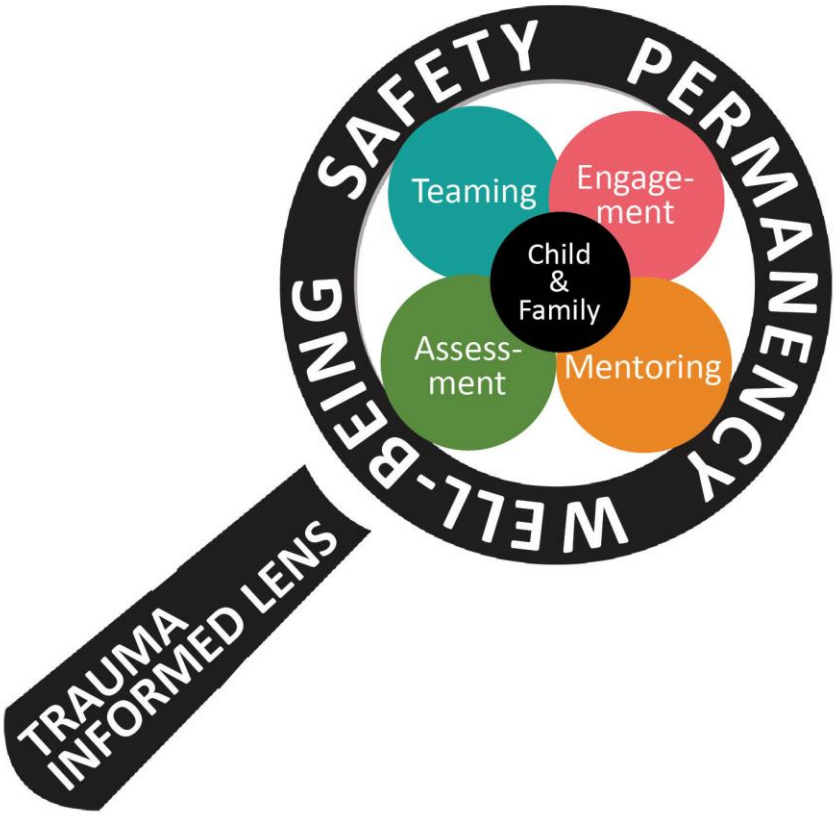
MiTEAM Practice Model Manual

Michigan Department of Health and Human Services
Children's Services Administration



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I. Introduction

A. Purpose of the MiTEAM Practice Model and Manual

The MiTEAM Practice Model is an approach to case practice that incorporates the vision, guiding principles, and Key Caseworker Activities (KCAs) needed to implement the mission of the Michigan Department of Health and Human Services (MDHHS) successfully. The model is a trauma-informed approach to child welfare practice based on the fundamental belief that all children deserve to be safe from harm, raised in loving, committed families, and provided the kinds of supports to build their well-being. This model was developed with the understanding that the vast majority of children in foster care have experienced complex trauma, which can significantly harm individual and familial development. Trauma-informed child welfare systems respond by educating parents and caregivers on the potential developmental impact of trauma, screen children for trauma, refer children and parents for clinical trauma assessments, collaborate with mental health providers to link children to evidence-based and supported trauma services, develop resiliency-based case plans and recognize the necessity of building workforce resiliency both at the individual staff and organizational levels. The MiTEAM Practice Model is built on recent research revealing that traumatic stress can have serious physiological, psychological and relationship impact on child and youth development.[1]

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[1]DeBellis, M., & Thomas, L. (2003). Biologic findings of post-traumatic stress disorder and child maltreatment. Current Psychiatry Reports, vol. 5, 108-117. Source: ACF Grant Literature Citation

Perry, B.D., (1999), *The neurodevelopmental impact of violence in childhood*. Source: SAMHSA Grant Literature Citation

