if your car breaks down like last week?</p>	<p>Past success questions are intended to help the client to describe specific times when s/he has had success in a situation that could be applicable to a current concern.</p> <p>Example(s): It's not easy to raise three children on your own. How did you do it? After having been through what you've been through, how did you find enough strength to keep pushing on? What do you need to do so that you'll feel good about yourself and in control again? What would it take for you to bring back the confidence you had when you were in high school?</p>

Keys to Engagement

REFRAMING	RECOGNIZING STRENGTHS	SCALING QUESTIONS
<p>Reframing helps clients change their way of looking at problems so that the positive aspects can be more clearly seen.</p> <p><i>Example(s):</i> <i>Parent:</i> So, there you have it. I guess what I am telling you is yes, I hit Andy with that strap and yes, that is how he got the bruises on his back. So, I guess you think I am worse than the wicked witch of Oz.</p> <p><i>Worker:</i> No. I think from what you told me that you are trying to find a way to keep Andy from touching his sister in a sexual way. I think you are concerned about both of your kids. I want to help you find a way to help them—and punishing Andy in this way will likely not stop him from doing it again. He needs a different kind of help.</p>	<p>Recognizing strengths involves identifying and emphasizing what the client can do to control safety concerns and reduce risks.</p> <p><i>Example(s):</i> <i>Father:</i> Well, yes, I do have some other ways that I discipline Rory. I send him to his room and I use that chair over there—I face it to the wall.</p> <p><i>Worker :</i> Tell me about a time you used one of these ways.</p> <p><i>Father:</i> I tried sending him to his room just before I had to spank him—but he tore up some books and that's when I had to spank him.</p> <p><i>Worker:</i> I can see that you have tried a different method and that is a real strength.</p>	<p>Scaling questions are a clever way to make complex features of a client's life more concrete and accessible. Scaling questions can be used to assess self-esteem, self-confidence, investment in change, perception of hopefulness, etc. They usually take the form of asking the client to give a number from 0-10 that best represents where the client is at some specified point. Ten (10) is the positive end of the scale, one is lower.</p> <p><i>Example(s):</i> Let me ask you, on a scale of 1 to 10, with 10 standing for 'as determined as anybody can be in your circumstances to get your daughter back,' how close would you say you are to 10?</p> <p>Okay, now this time 10 stands for 'as confident as anyone can be that you will get your child to come back to live with you.' Where would you put yourself on the same 1 to 10 scale?</p>

Keys to Engagement

OPEN-ENDED QUESTIONS

When you ask questions that are an open invitation to say whatever is on the person's mind, it is sometimes amazing what people will share. Solutions often begin to emerge from this type of processing out loud. This applies to any question for which "yes" or "no" or "I don't know" are not likely responses.

Example(s):

What else can you tell me about that?
Tell me about your family when you were young.

"WHEN..." RATHER THAN "IF..." QUESTIONS

"When" implies trust that the person is going to do something. "If" implies that they may or may not. "When" presumes a desire for, and the possibility of, a positive outcome. (Revisit your strength-based language list.)

Example(s):

When... (You're not drinking), how do you feel in the mornings when it's time to get the children off to school?

When you are in control of your temper...

When you go to your drug treatment program...

QUESTIONS THAT BEGIN WITH "HOW"

These questions tend to be more solution-oriented, and less likely to call for blame or defensive responses than "why" questions.

Example(s):

How can you tell? How do you know this?

How did you do it before?

How would that be helpful to you/ your family?

How long have you felt this way?

Keys to Engagement

QUESTIONS THAT BEGIN WITH “WH...”	STRENGTHS CHAT	EXCEPTION-FINDING QUESTIONS
<p>These questions are solution-oriented and imply the person’s ability to solve problems.</p> <p>Example(s): Where is the best place for this to happen?</p> <p>What would your children/mother/friend say to you about this?</p> <p>Who helped you when...?</p> <p>What difference would this make to you?</p> <p>What would it take...?</p> <p>What are your thoughts about this?</p> <p>What part of this do you agree with, and disagree with?</p> <p>Who can you call when you are feeling that way?</p> <p>Where can you go when you decide you want to get help for that?</p>	<p>This is a normal, informal conversation seeking information about the family’s “Positive Family Processes.” Responses to these questions can reveal strengths the family can rely on when times get tough or when there is a crisis.</p> <p>Example(s): What do you do for fun?</p> <p>What does your family do together?</p> <p>What is one of your comforting family traditions?</p> <p>What are some things you like best about your children?</p> <p>How do you blow off steam? How did you meet your spouse/significant other?</p> <p>What is one thing each week that you really look forward to doing?</p> <p>How do you picture yourself and your family five years from now?</p> <p>What is something that makes you smile when you think about your family?</p>	<p>Elicit information that addresses how a problematic situation might have been different. These questions allow the receiver to talk about their successes (strengths). Exceptions are the building blocks of success. They shrink the problem. Exceptions focus on the possibilities.</p> <p>Example(s): Tell me about the times, in recent days, when you could have hit Tommy (screamed at him, called him names, etc.), but somehow managed to handle it differently?</p> <p>When you are... (not drinking...), what is different at home?</p> <p>Let’s talk about the days when you do feel safe and hopeful. What is it you are doing differently on those days?</p> <p>Tell me about the most recent time when you could have gotten stoned, but you didn’t. How did you manage not to?</p>

Keys to Engagement

COPING QUESTIONS	MIRACLE QUESTIONS	ETHNOGRAPHIC INTERVIEWING
<p>When dealing with difficult behaviors or situations, ask questions in a way that demonstrates empathy and compassion. This acknowledges your understanding of the pain, fear or frustration they may be experiencing.</p> <p><i>Example(s):</i> I imagine these children are a real handful. I'm sure they keep you on your toes all day. What seems to help? That's very clever!</p> <p>How do you do it? Who do you turn to when you feel you need help?</p> <p>How did you manage to stay sober for a whole week? Considering how tough this week has been for you, it must have been hard to do.</p>	<p>These questions ask for families to disregard their current troubles and for a moment imagine what their lives would be like in a successful future. It creates a vivid image or vision of what life will be like when the problem is solved and hope that life can be different. These questions are inspirational because they help to remove hopelessness.</p> <p><i>Example(s):</i> Suppose one night there is a miracle while you were sleeping and your problem is solved. You don't know the miracle has happened. What will you notice that is different the next morning that will tell you that the problem is solved?</p>	<p>Interviewing people about their cultures helps us to understand a significant part of what influences their goals, values, problem-solving approaches, and child-rearing behaviors. This means focusing on their view of their culture first and only secondly on their view about how they are similar or different than their culture.</p> <p><i>Example(s):</i> Tell me about how your _____ view physical punishment of children?</p> <p>Most groups of people have ideas about what children ought to be doing at various ages. Tell me what people in your group think about how children ought to act by age 10?</p>

Initial Guide to Assess Potential Relative Caregivers' Safety and Placement Potential

OUTCOMES

- Child's need for safety, stability, continuity of care/relationships, nurturance and opportunities for growth and developmental well-being are met.
- Child has a caring environment, which supports family continuity through the delivery of a child-centered, family-focused system of practice to ensure permanency.

FAMILY IDENTIFICATION

- Can you identify the members of your family who have a healthy/positive relationship with you and your child or children?
- Who in your family do you think can care for your child or children?

INITIAL ASSESSMENT OF FAMILY INTEREST (Willingness of family member(s), length of relationship with family member(s), quality of relationship with family member(s), relationship with child or children, full disclosure of family circumstances)

- How have these family members helped you in the past?
- Has your child or have your children ever stayed with these family members over an extended period of time?
- What kind of relationship does your child or children have with these members of your family?
- Do these family members know the circumstances and conditions that have led to the need for your child or children's placement?

INITIAL ASSESSMENT OF ISSUES RELATED TO ENSURING A SAFE ENVIRONMENT -(ability to meet child's physical and emotional needs: does any person in the home have a history of abuse or maltreatment; willingness to work with agency; health of family member; protection from abuse or maltreatment; ability to develop a plan with the agency)

- Is the family member willing to share personal information about their past and present circumstances by being part of the family study/assessment process?
- Can the family member meet the child's physical and emotional needs?
- Does the family member or any member of household have a history of abuse or maltreatment?
- Is the family member willing to work with the agency to protect the children and provide for their developmental well-being?
- Will the health of the family member impact on their ability to care for the child/ren?
- Will family members be able to protect child or children from further abuse? Do parents believe this to be so?
- Do any of the family members have an interest/capacity to become a licensed foster parent or to assume responsibility of the child without becoming a foster parent?
- Are family members willing and able to provide short-term care and support family reunification efforts if they are required?
- Are any family members willing and able to provide a permanent legal home for the child or children as adoptive parents or legal guardians if this should become necessary?
- Will the family member work with the agency to develop a safety plan

Initial Guide to Assess Potential Relative Caregivers' Safety and Placement Potential

CLINICAL ISSUES FOR THE RELATIVE CAREGIVERS

Loss

- Interruption of life-cycle
- Future plans
- Space, privacy
- Priorities

Role/Boundary Definitions

- From supportive to primary caregiver
- From advisor to decision-maker
- From friend to authority

Guilt

- Fearful of contributing to family disruption
- Becoming a primary caregiver and raising child
- More committed to meeting the child's needs instead of parent's needs

Embarrassment

- Due to birth parent's inability to remain primary caregiver

Projections/Transference

- Unresolved issues- with birth parent transferred to the child
- Difficulty perceiving the child's personality as different from the birth parent

Loyalty

- Usurping or replacing birth parent's role
- Fear of hurting parent's feelings and being rejected

Child Rearing Practices

- Updating and recalling techniques and methods
- Need to learn non-corporal techniques of punishment and discipline

Stress Management/Physical Limitations

- Developing coping skills and support in managing children and additional responsibilities

Bonding and Attaching

- Establishing a parent/child relationship instead of a relative/child relationship

Anger and Resentment

- Birth parent's absence
- Birth parent's attempts to regain custody or continue contact
- Birth parent's sabotage or competition for child's loyalty to birth parent

Initial Guide to Assess Potential Relative Caregivers' Safety and Placement Potential

- Agencies and professionals
- At/with "themselves" for becoming a surrogate parent

Morbidity and Mortality

- Concerns of illness/death triggered by previous losses and separations
- Who will take care of me if grandma gets sick or dies?

Fantasies

- Many parents fantasize about reuniting with their children
- These fantasies can be sometimes unrealistic
- These fantasies may cause to maintain unrealistic expectation about reuniting with the parent

Overcompensation

- Caregiver may try to make up for the parent's failings or mistakes
- This reinforces child's experience of life as "extreme" and not balanced
- Challenge for caregiver is to provide balance and consistency

Competition/Sabotage

- Parent can sabotage the placement by undermining the authority of caregiver
- Parent may challenge, defy, or not comply with agreements regarding visiting, curfew
- Parent may give child permission to defy caregivers and professionals

MiTEAM Mentoring Supervisor-Job Aid

Purpose of Mentoring: To guide and empower staff through mentoring. The process of mentoring is a developmental partnership through which one person shares knowledge, skills, information and perspective to foster the personal and professional growth of someone else. The power of mentoring is that it creates a one-of-a-kind opportunity for collaboration, goal achievement and problem-solving.

Coaching:

Demonstrating practice skills that provide leadership, direction, education and support that will help staff to gain confidence in Teaming, Engagement, Assessment and Mentoring our families, their peers and community partners.

Skills of Coaching:

- Planning: with the Case Manager other team members that can assist in providing services, resources for the support of the family (supervisor, staff, family members and community support system) to establish and/or work towards the family goal(s);
- Leading: demonstrating professional behavior during interactions with others (verbal, written and non-verbal)
- Evaluating: providing information on the outcome of the plan and where resources used

Modeling: Engagement

Staying visible to staff and actively engaging staff in setting individual goals and objectives that reflect MiTEAM skills.

Skills of Modeling:

- Behavior: presenting sympathetic, respectable, genuineness in engagement with others;
- Communication: aware of body language, tone and non-verbal expression. Is open and listening with the intent to understand
- Competence: following up with others, expressing knowledge barriers, and continuing the process of learning.

Feedback: Engagement, Teaming and Assessment

Articulates expectations of Teaming, Engagement, Assessment and Mentoring. Gives frequent and effective feedback that is behaviorally specific. Effective feedback is timely, sharing of pertinent information, empathetic, concentrates on strengths and works toward solutions. The supervisor and/or manager will work with the case worker to clarify performance expectations and encourages them to take an active role.

Skills of Feedback:

- Is Specific: defines the action, desired outcome, and explains the actions steps required to reach the outcome professionally and for the family in which services are being rendered;

MiTEAM Mentoring Supervisor-Job Aid

- Provides staff with realistic, measureable, and expectations;
- Discuss issues/concerns that hinders in the achievement of reaching goals/outcome(s);
- Monitors workers and family progress and identifies areas of success and concerns;*
- Express genuine curiosity about concerns being addressed;*
- Provides follow-up*

MiTEAM Mentoring

Case Worker-Job Aid

Purpose of Mentoring: Mentoring is a developmental partnership through which one person shares knowledge, skills, information and perspective to foster the personal and professional growth of someone else. The power of mentoring is that it creates a one-of-a-kind opportunity for collaboration, goal achievement and problem-solving.

Educating Families:

To guide and empower parents and youth in Teaming, Engagement and Mentoring skills that provides a clear direction in the requirements to obtain identified outcomes, educate families on the processes and procedures of the Department of Human Services and other stakeholders and support that will help the family to gain confidence in process.

Tasks:

- Clearly define Child Welfare System and thoroughly explain their rights responsibilities and roles;
- Clearly communicates to the family specific expectations required by DHS policy and Court Orders that will need to be accomplished to obtain permanency;
- Support family in identifying specific desired outcome and action steps required to reach the outcome;
- Promote family connection to existent Community Services to reach the outcome.

Feedback:

Gives frequent and effective feedback that is behaviorally specific. Effective feedback is timely, sharing of pertinent information, empathetic, concentrates on strengths and works toward solutions.

Skills of Feedback:

- Express genuine curiosity about concerns being addressed;
- Clearly communicate with family how they are progressing toward reaching the required outcome(s);
- Identify and address families successes;
- Discuss issues/concerns that hinders in the achievement of reaching goals/outcome(s);
- Provide follow-up.

Modeling: Engagement

Case Worker will demonstrate engagement skills, professional boundaries and behaviors to families, youth and caregivers. Thus, allowing an atmosphere of open dialogue and collaboration.

Skills of Modeling:

- Presents sympathetic, respectable, and genuineness when engaging with others;

MiTEAM Mentoring

Case Worker-Job Aid

- Communication (body language, tone and non-variable expression) with others is intended to listen and to be open to understanding others;
- Competence in following up on items that you indicated that you will complete;
- Effectively communicating knowledge barriers and continuing the process of learning.

Permanency Planning Section

The Rationale and Purposes for Case Planning

4. FAMILY INVOLVEMENT

Ensure that the family and the family's team have opportunity and support for being involved in developing and implementing the plan, evaluating progress, and revising the plan as needed.

5. SPECIAL PLAN COMPONENTS

Ensure that special aspects of planning are completed:

- ⌋ In the case of removal and placement of children or youth, a placement plan (including visitation) and a concurrent plan (an alternate permanency goal and a plan for achieving it, usually involving placement of the child in the home of the family who is identified in the concurrent plan) can be created.
- ⌋ In the case of youth 16 and older who reside in out-of-home care, a Transitional Independent Living Plan (TILP) can be created

EFFECTIVE

Immediately following the agency/local office training.

OVERVIEW

Pursuant to the Adoption and Safe Families Act of 1997 (ASFA), P.L. 105-89, local Department of Human Services (DHS) offices and private agencies must develop a dual permanency plan for a child as early in the case as possible, when the goal is reunification. This process, known as “concurrent permanency planning,” requires foster care staff to provide reasonable efforts for reunification while at the same time developing an alternate permanency plan for the child if reunification efforts fail. Permanency planning must begin at the time of removal by Children’s Protective Services (CPS) and the first foster care placement of the child. If reunification is not possible, the identified alternative permanency plan must be implemented to ensure timely permanency for the child.

FEDERAL LAWS

Public Law 105-89

The Adoption and Safe Families Act of 1997 amended Titles IV-B and IV-E of the Social Security Act to clearly establish the national goals for children in the child welfare system: safety, permanency, and child well-being. The law reaffirmed the importance of making reasonable efforts to preserve and reunify families but also specified when efforts are not required if so doing jeopardizes a child’s safety. The act includes:

- A requirement for criminal history record checks for prospective foster and adoptive parents.
- A prohibition on placement of children with foster or adoptive parents convicted of certain felonies.
- A requirement for documentation of efforts to place a child in adoption or other permanent home when the permanency plan is adoption.
- A requirement for states to file a petition to terminate parental rights and concurrently identify, recruit, process, and approve a qualified adoptive family for an abandoned infant, for a child assaulted by a parent, or a child whose parent killed or assaulted another child, and for a child in foster care for 15 of the most recent 22 months, unless a compelling reason exists (see CFF 722-7, Foster Care-Permanency Planning).
- A requirement that states use cross-jurisdictional resources to facilitate timely adoptive placements, with financial

penalties for states and agencies that deny or delay an adoption when an approved family was available outside the jurisdiction, the approved family was denied an opportunity for a fair hearing, or the request for a fair hearing was not acted upon with reasonable promptness.

- A requirement that states provide health care coverage for non-Title IV-E eligible children with special health care needs.
- Authorization for continued eligibility for Title IV-E adoption subsidy payments when the adoption disrupts or both parents die.

Public Law 110-351

The Fostering Connections to Success and Increasing Adoptions Act of 2008 amended Titles IV-B and IV-E of the Social Security Act to connect and support relative caregivers, improve outcomes for children in foster care, provide for tribal foster care and adoption access, improve incentives for adoption, and for other purposes. The act includes:

- A requirement that states shall exercise due diligence to identify and provide notice to all adult grandparents and other adult relatives of the child, including any other adult relatives suggested by the parent(s), with exceptions to this notification for family or domestic violence.
- A requirement that the notice be made no later than 30 days after the removal of a child from home.
- A requirement that the notification must specify that the child has been or is being removed.
- A requirement that the notification explains the options the relative has under federal, state, and local law to participate in the care and placement of the child, including any options that may be lost by failing to respond to the notice.
- A requirement to explain how to become a foster family home and the additional services and supports that are available.
- A requirement to explain kinship guardianship assistance to relative guardians and how to receive financial payments.

STATE LAWS

2008 PA 202

Juvenile Code

2008 PA 202, effective July 11, 2008, amended MCL 712A.19. The act states:

- Reasonable efforts to finalize an alternate permanency plan may be made concurrently with reasonable efforts to reunify the child with the family.
- Reasonable efforts to place a child for adoption or with a legal guardian, including identifying appropriate in-state or out-of-state options, may be made concurrently with reasonable efforts to reunify the child and family.

PROGRAM PHILOSOPHY

Concurrent Permanency Planning (CPP) emphasizes family reunification, while at the same time engaging the family actively in on-going case planning and decision making, including helping to identify an alternative permanency plan for the child if the child cannot return home. CPP stresses finding a safe permanent home for the child as soon as possible by defining a successful outcome as achieving timely permanency for a child.

The primary goals and outcomes of CPP are:

- Provide for and support the safety and well-being of the child and family.
- Minimize the number of child replacements.
- Decrease the length of time spent in foster care.
- Timely legal permanency for children.
- Maintain continuity in attachment relationships for children.
- Decrease experience of traumatic loss for children.

Achievement of the above outcomes requires:

- Coordination and collaboration between CPS, FC and Adoption workers.
- Timely and accurate family assessments, which identify family strengths and primary barriers that necessitated out of home placement.

- Providing services to parent(s) as soon as the child enters foster care.
- Establishing two permanency plans for the child, referred to as Plan A and Plan B, as early as possible.
- Early diligent searches for absent parents and relative/non-relative caregivers for support, placement and/or maintaining established relationships.
- Use of foster families and relative caregivers as a source of support for parents and children.
- Family team meetings held throughout the life of the case, until permanency is achieved for the child.
- Full disclosure early on and throughout the case planning process.
- Caseworkers carefully document all information regarding the case in the case record.
- Reasonable efforts towards reunification with the birth family are well documented in the case file.
- In cases where Native American children are in care “active efforts” must be provided.
- Parents complete **and** demonstrate gained benefit from the services provided that rectify the conditions that caused the child’s out of home placement.
- The caseworker and the birth parents have a clear understanding of what is necessary for reunification to occur as outlined on the written Parent-Agency Treatment Plan. .
- An emphasis on frequent visitation with the birth family and the child in the most family-like setting.

DEFINITIONS OF TERMS

Family Team Meeting

Teaming process utilized to partner with the family, child, caregivers and other team members to develop the case service plan. The Family Team Meeting (FTM) is a strength based approach that utilizes a collaborative approach to address family and child concerns.

Frontloading Services

Foster Care (FC) worker makes appropriate service referrals for the family as soon as possible after the child enters foster care, but no later than 30 days after the initial placement. Parents should be encouraged to participate in services. However, parental compliance with service plan is voluntary until court disposition unless the court orders otherwise [*MCL 712A.13a(8)(c)*]. Declining to participate, prior to the dispositional

hearing, will not be determined as failure to comply with the supervising agency FOM 722-6.

Full Disclosure

The process of being open and honest with all parties (birth family, foster family, attorneys, etc.) about the concurrent permanency planning process. All parties are informed that there will be an *alternative* permanency plan for the child if the child can not safely return home within a reasonable amount of time. The birth parents must clearly understand what is required in order for the child to safely return home. They must also understand that if they do not meet the expectations required in a reasonable time frame, the agency will make a recommendation to the court to implement the alternative permanency plan.

Plan A and Plan B

When a child is placed in foster care and it is determined that concurrent permanency planning criteria are met then two permanency plans for the child are developed. Plan A is *reunification*. Plan B is the *alternative permanency plan* for the child. Plan B must be one of the following federally approved permanency goals in order of preference: adoption, guardianship, permanent placement with a fit and willing relative, or another planned permanent living arrangement (APPLA). The use of APPLA is outlined in FOM 722-7. The FC worker develops Plan B with input from the parent(s)/legal guardian(s), foster parent(s)/caregiver(s) and child (when appropriate). However Plan B is not fully implemented until the court has ruled that reunification is no longer a viable option.

Relative Diligent Search

Child Welfare staff must complete a diligent search for relatives or non-relatives for child(ren) in foster care. Specific guidelines for relative search requirements are outlined in FOM 722-6 and PSM 715-2. The relative search must be initiated by the CPS worker upon removal. The FC worker must continue quarterly search and engagement efforts until the child obtains legal permanency.

Foster Parents

Licensed non-related or related foster parents, relative caregivers or other placement adults responsible for the care, safety and well-being of children in foster care. Foster families are relative or non-relative licensed foster homes that actively support reunification efforts and also commit to providing permanency for the child if the child is not able to be reunified with the child's birth family. Foster families meet a child's need for continuity in attachment relationships by supporting safe, ongoing relationships between the child and important adults including birth parents, relatives and non-related significant relationships. Foster parents are considered to be part of the case planning team for the child. Some common roles of the foster family would be to:

- Attend family team meetings (FTMs).
- Attend court hearings.
- Help facilitate parenting time visits.
- Help facilitate sibling visits.

- Mentor birth parent(s).

CRITERIA FOR CONCURRENT PERMANENCY PLANNING

All cases transferred from CPS to FC that have a court approved permanency planning goal of “reunification” will be designated as a Concurrent Permanency Planning case. In situations where a case transferred from CPS to FC involves the filing or the intention to file a mandatory petition to terminate parental rights the case will continue to be designated as a Concurrent Permanency Planning case until the court issues an order that discontinues reunification efforts. Concurrent Permanency Planning policy only applies to cases in which the court approved permanency planning goal is “reunification”.

CONCURRENT GOAL(PLAN B)

The FC worker is required to engage the family in the development of the concurrent goal. This includes, but is not limited to allowing them input regarding who their child will be residing with, transitional planning and services provided to their children. The FC worker must introduce the process of concurrent permanency planning to the family as early as possible, but no later than the first Case Planning FTM. A specific concurrent goal must be identified no later than 120 days from initial out of home placement. In the event that the worker and family are unable to identify a specific placement caregiver for Plan B, and/or the current caregivers are unwilling to provide permanence for the child, the worker must clearly document all efforts to develop a concurrent goal. A specific concurrent goal consists of: a specifically identified caregiver, a federally approved permanency goal (adoption, guardianship, permanent placement with a fit willing relative and another planned permanency living arrangement – APPLA).