Perry, B. D. (2006). Applying principles of neurodevelopment to clinical work with maltreated and traumatized children: The neurosequential model of therapeutics. In N. B. Webb (Ed.), Working with traumatized youth in child welfare (pp. 27-52). New York: The Guilford Press. Source: SAMHSA Grant Literature Citation

Perry, B. D., & Szalavitz, M. (2007). The boy who was raised as a dog: And other stories from a child psychiatrist's notebook: What traumatized children can teach us about loss, love and healing. New York: Basic Books. Source: SAMHSA Grant Literature

Herman, J. L., Perry, C. J., & van der Kolk, B. A. (1989). Childhood trauma in borderline personality disorder. American Journal of Psychiatry, 146(4), 490-495. Source SAMHSA Grant Literature

Putnam, Frank W. "The Impact of Trauma on Child Development." Juvenile & Family Court Journal 57.1 (2006): 1-11. Source: ACF Grant Literature Citation

van der Kolk, B. A. (2005). Developmental trauma disorder: Towards a rational diagnosis for children with complex trauma histories. Psychiatric Annuals, 35(5), 401-408. Source: SAMHSA Grant Literature Citation

The MiTEAM Practice Model Manual provides practice guidance for caseworkers and supervisors on how to implement the core competencies, a summary of requirements, relevant policies, and additional resources to support implementation. Utilizing a trauma-informed approach, this manual is a vehicle for unifying practices with private agencies, tribal partners, policies, training, and other organizational resources within MDHHS. Child welfare staff and other stakeholders are provided consistent direction on casework activities and services to children and families.

B. Manual Development

This manual has been developed to build upon prior MiTEAM implementation efforts, address feedback from MDHHS staff, core team members and additional external stakeholders, and to accomplish the MDHHS goal of further developing the content of MiTEAM. MDHHS and the Center for the Support of Families (CSF) partnered to determine further development of MiTEAM. Broad stakeholder input was utilized in the development of this manual. A complete list can be found in Appendix B.

C. Mission, Vision and Guiding Principles

In 2012, MDHHS Children's Services Administration developed mission and vision statements to guide its work to "Strengthen Our Focus on Children and Families" in child welfare, as follows:

CSA Mission, Vision and Guiding Principles
Mission MDHHS will lead Michigan in supporting our children, youth and families to reach their full potential.
Vision Child welfare professionals will demonstrate an unwavering commitment to engage and partner with families we serve to ensure safety, permanency and well-being.
Guiding Principles The vision and mission are achieved through the following guiding principles: • Safety is the first priority of the child welfare system. • Families, children, youth and caregivers will be treated with dignity and respect while having a voice in decisions that affect them. • The ideal place for children is with their families; therefore, we will ensure children remain in their own homes whenever safely possible.

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S.,& Spinazzola, J. (2005) Disorders of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma. Journal of Traumatic Stress, 18(5), October 2005, 389–399. Source: SAMHSA Grant Literature Citation

- When placement away from the family is necessary, children will be placed in the most family-like setting and be placed with siblings whenever possible.
- The impact of traumatic stress on child and family development is recognized and used to inform intervention strategies.
- The well-being of children is recognized and promoted by building relationships, developing child competencies and strengthening formal and informal community resources.
- Permanent connections with siblings and caring and supportive adults will be preserved and encouraged.
- Children will be reunited with their families and siblings as soon as safely possible.
- Community stakeholders and tribes will be actively engaged to protect children and support families.
- Child welfare professionals will be supported through identifying and addressing secondary traumatic stress, ongoing professional development and mentoring to promote success and retention.
- Leadership will be demonstrated within all levels of the child welfare system.
- Decision-making will be outcome-based, research-driven and continuously evaluated for improvement.

D. Roles and Responsibilities to Operationalize the MiTEAM Practice Model

Operationalizing this model will require coordination of child welfare professionals at all levels of the child welfare system to support public and private agency caseworkers. The following table clarifies the roles and responsibilities shared by all staff.

Role	Responsibilities
Business Service Center (BSC) Directors	• Serve as visible spokespersons and advocates. • Create a culture that supports the identification of issues and development of plans for addressing secondary traumatic stress. • Pursue strategies to reduce organizational stress. • Provide necessary support to county directors while implementing the MiTEAM model for quality case practice.
County and Private Agency Directors	• Serve as visible spokespersons and advocates. • Create an office culture that supports the identification of issues and development of plans for addressing secondary traumatic stress. • Pursue strategies to reduce organizational stress. • Provide necessary support to section managers, supervisors and caseworkers.

	• Hold staff accountable by using effective approaches and methods that are consistent with MiTEAM.
District Managers	• Serve as visible spokespersons and advocates. • Lead the development of an organizational culture and climate that is proficient, engaged and functional. • Provide necessary support to section managers, supervisors and caseworkers with an emphasis on identification of issues and development of plans for addressing secondary trauma. • Hold staff accountable by using effective approaches and methods that are consistent with MiTEAM.
Program and Section Managers	• Create a safe and supportive environment to facilitate processing of secondary traumatic stress. • Review the performance of supervisors for the quality and substance of their work with caseworkers. • Coach, educate and model effective approaches and methods that are consistent with MiTEAM. • Monitor supervisors' implementation of the practice model.
Supervisors	• Review caseworkers' performance for the quality and substance of their work with children and families. • Provide direct and constructive feedback to caseworkers on the quality of their work. • Monitor use of the key caseworker activities. • Model, observe and coach staff by using effective approaches and methods that are consistent with MiTEAM. • Identify and address secondary traumatic stress. • Create a safe and supportive environment to facilitate processing of secondary traumatic stress.
MiTEAM Specialists	• Model the competencies to increase caseworkers' child welfare knowledge, exposure to skills associated with each competency, and awareness of abilities required to achieve core outcomes for families. • Coach caseworkers by offering guidance and processing circumstances to encourage them to create effective solutions by engaging, teaming, assessing, and mentoring. • Train caseworkers by sharing knowledge, information, or perspectives to foster the growth of caseworkers and

	supervisors as it relates to the practice model, the competencies, KCAs, and suggested practice guidance. • Observe child welfare professionals during interactions with families. Document observations in a behaviorally specific way to compare behaviors to the skills associated with each competency. • Provide meaningful feedback to caseworkers and supervisors based on observations to help individuals refine their skills regarding engagement, teaming, assessment and mentoring.
Caseworkers	• Demonstrate knowledge and consistency of the competencies identified in the MiTEAM Practice Model, during everyday child welfare activities. • Utilize the detailed practice guidance and resources as needed to further refine practices. • Include the MiTEAM Specialist during everyday child welfare activities to gain assistance with enhancing practice knowledge and skills. • Assess current level of functioning as it relates to the competencies, KCAs, and seeking the support of supervision as needed.
MiTEAM Analysts	• Offer expert consultation regarding the MiTEAM Specialists' job duties, the MiTEAM competencies, and the Strengthening our Focus on Children and Families Approach. • Provide support services, including modeling, coaching, training, and providing feedback to increase mastery of the MiTEAM Specialist core duties. • Revise and update the manual as needed. • Collaborate with leadership to create plans that will increase daily teaming, engagement, assessment, and mentoring. • Assist leadership with creating and maintaining an environment that supports the field as they plan, implement, and sustain the MiTEAM enhancements.
Central Office	• Review all initiatives prior to implementation to ensure alignment with the MiTEAM Practice Model. • Ensure policies and procedures are aligned with the MiTEAM Practice Model.

E. Michigan's Practice Model

With the overarching goal of improving safety, permanency and well-being outcomes for children and families, the practice model is comprised of four core competencies:

- Teaming
- Engagement
- Assessment (includes Case Planning, Case Plan Implementation and Placement Planning)
- Mentoring

A trauma lens is applied to practice within the context of each competency. Seven Essential Elements of a Trauma-Informed Child Welfare System have been connected to each MiTEAM competency within this manual to provide caseworkers with guidance.