RELATIVE DILIGENT SEARCH

Children’s Protective Services Worker

Every effort must be made to place the child with relatives who will meet the child’s needs. If no appropriate relative is available as a placement, a non-relative foster family should be identified for the child. (See PSM 715-2 regarding relative engagement and placement).

CPS must begin the relative search prior to transferring the case to foster care. The CPS worker must at minimum ask the parents and age appropriate children to identify the following relatives:

- Maternal and paternal grandparents.
- Maternal and paternal aunts.
- Maternal and paternal uncles.
- Adult siblings of the child.
- Any additional relatives the parent identifies.

Relative names, addresses and phone numbers must be obtained. The CPS worker must send the following to any relatives that the parents and children identify:

- Relative Notification, DHS-990.
- Relative Response, DHS-989.
- Relative Search Information, DHS-988.

If CPS receives responses from the relatives via the Relative Response form, DHS-989 and Relative Search Information form, DHS-988 or any other form of contact, such as telephone calls, CPS must forward the forms and any additional information to all workers assigned to the case, including public or private agency foster care workers and adoption workers, within three business days of receipt of information. CPS must document its findings of the relative search on the Relative Documentation form, DHS-987 and forward a copy of the Relative Documentation form, DHS-987 to the assigned foster care worker.

Copies of the Relative Notification form, DHS-990, Relative Response form, DHS-989, Relative Search Information form, DHS-988, and Relative Documentation form, DHS-987 must be filed in the case record. (See PSM 715-2.)

Foster Care Worker

FC worker is required to complete the following:

- Place copies of the Relative Notification form, DHS-990, Relative Response form, DHS-989, Relative Search Information form, DHS-988, and Relative Documentation form, DHS-987 completed by the CPS worker in the foster care case record.
- Within five business days of receipt of a Relative Response form, DHS-989, contact all relatives expressing an interest in having any contact with the child to discuss at what level the relative could be involved in the child's life.
- Within five business days of receipt of a Relative Search Information form, DHS-988 or if the worker has been informed of additional relatives through any other means of communication, such as telephone calls, the following forms must be sent to all additional relatives that have been identified:
 - Relative Notification, DHS-990.
 - Relative Response, DHS-989.
 - Relative Search Information, DHS-988.
- DHS staff must forward the forms and any additional information to all workers assigned to the case, including a public or private agency foster care worker

and adoption worker, within three business days of receipt of information.

- Place all Relative Notification, DHS-990, Relative Response, DHS-988 and Relative Search Information, DHS-989 forms in the case record.
- Document findings of the relative search on the Relative Documentation form, DHS-987 and update with new information quarterly.
- Forward copies of the Relative Documentation form, DHS-987 to all workers assigned to the case, including the public or private agency foster care worker and adoption worker.
- Relative search efforts shall be completed utilizing applicable relative search forms at a minimum of once per quarter until legal permanency for the child has been achieved. This must be documented in the “Social Work” Contacts section of all case service plans..
- When incomplete information about a potential relative is received the assigned worker must utilize the DHS-991 Diligent Search Checklist form to complete a relative search.
- Within 90 days of initial placement the Foster Care Placement Decision Notice DHS- 31 must be completed and sent to all relevant parties including relatives interested who expressed an interest in have the child placed with them (see FOM 722-3).

FAMILY TEAM MEETINGS

Family Team Meetings (FTMs) help facilitate family engagement and sharing in the case planning process. The process of Concurrent Permanency Planning must be introduced at the earliest possible moment in situations where out of home placement is being considered or has occurred, but no later than the first FC case planning FTM. All discussions and/or plans regarding CPP must be documented in the narrative section of the FTM activity report. A specific concurrent planning goal must be identified as early as possible following a child’s initial out of home placement, but no later than 120 days from that date. The appropriateness of the concurrent plan should be discussed at each subsequent FTM meeting until a child returns home or the court has ruled that reunification is no longer the permanency planning goal. Refer to the Family Team

Meeting Protocol for guidelines (In the MiTEAM handbook) as to how and when FTMs are to be conducted.

CHILDREN'S PROTECTIVE SERVICES (CPS) PRIOR TO OR AT REMOVAL

The CPS worker must complete the following during an Family Team Meeting to comply with CPP requirements:

- Assist the family in identifying relatives and non-relatives in their natural support network that could potentially care for their child(ren) if needed, and facilitate a conversation with all parties to discuss the plan if there is a risk of out of home placement.
- Document the identified family support system in the Children's Protective Services Investigation Report DHS-154 and on the Risk Assessment.
- Conduct an FTM for all court ordered out of home placements. The FTM must be held within 7 business days of the preliminary hearing. The FTM may also be held up to 24 hours before the preliminary hearing.
- In situations where out of home placement is being considered confer with FC staff as to whether or not they should attend the FTM.
- Place a completed FTM Activity Report detailing any court recommendations and case planning decisions from the meeting in the case record.
- Inquire if the parent(s) or child(ren) are Native American (PSM 716-1; See NAA 100-615 for procedures regarding Native American families/children).
- Begin a diligent search for absent parents, utilizing the Absent Parent Protocol (PSM-715-2).
- Complete a diligent search for relatives or unrelated caregivers for potential placement, support and for purposes of maintain established relationships (Refer to PSM 715-2).

- The first placement for the child should be viewed as the potential permanent placement, should reunification not occur. The child's needs must be matched with the prospective placement(s) available. The importance of providing the child with permanency must be discussed with the caregiver and the negative effects that can occur when a child does not obtain permanency.
- Coordinate the case transfer to FC. If possible FC worker should attend out of home placement FTM or CPS worker should plan on attending initial FC case planning FTM. The CPS worker must review the family history with the FC worker and inform him or her of any outstanding tasks that need to be completed so that there is not a lapse in service to the family during the case transfer. Documentation of the case conference must be included in the Initial Service Plan under the Legal Status-reasons children entered care section and in the case contacts.

FOSTER CARE

Foster care workers must ensure that plans for reunification and an alternate goal are developed and reviewed at all applicable FTM meetings. Guidelines for specific topics and needs to cover at each FTM meeting are outlined in the FTM protocol. As noted in the above section consideration by FC staff to participate in CPS team meetings should be considered based on the needs of the family and local office procedures related to CPS to FC case transfer procedures.

The FC worker must conduct an FTM meeting for the following case activities:

- Case planning prior to every ISP/USP.
- All child placement changes (planned or unplanned).
- Mental health hospitalizations.
- A child returns from AWOLP.
- Reunification.
- Child in care 6 months and reunification is unlikely within 12 months based on current parental progress.
- Case closure.
- Permanency goal change.
- 16+ Annual Transition Meeting. *
- 90 Discharge (youth 18 and older). *

*These FTMs cannot be facilitated by the child's assigned caseworker.

***Case Planning
Family Team Meeting***

The FC worker must conduct a case planning Family Team Meeting with the family within 30 days from the initial removal date and every quarter prior to completion of USPs. The purpose of this meeting is to develop and review case plans with the family for reunification and concurrent planning. This meeting may be combined with the two face-to-face visits required with the parent(s) per policy FOM 722-6.

The case planning FTM must involve the following:

- A thorough discussion with parents, youth, relatives and foster parents regarding the CPP process and planning requirements.
- A reunification plan that identifies intensive services with measured outcomes and an expected timeline for behavioral change to be documented in the Parent-Agency Treatment Plan, DHS-67 (PATP).
- Clearly written PATP with measurable outcomes that have a direct connection to the family's needs/reasons that necessitated the removal that is developed in conjunction with the parent(s).
- Parent(s) must be provided with a copy of the PATP within 30 days of the removal date. The parent(s) and youth over the age of 14 must be asked to sign the PATP. A signed copy of the PATP must be retained in the case record. If the parent(s) or child are unwilling to sign the PATP, that must be documented in the PATP.
- Foster parent(s)/caregiver(s) must request **in writing** copies of case plans. See SRM 131 for guidelines regarding release of written reports to foster parents.
- Development of the concurrent plan for the child, referred to as "Plan A and Plan B." The plans are to describe the reunification plan and identify an alternative permanency plan for the child should the plan for reunification be unsuccessful.

- The alternative permanency plan specifically identifies with whom the child will be placed should reunification not occur.
- If the child is currently placed in a home other than the alternative permanent placement identified in the Case Planning Family Team Meeting, a discussion must take place regarding the best interest of moving the child to the alternative permanent placement identified. See FOM 722-3 for placement/replacement policy.
 - If determined that the change of placement may be in the child's best interest, a written plan to transition the child to the new placement must be developed in an FTM.
 - If determined that the replacement is not currently in the child's best interest, a written plan with specific indicators when the change of placement will be reconsidered must be developed.
 - Transition plans must specifically identify: approximate date the child will move, how the relationship with the identified permanent family will be maintained through visitation, phone calls, etc. until the child is moved. The transition plan must be clearly documented in the ISP/USP/PATP.

Full Disclosure

Ensure full disclosure with the family by:

- Ensuring open and genuine communication on all aspects of the foster care case.
- Engaging parents in the development of the permanency plan by promoting early permanency through reunification as the primary goal and most preferred outcome.
- Explaining to parent(s) the importance of obtaining permanency quickly for the child.

- Explaining negative impacts of out-of-home placement on children, parental rights and responsibilities, available DHS assistance, and consequences for actions.
- Developing a permanency plan for the child with all relevant parties involved (i.e., parents, relatives, caseworkers, attorneys, etc.)
- Ensuring parent(s) understand time limits to achieve objectives (i.e., 12-month permanency plan achieved and 15/22 Rule).
- Providing regular progress updates on the PATP, acknowledging strengths, and addressing continued safety concerns.
- Obtaining additional information to complete a relative search or absent parent search.

Service Referral

During the family assessment for the ISP, identify services needed and make appropriate referrals for the family. Service referrals must occur as soon as possible, but no later than 30 days after the initial placement date.

- If the service provider is unable to immediately provide the service, document in the service plan that the service is unavailable and identify the date that the service will become available.
- If the service is unavailable for more than 30 days, determine if other service providers offer the same or similar service required and make a referral. If it's determined that there is no secondary service provider available, document that in the service plan.

Parenting Time

Visits (FOM 722-8C)

Review and discuss parent/child visitation plan and ensure visitation is occurring in the most family-like setting. Explore options of who is able to safely supervise parenting time visits if visits must be supervised. A relative, foster family, or contracted provider could potentially supervise some visits to allow more frequent parenting time. Any barriers to visiting must be clearly documented in the service plans and discussed with

the birth family and supervisor. Frequency of visits should correlate with the child's age and sense of time. If the goal is reunification, and unless otherwise ordered by the court, visits must occur as follows:

- For a newborn infant to age two, visits occur, at a minimum, three times per week.
- For children ages three to five, visits occur, at a minimum, twice a week.
- Children six and older, visits occur, at a minimum, once a week.
- Frequent visits above the minimum guidelines should always be explored when appropriate.
- Must take place in the least restrictive and most family-like setting.
- Supervised visits should take place only when necessary. The specific factors requiring supervised visits must be documented in the service plan. The service plan must outline specifically what is required of the parent(s) in order to achieve unsupervised visits. When the parent(s) has met the outlined requirements in the service plan for unsupervised visits, the worker must pursue this without delay. (FOM 722-8C)
- If visits are not occurring as outlined above, document in the service plan the barriers present that are preventing more frequent visits and how those barriers are being addressed.

Complete the written visitation agreement, involving the foster family, parents, child (if age appropriate) and relatives (if applicable) in the development of the plan. Well planned visits must be arranged to facilitate meaningful parent/child interaction and allow the development of a relationship between the biological family and the foster family. The assigned caseworker is required to observe parent and child visits at a minimum of once a month to assess parenting skills and attachment between the parent and child, even if visits are unsupervised.

FAMILY ASSESSMENT OF NEEDS/STRENGTHS

In completion of the SDM-Parents Needs and Strengths, ISP, and USP, special attention must be paid to common poor prognosis indicators that have been known to potentially reduce the likelihood of reunification. Some examples are:

- Parent previously killed or seriously injured another child.
- Parent has repeatedly and with premeditation harmed a child.
- Parent's main support system is that of a drug culture, with no effort to change over time.
- Parent has significant and untreated mental health issues.
- Parent's rights have been involuntarily terminated to another child.

If one or more of these risk factors are present, at the **first** refused or poor overall barrier reduction or unsafe safety assessment, the caseworker must discuss with the family a consideration for making a recommendation to the court to change the permanency goal at the next case planning Family Team Meeting. The outcome of the FTM must be documented in the service plan and the FTM Activity report.

FIRST AND SUBSEQUENT USP REPORTING PERIODS (FOM 722-3, 722-8A, 722-8B, 722-8C, and 722-9)

Court Reports The FC worker must submit copies of the service plans to the local court prior to all hearing dates. The number of days prior to the hearing that reports are required to be submitted are determined by each local court. The local court should be contacted to determine how many days in advance reports are required.

The FC worker must continue assessing progress with reunification:

- If *partial or substantial progress* toward reunification has been made, a Reunification FTM must be scheduled to discuss the child returning home. All safety risks to the child(ren), existing barriers to reunification and review of the visitation plan to determine if visits can be changed to unsupervised or overnight visits must be addressed during the FTM. The outcome of FTM must be documented on the FTM Activity report.

- If there has been *refused or poor progress* towards reunification the Case Planning FTM must include a discussion of a recommendation for a goal change to the identified alternative permanency plan, referred to as “*Plan B.*” The meeting outcomes must be documented on the FTM Activity report. If the outcome of the meeting is that a goal change recommendation is warranted, the worker must document the recommendation in the “Recommended Court Orders” section of the USP. If the child is currently placed in a home other than the identified alternative permanent placement, a discussion must take place during the FTM regarding the best interest of moving the child to the identified Plan B caregiver. If it is agreed that the child should not move at this time, a timeframe must be identified as to when the child will be moved. In addition, it must be determined how the relationship with the identified Plan B caregiver will be maintained through visitation, phone calls, etc. The transition plan must be clearly documented in the ISP/USP/PATP. (FOM 722-9 and FOM 722-3).
- SDM Permanency Planning Decision Tree Guidelines must be utilized regarding goal changes for CPP cases. Any time a discretionary override is made the FC worker must obtain supervisory approval and clearly document the rationale in the service plan. FOM 722-9A.
- *Voluntary termination* of parent rights should be explored with the birth family as a potential option. Otherwise, initiate a petition for *involuntary termination of parental rights* within 14 days of the decision that the child’s goal is changed to the concurrent goal.
- Within 14 days of the filing of a petition to terminate parental rights the FC worker must make a referral to adoption. The adoption agency has 7 business days to accept the adoption case and three business days to assign and adoption worker. The adoption worker must coordinate with the foster care worker to ensure timely progress towards adoption. The adoption worker shall take appropriate steps to obtain consent to adoption, if not already obtained in the CPP process.
- At the time the petition requesting *involuntary termination of parental rights* is filed or if the parents have agreed to a

voluntary termination and the child(ren) are not already placed in the home of the identified alternative permanent placement, know as “*Plan B*,” they shall be placed in that home within 30 days. Any exception to this must be documented in the file as to why it’s not in the child’s best interest and requires supervisory approval. FOM 722-3 Placement/Replacement.

MiTEAM Assessment

Job Aid

Components of Family/Child Assessments:

The ability to acquire accurate information about significant events and underlying causes that trigger a child and family's need for child welfare related services. The assessment process is not a point in time evaluation, but rather a dynamic process that begins at initial agency contact with the family and continues throughout the duration of the case. Effective assessments are comprehensive in nature and require substantial family engagement efforts on the part of the agency.

Skills of Assessing:

- Demonstrate a clear understanding of strengths and needs of the parent and child;
- Appreciate the "expertise/authority" of the family;
- Recognize and evaluate patterns of behavior;
- Understand the correlation and differences between multiple need areas;
- Ensure open and genuine communication in all aspects of the child welfare case;
- Match services to needs, not needs to services;
- Document updated information regarding permanency;
- Discuss the needs of the child, including outcome of safety assessment, safety planning, and risk reduction;
- Actively discuss Department of Human Services (DHS) and Courts primary concerns and actions steps to address risk that lead to the DHS services;
- Express genuine curiosity: questions are open-ended, expansive, and leading toward an enlarged view of the person's capacity to create solutions;
- Use core engagement (empathy, respect, genuineness, competence) skills when gathering information;

Case Plan Development/Review:

The purpose of a comprehensive family assessment is to develop a service plan or strategy for intervention that addresses the major factors affecting a child's well-being, safety, and permanency over time. The plan is aimed to help the family identify all steps necessary for improved functioning that led them to utilize DHS services.

Skills of Case Plan Development:

- When establishing goals attribute all intent, plan, and strategies to the underlying needs, not to the identified individual;
- Identify realistic and measureable goal(s) that will assist the agency in helping the family obtain permanency for the child(ren);
- Action steps are clear, doable, and time limited.
- Allow the family to identify and address their needs;
- When services are not available or agreeable, discuss alternatives and implement a plan;
- Work to promote family connections to community entities, such as churches and schools;
- Provide regular updates to team members on status of assigned tasks;
- Refer, evaluate, and support service delivery;
- When needed develop a crisis intervention plan with the family;

MITEAM

Concurrent Permanency Planning

Job Aid

Concurrent Permanency Planning (Plan A and Plan B):

The process of working towards the permanency goal of reunification (**Plan A**) while at the same time planning an alternative permanency goal (**Plan B**), in the event that the permanency goal of reunification cannot be achieved.

Skills of planning with the family for an alternate permanency goal:

- Fully disclose with the team members (e.g. family, caregiver, GAL, attorneys) the process of Concurrent Permanency Planning.
- Engage parents in the development of the permanency goal(s) by promoting early permanency through reunification as the primary goal and most preferred outcome;
- Plan with the family and caregiver(s) to identify **Plan A** (reunification) and **Plan B** (adoption, guardianship, permanent placement with a fit and willing relative and another planned permanency living arrangement-APPLA);
- Ensure open and genuine communication on all aspects of the child welfare case;
- Explain to parent(s) the importance of obtaining permanency quickly for the child;
- Discuss parental rights and responsibilities.

Front Loading Services:

Appropriate service referrals for the family are made as soon as possible after the child enters foster care, but no later than 30 days after the initial placement. Parents should be encouraged to participate in services. However, parental compliance with service plan is voluntary until court disposition unless the court orders otherwise [*MCL 712A.13a(8)(c)*]. Declining to participate, prior to the dispositional hearing, will not be determined as failure to comply with the supervising agency FOM 722-6.

Tasks:

- Identify services appropriate for the family, child, and caregiver;
- Clearly address DHS's desired outcomes to support the goal of reunification with family and providers;
- Provide family with available community services and supports.

Diligent Relative Search:

Conducting a diligent search for relatives or non-relatives for child(ren) in foster care. The relative search is initiated by the CPS worker upon removal. The FC worker continues quarterly search and engagement efforts until the child obtains legal permanency. Specific guidelines for relative search requirements are outlined in PSM 715-2 and FOM 722-6.

Tasks:

- Ongoing completion of the Relative Search Forms (DHS-987 through DHS-991);
- Inquiries are made with the parent and child regarding the identification of relatives;
- Encourage the relatives to participate in all aspects of the case plan;

Visiting for Infants and Toddlers – 0-2 YEARS

What we know about the social/emotional development of this age range:

- ❑ Infants primary task is to attach to caregivers, which forms the basis for trust and all future relationships.
- ❑ For toddlers the primary task is to learn to see themselves as separate from their primary attachment figures, to begin to see themselves as a separate entity.
- ❑ For both infants and toddlers consistency and routine is most important.
- ❑ For both infants and toddlers nonverbal cues are extremely important.
- ❑ Infants and toddlers will have reactions to changes in their living situations, which need to be understood by their caregivers.
- ❑ Overlooking the needs of children in this age range during visits sets the stage for ongoing problems.

What to keep in mind when arranging visitation:

- ❑ Infants and toddlers need to have frequent contact with birth family to continue attachment – frequent shorter visits are best.
- ❑ Ideally the visits occur in an environment that is familiar to the child.
- ❑ Ideally the birth parent(s) would come into the home of the child's current caregiver to provide physical care for the child.
- ❑ If the environment is not familiar then the child needs to be surrounded by those things that are familiar – favorite blanket, toys, etc.
- ❑ The birth parent(s) need to be given the opportunity to provide for the child during the visit – feed, change, play with the child.
- ❑ The current caregiver needs to be the one to physically take the child to the visit so that they can hand over the child to the birth parent(s) which gives the child non-verbal permission to be with the birth parent(s).
- ❑ In the early stage of visits, the current caregiver would ideally be available to ask and answer questions about the child's care, reactions, schedule etc.
- ❑ The number of "outside" people that interact with the child during the visit needs to be kept to a minimum so as not to over stimulate or confuse the child.

Adapted from material by Vera Fahlberg: A Child's Journey Through Placement

Visiting for Infants and Toddlers – 0-2 YEARS

What caregivers need to be prepared for during and following visits:

- ❑ Typical reactions for infants and toddlers:
 - ❑ Confusion
 - ❑ Irritability and inability to soothe
 - ❑ Sadness
 - ❑ Poor eating and sleeping
 - ❑ Clingy behavior
 - ❑ Temper tantrums
 - ❑ Increased physical aggression
- ❑ Following the visits, the caregiver needs to verbalize for the child what they think the child may be feeling (even with infants this technique helps parents to empathize with the child.)
- ❑ Typical feelings for the birth family and caregiver during and following visits may include:
 - ❑ Feeling overwhelmed
 - ❑ Resentful of the child's behaviors
 - ❑ Feeling rejected by the child
 - ❑ Emotionally distancing themselves from the child
 - ❑ Fearing getting too close lest they lose the child
- ❑ It is important to give the current caregiver permission to get close to the child, as well as encouragement and praise for the work they put in to making the visit go well.
- ❑ It is important to support the birth parent during and following visits to maintain emotional connection with the child, though they may want to pull back to protect from possible loss.

Visiting for Preschoolers – 3 – 5 Year Olds

What we know about the social/emotional development of this age range:

- ❑ The major social development task of the preschool child is making sense of the world outside of their immediate family.
- ❑ Preschoolers use magical and egocentric thinking which can cause them great confusion if adults are not aware of what is happening.
- ❑ In order to make sense of their world they ask the same questions over and over.
- ❑ Overlooking the needs of children in this age range during visits sets the stage for ongoing problems.

What to keep in mind when arranging visitation:

- ❑ This age range needs to be prepared for visits – but not too far in advance.
- ❑ Caregivers need to talk about going to visit: going in the car, going to the agency; who they will be seeing; reassurance that the caregiver will be there.
- ❑ Caregivers will need to help the child verbalize their feelings.
- ❑ Caregivers may have to tell the child the same thing over and over again and answer repeated questions.
- ❑ Caregivers and birth parent(s) need to be prepared for physical/verbal acting out by the child before and on the day of a visit.
- ❑ Preschoolers need visits to be shorter, but more intense.
- ❑ Favorite toys or attachment objects need to go with the child on visits.
- ❑ Physical and verbal permission by the caregiver to go to the birth parent(s) may be needed.
- ❑ In the early stage of visits, the current caregiver would ideally be available to ask and answer questions about the child's care, reactions, schedule etc.

What caregivers need to be prepared for during and following visits:

- ❑ Typical reactions for preschooler:
 - ❑ Confusion/not wanting to leave the visit
 - ❑ Irritability and inability to self soothe
 - ❑ Sadness

Adapted from material by Vera Fahlberg: A Child's Journey Through Placement

Visiting for Preschoolers – 3 – 5 Year Olds

- ❑ Poor eating and sleeping
- ❑ Temper tantrums
- ❑ Clingy behavior
- ❑ Increased verbal and physical aggression
- ❑ Verbalizations of anger/hate toward the birth parent and/or the current caregiver

- ❑ Allow and encourage the child to ask questions about the visit.
- ❑ Give the child permission to express feelings of sadness; anger; confusion.
- ❑ Typical feelings for the birth family and current caregiver following visits may include:
 - ❑ Feeling overwhelmed
 - ❑ Resentful of the child's behaviors
 - ❑ Feeling rejected by the child
 - ❑ Emotionally distancing themselves from the child
 - ❑ Fearing getting too close lest they lose the child

- ❑ It is important to give the current caregiver permission to get close to the child, as well as encouragement and praise for the work they put in to making the visit go well.

- ❑ It is important to support the birth parent during and following visits to maintain emotional connection with the child, though they may want to pull back to protect from possible loss.

What we know about the social/emotional development of this age range:

School age:

- ❑ There is a large range of development for school age children and much of it is centered around learning vast amounts of information about the world and interpersonal relationships.
- ❑ Young school age children most want to please adults.
- ❑ Young school age have a hard time talking about feelings.
- ❑ Middle school age children can be absent minded and deep in thought.