1. Trauma-Informed Practice

The Chadwick Trauma-Informed Systems Project within the National Child Traumatic Stress Network, developed a resource: “Guidelines to Applying a Trauma Lens to Child Welfare Practice Model”; developed to assist all child welfare agencies in the application of trauma. The Essential Elements of a Trauma-Informed Child Welfare System found in this manual were defined in this resource.

The Essential Elements are:

- Maximize physical and psychological safety for children and families.
- Identify trauma-related needs of children and families.
- Enhance child well-being and resilience.
- Enhance family well-being and resilience.
- Enhance the well-being and resilience of those working in the system.
- Partner with youths and families.
- Partner with agencies and systems that interact with children and families.

In addition to the essential elements, nine Trauma-Informed Practice Strategies (TIPS) were identified by MDHHS in collaboration with the Children's Traumatic Stress Center to further operationalize trauma-informed practice in the context of the MiTEAM Practice Model.

The Trauma-Informed Practice Strategies are:

- **Identify Trauma:** Continually assess/screen for potentially traumatic/secondary traumatic events and potential trauma as a result of agency involvement.
- **Identify Trauma:** Refer for further trauma assessment when necessary as indicated by preliminary assessment/screen.
- **Utilize Trauma Knowledge:** Continually consider the impact of trauma on children, youth, parents, team members, workers, supervisors, and relationship during agency intervention.
- **Utilize Trauma Knowledge:** Consider the impact of potentially traumatic events when making decisions and plans.
- **Utilize Trauma Knowledge:** Connect behaviors, emotions, school problems and relational attachment difficulties to the impact of traumatic events.
- **Utilize Trauma Knowledge:** Reframe trauma history as what has happened versus what is wrong with the person.
- **Address Trauma:** Build resiliency in children and families, family team members, and self through building trauma-informed case plans that:
    - Promote competency.
    - Promote ability to develop and build relationships.
    - Promote ability to regulate emotion and behavior.
    - Foster development of self-esteem.
- **Address Trauma:** Refer for evidence based/evidence supported trauma intervention when appropriate.
- **Educate About Trauma:** Proactively transfer trauma knowledge through ongoing conversations that build understanding from the first interaction to the last. May include discussion around:
    - What trauma is.
    - What can be traumatic to a child or an adult.
    - How trauma changes the brain.
    - How trauma impacts people differently.
    - The impact and symptoms of trauma.
    - What resiliency is.
    - How resiliency works to address trauma.
    - How resiliency can be built.
    - How resiliency can impact long-term view.

The essential elements and trauma-informed practice strategies were integrated into this practice manual based on the content and key caseworker activities specific to each MiTEAM competency.

2. Key Caseworker Activities

Twenty-nine Key Caseworker Activities (KCAs) have been identified to help caseworkers understand what it means to implement these core competencies. They will help caseworkers prioritize their work with children and families to promote life changes leading to more children and youth who are safe, living in permanent homes, and thriving. Specific steps are also provided to guide the work of supervisors. Recommended KCAs and detailed guidance offered in this document are intended for MDHHS and private agency child welfare staff working to provide services and assistance to children and families. Outlined below is a summary of each competency and the corresponding KCAs.

Competency 1: Engagement	
Engagement is a series of intentional interventions that work together in an integrated way to successfully establish a relationship with children, parents and other individuals. Caseworkers will engage with the child, mother, father, extended family, primary caregiver, professionals working with the family, and other team members for the purpose of building an authentic and collaborative working relationship. Supervisors will educate, model, and coach caseworkers in the Key Caseworker Activities of engagement.	
KCA 1: Engagement	Create an environment of empathy, genuineness, respect, and empowerment that supports a child and family entering into a helping relationship and actively working toward change.
KCA 2: Engagement	Search for and engage parents, family members, and other support persons from the child's community in the family team process.