Adolescents:

- ❑ The job of adolescents is to differentiate from the adults in their lives so that they can come to terms with the world as individuals.
- ❑ Sensitivity to criticism and being different are key elements in the adolescents development though they are often critical of adults
- ❑ Due to all of the changes they are experiencing, adolescents focus most of their energy inward and toward peers.

What to keep in mind when arranging visitation:

- ❑ School age children and adolescents can maintain their attachments in the absence of physical contact, therefore, visits do not need to be as frequent as for younger children.
- ❑ Phone calls, emails, text messages can all serve as ways for this age range to keep in contact between visits.
- ❑ School age children and adolescents need face to face contact with birth parents to relieve their anxiety, maintain connections and be reassured of their parent(s) commitment to them.

School age:

- ❑ This age does best when they can feel confident that the adults in their lives are in control and have their best interest at heart.
- ❑ They also like to know what to expect and having dates marked on a calendar when visits will occur so that they can “see” when they will be with their birth family is helpful.
- ❑ School age children may need permission and help to verbalize feelings especially if they think adults may want them to respond in a certain way.

Adapted from material by Vera Fahlberg: A Child’s Journey Through Placement

- ❑ They need reassurance that adults are in control.
- ❑ May verbalize or act out wanting to visit more or not wanting to go to a planned visit.

Adolescents:

- ❑ This age range needs as much information and control about the visitation process as possible.
- ❑ Adolescents might verbalize the thought that they are too busy, or do not want to visit as planned.
- ❑ Avoiding overt power struggles over visitation is of paramount importance.
- ❑ Despite the fact that adolescents often need help to work through feelings, adults will want to take a more passive approach, by being in the moment with the adolescent and allowing him/her to take the lead in sharing or not sharing thoughts and feelings.

What birth family and caregivers need to be prepared for following visits:

- ❑ Both school age and adolescents may verbalize negativity or act out following visits, which can occur at home or in the school setting.
- ❑ Adults need to be aware of how the child/youth reacts to visits, but not to assume that the behavior or verbalization means that the visits are not a good thing for the child/youth.
- ❑ Adults need to be supportive of the child/youth following visits, while reinforcing the rules and expectations about behavior.
- ❑ Adults need to work not to personalize what the child/youth says or does following visits.
- ❑ Child welfare workers may need to be more available, especially to teens who may not feel comfortable talking with care givers about how they are feeling.

RESOURCE SECTION

Michigan Mission, Vision and Principles

DHS Mission

DHS assists children, families, and vulnerable adults to be safe, stable and self-supporting.

Michigan's Child Welfare Mission

The State of Michigan is committed to ensuring that economic, health and social services are available and accessible to vulnerable families, children and youth.

Services are designed to:

- Strengthen families and help parents create safe, nurturing environments for their children.
- Reduce child maltreatment, abandonment, neglect, preventable illness, delinquency, homelessness, and other risks to a child's development and well-being.
- Strengthen economic security, promote strong nurturing parenting and improve access to health care and safe housing.

DHS Vision

We will:

- Reduce poverty.
- Help all children have a great start in life.
- Help all clients achieve their full potential.

Principles

Michigan achieves its mission and vision through the following guiding principles:

SAFETY

Our first priority is to keep children safe. We recognize that parents (or other legal guardians) have primary responsibility for keeping their own children safe, but when they cannot or do not, we have been entrusted with the authority to intervene on behalf of the child.

CHILDREN'S NEEDS

Children must have a voice in decisions that affect them. We must consider the specific needs of each child as we make decisions on his or her behalf. Those decisions must reflect consideration of community, ethnic, and cultural values, and be free of bias.

FAMILIES' NEEDS

We must treat families with dignity and respect, recognize and value their ethnic and cultural traditions, and actively include them in decisions that affect them and their children. We must help families identify and use their existing strengths and we must consider family safety as we determine the intervention plan for a child. We must ensure that birth and adoptive families have access to at least the same level resources and services as those available to foster parents.

Michigan Mission, Vision and Principles

COMMUNITIES

We must actively partner with communities to protect children and support families. We must take into consideration community safety issues as we determine the intervention plan for a child and family.

PLACEMENT

The ideal place for children is in their own home with their own family. When we cannot ensure their safety in the family home we must place siblings together whenever possible and place them in the most family-like and least restrictive setting required to meet their unique needs, and we must strive to make the first placement the best and only placement. We must first consider placement with the non-custodial parent or extended family (maternal or paternal relatives, or appropriate non-relatives known and trusted by the child); if that is not possible or appropriate, we must strive to place the child with a foster or adoptive family so the child can stay in his or her school and maintain relationships with friends and family. When it is not possible or appropriate to place the child with siblings or relatives, we must make every effort to ensure that those relationships are maintained and fostered.

REUNIFICATION AND PERMANENCE

We must reunify children with their siblings and families as soon as safely possible. When reunification is not possible, we must provide children with a permanent home and/or a permanent connection with caring, supportive adults as soon as possible. We must also ensure that children under our care are connected with the resources necessary for physical and mental health, education, financial literacy, and employment; and that they acquire the life skills necessary to become successful adults.

SERVICES

When we intervene on behalf of children we must strive to leave children and families better off than if there had been no intervention. We must tailor services to meet the unique needs of each family member, and provide those services in a manner that is respectful of the child and family. Services should be outcome based, data-driven and continuously evaluated.

**Modified Settlement Agreement:
G. Caseworker Contacts and Visits**

Policy:

(FC) FOM 722-6

(CPS) PSM 713-3

G. Caseworker Contacts and Visits

1. The provisions of this section shall apply to all children in DHS foster care custody, including those children placed through private CPAs.
2. *Worker-Child Contacts:* By October 2011, each child in foster care shall be visited by the assigned foster care case manager at least two times during the child's first month of placement, and at least one time per month thereafter. At least one visit each month shall take place at the child's placement location and shall include a private meeting between the child and the case manager. By October 2012, the requirement of two visits per month shall apply for the first two months following an initial placement or a placement move.
1. *Worker-Parent Visits:* For each child in foster care with a permanency goal of reunification, the child's caseworker shall have face-to face contacts with the child's parent(s) as follows: (a) for the first month the child is in care, two face-to-face contacts with each parent, at least one of which must occur in the home; (b) for each subsequent month, at least one face-to-face contact with each parent and phone contact as needed, with at least one contact in each three-month period occurring in the parent's place of residence.
4. *Parent-Child Visits:* DHS shall take all reasonable steps to assure that children in foster care with a goal of reunification shall have at least twice-monthly visitation with their parents. Reasonable exceptions to this requirement shall include cases in which: (a) a court orders less frequent visits; (b) the parents are not attending visits despite DHS taking adequate steps to ensure the parents' ability to visit; (c) one or both parents cannot attend the visits due to exigent circumstances such as hospitalization or incarceration; or (d) the child is above the age of 16 and refuses such visits. All exceptions, and all reasonable steps to assure that visits take place, shall be documented in the case file. If such exceptions exist, DHS shall review the appropriateness of the child's permanency goal.
5. *Sibling Visits:* DHS shall take all reasonable steps to assure that children in foster care who have siblings in custody with whom they are not placed shall have at least monthly visits with their siblings who are placed elsewhere in DHS foster care custody. Reasonable exceptions to this requirement shall include cases in which: (a) the visit may be harmful to one or more of the siblings; (b) the sibling is placed out of state in

**Modified Settlement Agreement:
G. Caseworker Contacts and Visits**

compliance with the Interstate Compact on Placement of Children; (c) the distance between the children's placements is more than 50 miles and the child is placed with a relative; or (d) one of the siblings is above the age of 16 and refuses such visits. All exceptions, and all reasonable steps taken to assure that visits take place, shall be documented in the case file.

**Modified Settlement Agreement:
B. Provision of Health Services**

Policy:

FOM 722-6

B. Provision of Health Services

1. *Health Services Plan*: By September 30, 2011, DHS shall submit to the Monitors a detailed Health Services Plan, which shall set forth the specific action steps DHS shall implement in order to ensure that each child entering foster care receives medical, dental, and mental health services as described in Section VIII(B)(2). The Health Services Plan shall be subject to the approval of the Monitors. DHS shall implement the plan after the Monitors' approval.

2. *Medical, Dental, and Mental Health Services*: DHS shall take all necessary and appropriate steps to ensure that each child entering foster care receives each of the following:
 - a. Any needed emergency medical, dental, and mental health care.
 - b. A full medical examination and screening for potential mental health issues within 30 days of the child's entry into care and a referral for a prompt further assessment by an appropriate mental health professional for any child with identified mental health needs. DHS shall implement this provision as follows:
 - i. By December 31, 2011, 75% of children shall have the initial medical and mental health examination within 45 days of the child's entry into foster care.
 - ii. By June 30, 2012, 95% of children shall have the initial medical and mental health examination within 45 days of the child's entry into foster care.
 - iii. By December 31, 2012, 75% of children shall have the initial medical and mental health examination within 30 days of the child's entry into foster care.
 - iv. By June 30, 2013 and thereafter, 95% of children shall have the initial medical and mental health examination within 30 days of the child's entry into foster care.
 - c. An initial dental examination within 90 days of the child's entry into care unless the child has had an exam within six months prior to placement or the child is less than four years of age. DHS shall implement this provision as follows:
 - i. By December 31, 2011, 40% of children shall have a dental examination within 90 days of the child's entry into foster care.
 - ii. By June 30, 2012, 60% of children shall have a dental examination within 90 days of the child's entry into foster care.
 - iii. By September 30, 2012, 80% of children shall have a dental examination within 90 days of the child's entry into foster care.
 - iv. By June 30, 2013, and thereafter, 95% of children shall have a dental examination within 90 days of the child's entry into foster care.
 - d. All required immunizations, as defined by the American Academy of Pediatrics, at the appropriate age.
 - e. Periodic and ongoing medical, dental, and mental health care examinations and screenings, according to the guidelines set forth by the American Academy of

**Modified Settlement Agreement:
B. Provision of Health Services**

Pediatrics. DHS shall implement this provision as follows:

- i. By December 31, 2011, the Monitors, in consultation with DHS, shall determine the baseline for periodic medical, dental, and mental health examinations and set an interim target to be met by September 30, 2012.
 - ii. By June 30, 2013, DHS shall ensure 80% of children have received periodic medical, dental and mental health care examinations.
 - iii. By December 31, 2013 and thereafter, DHS shall ensure 95% of children have received periodic medical, dental and mental health care examinations.
 - f. Any needed follow-up medical, dental, and mental health care as identified.
3. *Medical Files:* DHS shall maintain an up-to-date medical file for each child in care, including medical history information reasonably available to DHS.
- a. At the time a child is placed in a foster home or residential care facility, the foster care provider receives specific written information about the child's present health status and any present medical needs or health concerns, as well as any medical history of which DHS is aware, that is reasonably necessary for the foster care provider to responsibly care for the child.
 - i. By December 31, 2011, the Monitors, in consultation with DHS, shall determine the baseline for foster care providers receiving specific written health information about the child entering their care and set interim targets to be met by September 30, 2012 and June 30, 2013.
 - ii. The Monitors, in consultation with DHS, shall also set the final standard, which shall not be later than December 31, 2013, or less than 95%.
 - b. In maintaining medical records, DHS shall ensure that it is in compliance with MCL 722.954c(2) by preparing, updating, and providing medical passports to caregivers. In addition, DHS shall ensure that the medical passport, or some other DHS document inserted in each child's file, includes a complete and regularly updated statement of all medications prescribed to and given to the child. All such information shall be provided to all medical and mental health professionals to whom the child is referred and accepted for treatment, as well each foster care provider with whom a child is placed.
 - i. By December 31, 2011, the Monitors, in consultation with DHS, shall determine the baseline for foster care providers receiving specific written health information about the child in their care and set interim targets to be met by September 30, 2012 and June 30, 2013.
 - ii. The Monitors, in consultation with DHS, shall also set the final standard, which shall not be later than December 31, 2013, or less than 95%.

4. *Medical Care and Coverage:*

- a. Each child entering foster care shall be provided access to medical care immediately upon placement. The foster parent or other placement provider shall receive a Medicaid card, or an alternative verification of the child's Medicaid status and number as soon as it is available, but in no case later than 30 days of the child's entry into foster care.

**Modified Settlement Agreement:
B. Provision of Health Services**

- i. By December 31, 2011, DHS shall assure 90% of children have access to medical coverage within 30 days of entry into foster care.
 - ii. By June 30, 2012 and thereafter, DHS shall assure 95% of children have access to medical coverage within 30 days of entry into foster care.

 - b. For any subsequent placement during the same episode of care, the foster parent or other placement provider shall receive the child's Medicaid card or alternative verification of Medicaid status and number upon the child's placement.
 - i. By October 31, 2011, the Monitors, in consultation with DHS, shall determine the baseline for foster children to have access to medical coverage upon the child's placement for any subsequent placement during the same episode of care.
 - ii. If the baseline determines that DHS's compliance is at 85% or greater, then, by June 30, 2012 and thereafter, DHS shall assure 95% of children have access to medical coverage upon subsequent placement.
 - iii. If the baseline determines that DHS's compliance is less than 85%, then, by December 31, 2012 and thereafter, DHS shall assure 95% of children have access to medical coverage upon subsequent placement.
5. *Psychotropic Medications:*
- a. DHS shall maintain a full-time Health Unit Manager, with appropriate qualifications, who shall, among other things, be responsible for overseeing the implementation of policies and procedures concerning the use of psychotropic medications for all children in DHS foster care custody. The Health Unit Manager shall have the authority to recommend corrective actions. The Health Unit Manager shall report directly to the Children's Services Administration. DHS shall hire or contract for the services of a medical consultant who shall be a physician. The medical consultant shall provide consultation on all health related matters required under this Agreement. The medical consultant shall report to the Health Unit Manager. The duties and responsibilities of the medical consultant and the hours required to fulfill those duties and responsibilities shall be set forth in the health services plan required in Section VIII(B)(1) and subject to approval of the Monitors.

 - b. When possible, parents shall consent to the use of medically necessary psychotropic medication. In the event that a parent is not available to provide consent for psychotropic medication, DHS shall comply with applicable sections of state law.

 - c. DHS shall maintain processes to ensure documentation of psychotropic medication approvals, documentation of all uses of psychotropic medication, and review of such documentation by appropriate DHS staff, including the Medical Consultant. The Medical Consultant and the Health Unit Manager shall take immediate action to remedy any

**Modified Settlement Agreement:
B. Provision of Health Services**

identified use of psychotropic medications inconsistent with the policies and procedures approved by the Monitors.

6. *Reconfiguration of Mental Health Services Spending*: Beginning October 2008, DHS was to redirect at least \$3 million to fund mental health services. In order to help ensure that children in foster care in each county have access to the range of mental and behavioral health services and supports necessary to address their needs, including behavior management training and supports for caregivers working with children with behavioral problems, DHS shall gather and analyze data on the way in which DHS funds are utilized to provide mental health services. DHS shall determine whether the allocation of these funds matches the priority needs of the children served, and if not, shall implement a plan to reallocate those funds to support the development and provision of services to meet the priority needs.

Mental Health Services Spending has been reconfigured using the SED waiver and implemented as follows:

- a. By October 2009, in Wayne, Kent, Oakland, Genesee, and Macomb Counties;
- b. By October 2010, in Ingham, Kalamazoo, and Saginaw Counties; and
- c. By October 2011, in Muskegon, Washtenaw, Eaton, and Clinton Counties.
- d. For all remaining counties, DHS shall continue to engage the Michigan Department of Community Health, Community Mental Health Service Providers, and Medicaid Health Plans to ensure that all children with mental health needs are assessed and served.

This paragraph is not intended to limit any other obligations under this Agreement.

**Modified Settlement Agreement:
X. Placement Standards & Limitation**

Policy:

FOM 722-3

A. General Standards:

DHS shall place children according to the following standards:

1. All children shall be placed in accordance with their individual needs, taking into account a child's need to be placed as close to home and community as possible, the need to place siblings together, and the need to place children in the least restrictive, most home-like setting.
2. Children for whom the permanency goal is adoption should, whenever possible, be placed with a family in which adoption is a possibility.
3. Race and/or ethnicity and/or religion shall not be the basis for a delay or denial in the placement of a child, either with regard to matching the child with a foster or adoptive family or with regard to placing a child in a group facility. Race and/or ethnicity shall otherwise be appropriate considerations in evaluating the best interest of an individual child to be matched with a particular family. DHS shall not contract and shall immediately cease contracting with any program or private CPA that gives preference in its placement practices by race, ethnicity, or religion.
4. Children in the foster care custody of DHS shall be placed only in a licensed foster home, a licensed facility, or, subject to the requirements of Section VIII(C)(6) of this Agreement, an unlicensed relative home.

B. *Placement Limitations:* DHS shall make placement decisions pursuant to DHS placement selection criteria.

1. *Limitations on Placements Outside a 75-Mile Radius:* DHS shall place all children within a 75-mile radius of the home from which the child entered custody unless:
 - a. The child's needs are so exceptional that they cannot be met by a family or facility within a 75-mile radius;
 - b. The child needs re-placement and the child's permanency goal is reunification with his/her parents who at that time reside out of the 75-mile radius;
 - c. The child is to be placed with a relative/sibling out of the 75-mile radius; or,
 - d. The child is to be placed in an appropriate pre-adoptive or adoptive home that is out of the 75-mile radius.

If a child is placed outside the 75-mile radius:

- a. In a Designated County, the county Child Welfare Director shall be specifically required to certify the circumstances supporting the placement in writing, based on his or her own examination of the circumstances and the child's needs and best interests;

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X. Placement Standards & Limitation**

b. In any other county, the County Director shall be specifically required to certify the circumstances supporting the placement in writing, based on his or her own examination of the circumstances and the child's needs and best interests.

2. *Limitations on Separation of Siblings:* Siblings who enter placement at or near the same time shall be placed together, unless doing so is harmful to one or more of the siblings, one of the siblings has exceptional needs that can only be met in a specialized program or facility, or the size of the sibling group makes such placement impractical notwithstanding efforts to place the group together. If a sibling group is separated at any time, except for reasons set forth above, the case manager shall make immediate efforts to locate or recruit a family in whose home the siblings can be reunited. These efforts shall be documented and maintained in the case file and shall be reassessed on a quarterly basis.

3. *Limitations on Number of Children in Foster Home:* No child shall be placed in a foster home if that placement will result in more than three foster children in that foster home, or a total of six children, including the foster family's birth and/or adopted children. No placement shall result in more than three children under the age of three residing in a foster home. Exceptions to these limitations may be made, on an individual basis, documented in the case file, when in the best interest of the child(ren) being placed, as follows:

- a. In a Designated County, by the county Child Welfare Director;
- b. In any other county, by the County Director.

4. *Limitations on Use of Emergency or Temporary Facilities:*

a. *Time limit for placement in emergency or temporary facility:* Children shall not remain in emergency or temporary facilities, including but not limited to shelter care, for a period in excess of 30 days. An exception to this limitation may be made for:

- i. Children who have an identified and approved placement but the placement is not available within 30 days of the child's entry to an emergency or temporary facility.
- ii. Children whose behavior has changed so significantly that the County Director or his/her manager designee has certified that a temporary placement for the purposes of assessment is critical for the determination of an appropriate foster placement. In no case shall a child remain in an emergency or temporary facility more than 45 days.

b. *Number of placements in an emergency or temporary facility:*

Children shall not be placed in an emergency or temporary facility, including but not limited to shelter care, more than one time within a 12-month period. An exception to this limitation shall be made for:

- i. Children who are absent without legal permission;
- ii. Children facing a direct threat to their safety, or who are a threat to the safety of others such that immediate removal is necessary; or

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iii. Children whose behavior has changed so significantly that the County Director or his/her manager designee has certified that a temporary placement for the purposes of assessment is critical for the determination of an appropriate foster placement.

iv. Children experiencing a second emergency or temporary-facility placement within one year shall not remain in an emergency or temporary facility for more than seven days.

5. Limitations on Placement in Jail, Correctional, or Detention Facility: No child in DHS foster care custody shall be placed, by DHS or with knowledge of DHS, in a jail, correctional, or detention facility unless such child is being placed pursuant to a delinquency charge. DHS shall notify the State Court Administrative Office and the Michigan State Police of this prohibition, and provide written instructions to immediately notify the local DHS office of any child in DHS foster care custody who has been placed in a jail, correctional, or detention facility.

If it comes to the attention of DHS that a child in DHS foster care custody has been placed in a jail, correctional, or detention facility, and such placement is not pursuant to a delinquency charge, DHS shall ensure the child is moved to a DHS foster care placement as soon as practicable, and in all events within five days, unless the court orders otherwise over DHS objection.

If a child in DHS foster care custody is placed in a jail, correctional, or detention facility pursuant to a delinquency charge, and the disposition of such a charge is for the child to return to a foster care placement, then DHS shall return the child to a DHS placement as soon as practicable but in no event longer than five days from disposition, unless the court orders otherwise over DHS objection.

6. Limitations on Placement of High Risk Youth: DHS shall not place any child determined by a clinical assessment to be at high risk for perpetrating violence or sexual assault in any foster care placement with foster children not so determined without an appropriate assessment concerning the safety of all children in the placement.

7. Limitations on Residential Care Placements: No child shall be placed in a child caring institution unless there are specific findings, documented in the child's case file, that: (1) the child's needs cannot be met in any other type of placement; (2) the child's needs can be met in the specific facility requested; and (3) the facility is the least restrictive placement to meet the child's needs. A description of the services available in the facility to address the individual child's needs must also be documented in the case file. The initial placement must be approved as follows:

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- a. In a Designated County, the county Child Welfare Director;
- b. In any other county, the County Director.

The need for a residential placement shall be reassessed every 90 days. Children shall not be placed in a residential placement for more than six months without the express authorization, documented in the foster care file, of:

- a. In a Designated County, the county Child Welfare Director;
- b. In any other county, the County Director.

No child shall be placed in a residential placement for more than 12 months without the express authorization, documented in the foster care file, of Child Welfare Field Operations.

**Modified Settlement Agreement:
VII. Assessment, Case Planning & Provision of Services**

Policy:

FOM 722-6, FOM 722-7, FOM 722-8, FOM 722-8A, FOM 722-8B, FOM 722-8C, FOM 722-9, FOM 722-9A, FOM 722-9B, FOM 722-9C, and FOM 722-9D

A. Assessments and Service Plans: DHS shall complete a written assessment of the child(ren)'s and family's strengths and needs, designed to inform decision-making about services and permanency planning, within 30 days after a child's entry into foster care, and shall update the assessment at least quarterly thereafter. Assessments shall be of sufficient breadth and quality to usefully inform case planning. DHS shall complete an Initial Service Plan within 30 days of placement, and an Updated Service Plan at least quarterly thereafter. The written service plan shall accord with the requirements of 42 U.S.C. § 675(1), and shall indicate:

1. The assigned permanency goal;
2. How DHS, other service providers (including the private CPAs, where applicable), parents, and foster parents shall work together to confront the difficulties that led to the child's placement in foster care and achieve the permanency goal;
3. The services to be provided to the child(ren), parent(s), and foster parent(s);
4. Who is to provide those services and by when they are to be initiated; and
5. The actions to be taken by the caseworker to help the child(ren), parent(s), and foster parent(s) connect to, engage with, and make good use of services.

The service plan shall contain attainable, measurable objectives with expected timeframes, and shall identify the party or parties responsible for each task. Service plans shall be signed by the caseworker, the caseworker's supervisor, the parent(s), and the child(ren), if of age to participate. If the parent(s) and/or child(ren) are not available or decline to sign the plan, the service plan shall include an explanation of the steps taken to involve them and shall identify any follow-up actions to be taken to secure their participation in services. When a child is placed with a private CPA or CCI, the private CPA or CCI shall complete the assessment and the service plan in accordance with the provisions above.

B. Supervisory Oversight of Assessments and Service Plans: Supervisors shall meet at least monthly with each assigned worker to review the status and progress of each case on the worker's caseload. Supervisors shall review and approve each service plan. The plan can be approved only after the supervisor has a face-to-face meeting with the worker, which can be the monthly meeting.

C. Provision of Services: DHS shall ensure that the services identified in the service plan are made available in a timely and appropriate manner to the child and family, and shall monitor the provision of services to determine whether they are of appropriate quality and are having the intended effect. DHS is responsible for helping the parent(s) from whom the child has been or may be removed, the child(ren), and the foster parent(s)

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VII. Assessment, Case Planning & Provision of Services**

identify appropriate, accessible, and individually compatible services; assisting with transportation when necessary; helping to identify and resolve any barriers that may impede parent(s), child(ren), and foster parent(s) from making effective use of services; and intervening to review and amend the service plan when services are not provided or do not appear to be effective.