Competency 2: Teaming
Teaming is a collective effort that necessitates a team approach. Caseworkers will form a team comprised of the important people in the child's and family's life that meets, talks, and plans together. Caseworkers will ensure team functioning by making sure the team has the ability and cultural competence to design effective services and supports, adjust as may be needed, and use collaborative problem solving. Supervisors will educate, model and coach caseworkers in effective teaming practices

such as team formation, coordination, and facilitation to ensure proper team functioning.	
KCA 3: Teaming	Form a family team.
KCA 4: Teaming	Prepare members of the family team for participation on the team and for upcoming decisions.
KCA 5: Teaming	Ensure members of the team meet and participate in shared decision-making on a regular basis.

Competency 3: Assessment	
Assessment is an ongoing process of information gathering, analysis and collaborative decision-making that includes parents, children, extended family members, caregivers and professionals as partners. A comprehensive family assessment is a compilation of evaluations used to design plans and provide children and families services that focus on safety, permanency and well-being. The assessment phase includes planning, implementation and placement activities.	
KCA 6: Assessment	Use formal and informal assessment techniques to collect information.
KCA 7: Assessment	Collaborate with team members to identify child and family strengths, trauma histories, and needs.
KCA 8: Assessment	Organize and analyze all information that is collected to develop a comprehensive family assessment.
KCA 9: Assessment	Update comprehensive family assessment on a regular basis, and prior to case closure.
KCA 10: Case Planning	Involve families and other team members in a case planning process with a long-term view toward safety and permanency.
KCA 11: Case Planning	Link services to individual strengths, potential traumatic stress, and specific needs of each relevant family member to the identified permanency goal or goals.
KCA 12: Case Planning	Develop plans that have behaviorally specific and achievable goals and action steps.

KCA 13: Case Planning	Use visits with the child and parents to make progress on goals and action steps.
KCA 14: Case Planning	Track progress on case plan implementation and adjust as needed.
KCA 15: Case Plan Implementation	Engage with service providers.
KCA 16: Case Plan Implementation	Clarify specific service needs when making referrals.
KCA 17: Case Plan Implementation	Provide services promptly and on an ongoing basis to increase safety, reduce risk, address well-being, and promote timely permanency.
KCA 18: Case Plan Implementation	Use caseworker visits to mobilize services.
KCA 19: Case Plan Implementation	Evaluate the appropriateness and effectiveness of services.
KCA 20: Case Plan Implementation	Provide services at the time of discharge and case closure.
KCA 21: Placement Planning	Assess whether potential relative or kin caregivers are willing and able to safely care for children and youths.
KCA 22: Placement Planning	Work closely with members of the family team to make initial placement decisions, support those placements, and plan for transitions.
KCA 23: Placement Planning	Use assessment information to match children and youths to the most suitable placements.
KCA 24: Placement Planning	Use visits to preserve connections, strengthen relationships, and make progress on identified goals. Facilitate parent involvement with their children.

KCA 25: Placement Planning	Help children stay connected to their siblings.
KCA 26: Placement Planning	

Competency 4: Mentoring	
Mentoring is a developmental partnership in which one person shares knowledge, skills, information and perspective to foster and empower the personal and professional growth of another person. This may mean, for example, a caseworker mentoring a parent or a supervisor mentoring a caseworker. Teaming and mentoring work together to create opportunities for collaboration, goal achievement and problem solving on multiple levels within the system. Mentoring is the ability to empower others by demonstrating and reinforcing the desired skills needed to promote positive outcomes and growth for children, families and professionals.	
KCA 27: Mentoring	Promote growth through coaching.
KCA 28: Mentoring	Create a learning environment through observation and feedback.
KCA 29: Mentoring	Support change through building honest and genuine relationships.