D. Family Engagement Model: DHS shall develop the policies, procedures, and organizational structure necessary to implement a family engagement model, which shall include family engagement, child and family team meetings, and concurrent permanency planning. DHS shall implement the model under the timetables set in Section VII(D)(6) below.

1. *Family Team Meetings:* Family Team Meetings shall be utilized to engage families in case planning, service identification, assessing progress, and safety planning. A Family Team Meeting (FTM) shall be offered to make or recommend critical case decisions. Should the family decline to attend, the meeting shall proceed with the other participants in attendance. FTMs shall be led by a trained facilitator, and shall include written invitations in advance of the FTM whenever possible to the parent(s) of the child; foster parent(s); child(ren) if of age to participate; family, friends, or other supports identified by the parent(s) and child(ren); other service providers as appropriate; Lawyer Guardians Ad Litem (LGALs), parents' attorneys and the caseworker, with supervisory participation when necessary.

a. At a minimum, the following events shall trigger Family Team Meetings for in-home cases:

- i. CPS case opening/transfer to ongoing worker
- ii. Case service plan development/identification of safety issues
- iii. Prior to removal or at the earliest date possible after removal
- iv. Case closure

b. At a minimum, the following events shall trigger Family Team Meetings for out-of-home cases:

- i. Case service plan development
- ii. Permanency goal change
- iii. Placement preservation/disruption
- iv. Permanency Planning at six months in care
- v. Annual Transition Planning for Youth – every six months from age 16 to case closure
- vi. 90-Day Discharge Planning for Youth
- vii. Case closure

2. At the conclusion of each FTM, the facilitator shall prepare a written report detailing the decisions and recommendations emerging from the meeting. The report shall be provided to the worker, family, the worker's supervisor, and other appropriate team members and shall include a section identifying areas in which follow-up is needed.

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3. *Transition from PPC to FTM:* PPCs shall continue to occur at three trigger points in the case until full implementation of the FTM:
 - d. Removal
 - e. Re-placement
 - f. Six months in care to review permanency plan

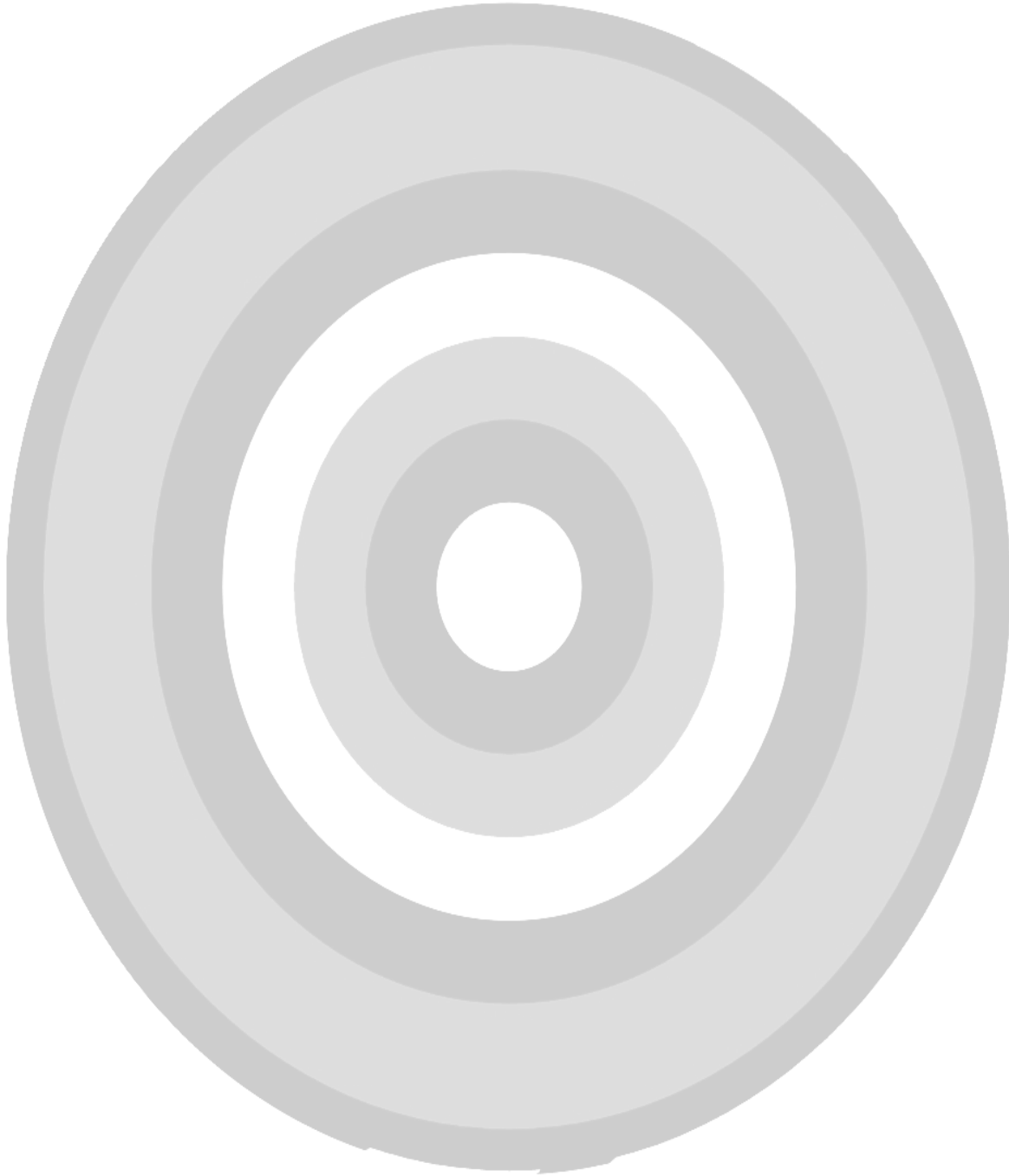
4. Concurrent planning shall continue in Clinton, Gratiot, and Ingham counties and shall be fully implemented in the Family Engagement Model.

4. *Pre-Implementation:* Prior to full implementation of the FTM, the State shall engage in the following activities:
 - a. Finalization of the Family Engagement Model by March 2012.
 - b. Policy development surrounding the Family Engagement Model by June 2012.
 - c. Communication of model to all counties, private CPAs, and key stakeholders by June 2012.
 - d. Identification of Peer Coaches in county offices and private CPAs – ongoing.
 - e. Conduct training for peer coaches, management, and caseworkers – ongoing.

6. *Implementation:* The FTM model, including concurrent planning, shall be implemented in phases as follows:
 - e. Big 14 counties by March 2013.
 - f. Big 14 contiguous counties by February 2014.
 - g. Northern Michigan counties by August 2014.
 - h. Upper Peninsula counties by December 2014

ACTIVITY SECTION

Empathy Circle Activity



DFCS Education & Training Section March 2009
Family Team Meeting Facilitator Training
(Modified from Family to Family- Annie E. Casey, May 2005)

PARKER FAMILY SCENARIO

Pre-Meeting Discussion & FTM Family Preservation (Removal) Scenario:

Allison Parker is a quiet woman who wears an anxious expression. She is the mother of four children: Brandy 14, Joey 9, Caleb 4 and Mia 1 month old. Mia tested positively for drugs at birth. Allison has a history with CPS involvement as an adult that includes two previous referrals for unsubstantiated allegations of neglect. Over the past 18 months she has had Families First in her home as well as mental health services when CPS substantiated a new complaint that Allison was leaving Brandy with the two younger children, often overnight. Prior to that Brandy had confided to her school counselor that her mother's boyfriend was abusing her mother and "threatening" the children. Allison was never fully compliant with treatment and now the baby tested positive.

Allison feels she has lost control of her children and her "sanity". Life began a downward spiral 6 years ago when her husband Joe was killed in an auto accident on his way home from work. Back then there were just the 4 of them. Little Caleb and Mia hadn't been born yet. She and Joe had just moved to Michigan shortly before he died. Joe had wanted to be closer to his parents (John and Mary Parker), but Allison never felt close to them. She felt they never really accepted her. She knew they always thought that Joe could have done better than marrying her. Once Joe died, she didn't have much to do with his family. Her family was in Alabama and she was never really that close to them anyway.

Allison took the death of her husband hard and it seemed like her bipolar disease got out of control after Joe was gone. She had to get a job and there just wasn't enough money for the pills she needed once Joe's insurance stopped. It seemed like her moods always got her in trouble at work and she had a string of minimum wage jobs that never seemed to last. Allison was never one to make a lot of friends. She counted on Joe for that. He was the social one. He was the one who took care of everything. She was lost without him.

Shortly after her husband's death, Allison met Ted at a party at one of her friend's homes. Ted seemed like a nice guy and Allison was really lonely. Before she knew it, she was pregnant with Caleb and she and her two children had moved in with Ted. During her pregnancy, Ted was always in trouble with the law, and he would abuse her when he drank. He drank a lot and was a small time crack dealer. When Allison was pregnant with Mia, Ted got into a fight and stabbed someone. He is currently serving time for murder. Allison was lost without Ted and started to use crack, just a little, every now and then to take the edge off of her anxiety. Brandy pretty much took over the care of the younger kids, something she always did when her mom's moods got bad.

When Mia was born and tested positive for cocaine Allison's children were removed. Now her kids are in foster care and she is not sure she has the strength to get them back. Brandy and Joey have been placed with Joe's parents since coming into care. Mary Parker does not appear to get along with Allison at all. Mary feels that Allison is a "drug addict" and they had learned to distance themselves from her as the years have gone on. The grandparents can see how much Brandy and Joey miss their mom and their siblings. They are concerned that Brandy in particular is really worried about her family. They know that in

PARKER FAMILY SCENARIO

some ways, Brandy is more a mother to Caleb than Allison is. Brandy took care of him every day after school and feels responsible for him. She also feels responsible to be there for her mother. Brandy's grandparents are concerned that she has not had the opportunity to be a child herself. She is a really smart girl who can get good grades when she has time to concentrate on her studies. They are also concerned about Joey who is ADHD and is a handful to take care of. Both Brandy and Joey ask about their mother daily. Caleb and Mia are both placed with Bill and Cathy Jenkins (unrelated licensed foster parents). They appear supportive of Allison seeing her children as much as possible and have indicated that they are willing to support her as much as possible.

Case Review (USP & Visitation) FTM Update:

Note: read scenario above

At the Initial Disposition the court ordered that DHS provide Allison with the following: "mental health screening/services, substance abuse treatment, parenting classes and/or other appropriate services to address her parenting skills, regular and frequent parenting time and any other services deemed necessary to address the safety needs of the children."

During the last reporting period Allison arranged for individual counseling with a local counselor that comes to her home twice per week. The counselor is licensed and on the DHS Fair Market list, but is not a counselor you would have preferred due to past issues with providing late or incomplete progress reports. Allison however likes the counselor and feels she is helping her. Allison also arranged to complete a substance abuse assessment and has begun participating in a basic parenting skills class at the local Community Mental Health Department. Despite being diagnosed with bi-polar disorder several years ago, she is questioning the accuracy of the diagnosis and whether or not she needs her medication. During a previous conversation you had with her she alluded to the fact that she was not consistently taking her prescribed medication, but when asked about this directly she backtracked and reported that she is reluctantly taking her medication as prescribed. She has made most of her scheduled parenting time visits during the last reporting period only missing three out of the last fifteen (once for a scheduling conflict with her counseling and twice due to transportation issues). Brandy and Joey's grandparents are not in support of additional parenting time because they have reported that the children always return from the visits "upset". In addition they contend that the children misbehave immediately before and for days following visits. The grandmother on one occasion indicated that she does not believe that visitation should continue. The L-GAL has indicated that he supports visitation, but also believes that the children should remain in relative care. The foster parents of Caleb and Mia reportedly have room for the older two children and are fully supportive of additional visitation. They have indicated that they would be willing to supervise visitation and provide transportation whenever they can.

Since the children were removed Allison indicated that she has really struggled with feelings of being "sad" and "lonely". She states that she feels as though she has no one to talk to or depend on. She also indicated that she would like to see the kids more often. Allison's attorney agrees that she needs

PARKER FAMILY SCENARIO

intensive substance abuse and mental health services, but does not agree that inpatient is appropriate for her at this time. She has indicated that she feels that Allison needs intensive outpatient services that will allow her to remain in the community. She also indicated that her client has stated that if she has to participate in inpatient services she is likely to "let the State have her kids." The attorney also is not at all in agreement with developing a concurrent plan because it is a "set up for failure."

Case Closure (Reunification & Safety Plan) FTM Update:

Note: read scenario and update above

Allison has completed her substance abuse treatment and all aspects of her treatment plan. She finally recognizes that she is Bi-polar and is completely compliant with mental health services. Allison has identified supportive people through her mental health treatment and substance abuse treatment. In addition, throughout the FTM process Allison has been able to re-build her relationship with her relatives in Alabama as she reached out to them as part of the treatment process. These relatives are located in another state, but Allison has identified them as support in times of distress. Allison has fully complied with the visitation plan, and she has progressed to having the children for the majority of the week in preparation for their return home. At this time, she has fully participated with Family Preservation and her case is ready to be closed citing substantial progress in all areas. The case manager is prepared to develop a transition plan with Allison and the team. The therapist is on board with the planned reunification, however she believes that it is essential that a safety plan be created in the case that Allison experiences some anxiety during the transition of the children to her home.

Sample Family Team Meeting Introduction

Welcome, thank you for coming. My name is _____ and I am the _____ caseworker for the _____ family. I will be facilitating this meeting along with _____ (parent/ youth). This meeting is in regards to _____ (see further samples) below. It is our desire to work together as a team to come up with the best possible case plan. We believe the more input the better the plan. Everyone's ideas are valued and important.

Before we start I must read the confidentiality statements and the information sheet that is provided. (Read the two confidentiality statements on attendance sheet and info sheet that are provided-see Handbook). Does everyone agree to respect the privacy of the information discussed today? Please sign showing that you are present and understand the statements I read to you. Ok, now that we have covered both those items, can everyone introduce themselves and their relationship to _____ (youth)? Please complete the name tent in front of you with the name you would like to be referred to.

_____ (Parent/ youth) can you begin by providing the ground rules that you developed in our prep discussion? Does anyone want to add any further comfort agreements? (Add any more from the info/ ground rule sheet, if needed).

Again, the purpose of today's meeting is to come up with a case plan that provides safety, permanency and or well-being for _____ (youth). _____ (Parent/ youth) can you provide the group with the items you want to make sure we address today? In addition, we must also address _____ (please add any non-negotiable(s) i.e., court ordered substance abuse treatment).

Parents/ youth are the experts about themselves and how we got here today. We want this meeting to begin with _____ (parent/youth) because her/his needs and desired outcome should be part of the focus of today's meeting. _____ (Parent/ youth) can you begin by sharing your family story?

***Family Preservation/ Considered Removal verbiage:**

We are here because we have identified risk issues and safety concerns that lead the agency to believe that we may need to consider removal of _____ from your home. We want to discuss the risks and safety concerns and determine how we can address them and keep your child safe, while we work with you, his/her family. The goal of this meeting is to make a decision that will provide safety and stability for _____ while maintaining and supporting your family.

The decision could range from _____ remaining home with a plan that will keep him/her safe, while we are involved with services or we could decide that _____ should be placed temporarily out of the home while we address the concerns that brought him/her to our attention.

Sample Family Team Meeting Introduction

Placement preservation/ disruption verbiage:

We are here because of concerns about _____ placement in his/her foster home. We will need to decide if _____ can remain in his/her present placement or if he/she should move, how, when and where the change will occur.

Reunification verbiage:

We are here to determine if _____ can return home. We want to discuss what brought _____ into the agency's care initially and determine if (Mr. / Mrs. / Ms.) present situation is such that _____ can return home safely.

Other permanency decisions verbiage:

We are here to decide how _____ can be provided permanence-in other words, every child needs to grow up in a stable, permanent family that's what we want for _____. We will discuss why _____ has been in the agency's care, the progress that you, his parents, have made in addressing concerns, and what should be done to ensure stability for his/her future. We want to consider _____ individual and family needs.

PARKER FAMILY SCENARIO: CPP

Choose a Case Worker to facilitate and someone to be the Reporter.

Case Worker: ensure everyone's voice is heard within the timeframe, summarize for larger group.

Reporter: act as "back-up" should the Case Manager miss something, Chart and accurately record the information.

Full Disclosure

1. What is the permanency planning goal for one of the youth?
2. What will be the concurrent goal?
3. Who needs to be informed of the permanency plans and what is your plan for providing that information?
4. What other additional information needs to be discussed with regards to the permanency plan?

Services

1. What is the plan for setting up services for Ms. Parker substance abuse issues?
2. What other services based on the scenarios does Ms. Parker need?
3. What services does the youth/children need?
4. What services, if any, would you recommend that father (Ted) participate in?

Relative Search

1. What relative search activities will be utilized during this reporting period?
2. How will the relatives be incorporated in the case service plan?
3. List the relatives that you would search for (do not write every relative, be specific grandmother, uncle, etc.)
4. Describe reasons that you would not contact certain relatives.

PARKER FAMILY SCENARIO: Family Team Meeting Pre-Meeting Discussion

Time: 30 minutes

Facilitator Name: _____ Co-facilitator: _____

Directions:

1. Choose a Case Worker to facilitate and someone to co-facilitate.
Case Worker: ensure everyone's voice is heard within the timeframe, summarize for larger group.
Reporter: act as "back-up" should the Case Manager miss something, Chart and accurately record the information.
2. Choose an Allison (Allison can adlib her role using the information from the scenario).
3. Case Worker will take notes or use the Family Team Meeting Pre-Meeting Tool.
4. The Case Worker will focus on these aspects of the Family Teaming Meeting Pre-Meeting:
 - a. Full disclosure regarding the referral and provide an explanation of the purpose of the FTM, what Allison can expect to see at the FTM. Explain the non-negotiable(s), (the whys), using skills of engagement (being genuine, showing empathy, respect and competence).
 - b. Give Allison the opportunity to tell her story about what brought her to have her children in care.
 - c. Have a strengths conversation with Allison asking questions that can reveal some of her strengths and what she identifies as needs.
 - d. Have a discussion regarding what Allison thinks the agenda of the meeting should be and what ground rules she thinks would be helpful during the meeting.
 - e. Help Allison Identify who she many want to attend the FTM, explaining the importance of having people who know and support her there, and explain their role. Include an explanation of confidentiality during the meeting.
 - f. Discuss with Allison as to where she would like the meeting to be held (providing options) and when and what time would work best for her.
5. At the conclusion of the exercise, the group will share with the Case Worker what they did that was helpful and what area was not as helpful.
6. Worker should reveal what they felt they did a good job on and what was more difficult for them.
7. At the end of 30 minutes, each group would have charted their response to the below questions and will be prepared to discuss in a large group what was learned from the activity.
 1. What behaviors indicated that you are engaging with the family?
 2. What are some additional tasks would you need to complete during this Family Team Meeting?

(When conducting the Pre-Meeting be sure to not go into too much detail. Give enough information to prepare for the FTM, but not so much as to make the FTM redundant.)

PARKER FAMILY SCENARIO: Family Team Meeting Removal

Time: 30minutes

Facilitator Name: _____ Co-facilitator: _____

1. Choose a Case Worker to facilitate and someone to be the Reporter.
Case Worker: ensure everyone's voice is heard within the timeframe, summarize for larger group.
Reporter: act as "back-up" should the Case Manager miss something, Chart and accurately record the information.
2. Each participant will read the Parker Family Scenario and the Reporter will assign each participate a role.
3. Utilize the Sample Family Team Meeting Introduction and the completed sample Pre-Meeting Discussion Tool to start this meeting. *Allison has been properly prepared for this meeting and will take an active role in stating the ground rules she developed, items she is ready to work on and sharing part of her story.*
4. Participants include those identified on Pre-Meeting Discussion Tool. The father of the two youngest, Ted should be participating via speaker phone from the penitentiary.
5. The recommendation for this meeting will be removal –temporary court wardship (eldest two children with paternal grandparents, youngest two placed with a licensed foster parent until relatives are located).
6. The Case Manager will also focus on these aspects of the Family Teaming Meeting:
 - a. Full Disclosure of Plan A and B, the child welfare process, relative licensing, visitation and court process and any non-negotiable(s).
 - b. Set up initial visits and review parental roles and responsibility (include medical/dental visits and educational programs).
 - c. Discussion of the requirement of engaging parents in the development of the plan, goals, needs, strengths etc. Identify indicators for successful completion of services.
 - d. Identify what relative search activities will be utilized and discuss how will the relatives be incorporated in the case service plan
7. At the end of 30 minutes, each group would have charted their response to the below questions and will be prepared to discuss in a large group what was learned from the activity.
 1. What behaviors indicated that you are engaging with the family?
 2. What are some additional tasks would you need to complete during this Family Team Meeting?

PARKER FAMILY SCENARIO: Family Team Meeting Updated Service Plan

Time: 30 minutes

Facilitator Name: _____ Co-facilitator: _____

Directions:

1. Choose a Case Worker to facilitate and someone to be the Reporter.
Case Worker: ensure everyone's voice is heard within the timeframe, summarize for larger group.
Reporter: act as "back-up" should the Case Manager miss something, Chart and accurately record the information.
2. Each participant will read the Parker Family Scenario.
3. Each participant will choose a role identified in the Parker Family Scenario.
4. The Case Worker will focus on these aspects of the Family Teaming Meeting:
 - a. Reassess Safety issues and risks that brought children into care, and any new safety and risk factors;
 - b. Reassess parental capacity and child vulnerabilities since the last case plan,
 - c. Evaluate the effectiveness of the Family Service Plan. Review the case plan goals and discuss the level of achievement to determine if family is on track or if any revisions are needed. (Full-disclose non-negotiable(s))
 - d. Review of all case activities since last plan,
 - e. Are services being provided effective in addressing the specific parental behavior deficits and child vulnerabilities identified,
 - f. What are the barriers to permanency and specific plans to overcome barriers? Have barriers been resolved? Review or recommend concurrent plans (Plan A and Plan B)
 - g. If applicable: Discuss Young Adult Voluntary Foster Care requirements/timeframes and progress: i.e. educational, health and mental health needs, as well as concrete needs (food, shelter, clothing),
5. At the end of 30 minutes, each group would have charted their response to the below questions and will be prepared to discuss in a large group what was learned from the activity.
 1. What behaviors indicated that you are engaging with the family?
 2. What are some additional tasks would you need to complete during this Family Team Meeting?

PARKER FAMILY SCENARIO: Family Team Meeting Reunification/Safety Plan Development

Time: 30 minutes

Facilitator Name: _____ Co-facilitator: _____

Directions:

1. Choose a Case Worker to facilitate and someone to be the Reporter.
Case Worker: ensure everyone's voice is heard within the timeframe, summarize for larger group.
Reporter: act as "back-up" should the Case Manager miss something, Chart and accurately record the information.
2. The recommendation for this meeting will be reunification.
3. Each participant will read the Parker Family Scenario and be prepared to play the role they selected.
4. At this stage of an FTM participants have previously participated in meetings and are aware of the process. The Case Worker and Allison should however take the time to ensure that all the ground rules are reiterated. Allow Allison the opportunity to speak early into the meeting to ensure that she take an active role in stating by adding to the ground rules, identifying the items she is ready to work on and sharing her story which should be a update on her progress.
5. Identification of participants they can include those whom participated in previous FTM's if they play an essential role at this point of the case.
6. The Case Manager will also focus on these aspects of the Family Teaming Meeting:
 - a. Review safety and risk factors to ensure they have been sufficiently addressed,
 - b. Discuss the reasons reunification is being recommended,
 - c. Ensure that all necessary supports are in place prior to the reunification and eventually case closure,
 - d. The transition plan for the following:
 - i. services that are ending or continuing,
 - ii. children returning home (school, medical transition if needed)
 - e. Are there any outstanding issues to be addressed: i.e. educational, health and mental health needs, as well as concrete needs (food, shelter, clothing),
 - f. Any additional non-safety needs the family may identify.
7. Development of a safety plan, please include the following:
 - a. Safety concern/Problem Identification
 - b. Triggers (person, place or thing),
 - c. Red Flags or Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing/occurring,
 - d. Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity),
 - e. Family and Friends whom should be immediately contacted in case of crisis,
 - f. Professionals whom should be immediately contacted in case of crisis.

PARKER FAMILY SCENARIO: Family Team Meeting Reunification/Safety Plan Development

8. At the end of 30 minutes, each group would have charted their response to the below questions and will be prepared to discuss in a large group what was learned from the activity.
 1. What behaviors indicated that you are engaging with the family?
 2. What are some additional tasks would you need to complete during this Family Team Meeting?

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