3. Licensing Activities

Licensing is the process of collecting and assessing information to determine if a home is suitable for a foster care placement. The assessment process involves the licensing staff engaging with potential caregivers to acquire the information needed to assess compliance, along with the caregiver's capacity and commitment to serve the characteristics of the children in care. Licensing staff utilize opportunities for engagement to assess the needs of caregivers in an effort to provide support and aide in recruitment and retention strategies. Outlined below is a list of licensing activities that corresponds to the core competencies.

Licensing Activities: Engagement	
Licensing Activity: Engagement	Create an environment of empathy, genuineness, respect and empowerment for all caregivers. Support foster/adoptive/kinship parents.

Licensing Activity: Engagement	Use child-specific, targeted, and general recruitment efforts to increase the number of appropriate foster homes.
Licensing Activity: Engagement	

Licensing Activities: Teaming	
Licensing Activity: Teaming	Assist caregivers in identifying formal and informal supports for the child and caregiver.
Licensing Activity: Teaming	Prepare caregivers to be an active part of the family team.
Licensing Activity: Teaming	Build working relationships with other programs/agencies to positively impact the continuum of care.

Licensing Activities: Assessment	
Licensing Activity: Assessment	Assess the foster/kinship parent's ability, strengths and needs.
Licensing Activity: Assessment	Use assessment information to match children and youth to the most suitable placements and inform recruitment efforts.

Licensing Activity: Mentoring	
Licensing Activity: Mentoring	Educate caregivers.

F. Use of the MiTEAM Practice Model Manual

There are three levels of information in this manual that have been written specifically for caseworkers and supervisors:

1. **Practice Guides**

These are easy-to-read, stand-alone tools for each competency. There are seven practice guides for caseworkers and seven associated practice guides for supervisors. Each practice guide contains:

a. MiTEAM competency definition.
b. Fidelity measures.
c. Policy requirements.
d. How to use your supervisor.
e. Key Caseworker Activities.
f. Practice Guidance Techniques.

2. **Detailed Practice Guidance**
   Several practice guidance techniques have additional guidance for caseworkers. To access the detailed practice guidance, users can click on the hyperlink of the technique within the practice guide.

3. **Resource section**
   In the resource section there are many web-based examples, papers or journal articles to give users more detailed information in each of the competency areas.

Language and Terms

Department: Michigan Department of Health and Human Services (MDHHS), specifically the Children's Services Agency.

Child Welfare Professionals: Staff at all levels within MDHHS and private agencies contracting with the department.

Caseworker: Child welfare professionals providing direct services for cases involving children served by MDHHS including Children's Protective Services (CPS), foster care, licensing, adoption, residential, and other non-case carrying child welfare staff.

Supervisor: Person directly responsible for monitoring and evaluating the work of a caseworker.

Child or Children: Youth under Michigan court the jurisdiction. The term is used without regard to the young person's age. For example, the term "child" may apply to a 2 year-old child in a foster home or a 17 year old in a group home.

Family: When not accompanied by "foster" or "adoptive", family refers to the birth or legal family of a child at the time he or she came to the attention of the department.

Caregiver: Any person(s) currently caring for a child under Michigan court jurisdiction. This term is commonly used to describe foster parents, relatives or potential adoptive parents a child is living with while in out of home placement.

Fidelity Measures: The measures used to understand the extent to which caseworkers and supervisors are teaming, engaging, assessing and mentoring with children and families as envisioned in the practice model. These measures are designed to help staff at all levels understand the extent to which the practice model is being implemented.

Key Performance Indicators (KPIs): The measures used to determine the extent to which Key Caseworker Activities (KCAs) in the practice model are occurring. One Key Performance Indicator, for example, is the extent to which children are visiting with their parents.

Key Outcomes: Those outcomes that help the department understand safety, permanency and well-being outcomes for children and families involved in the system. One Key Outcome, for example, is the percent of children reunified within 12 months of the date of removal who have a recurrence of maltreatment within six months.

II. MiTEAM Competencies

A. Competency One: Engagement

1. Overview of Engagement

Engagement is a series of intentional interventions that work together in an integrated way to successfully establish a relationship with children, parents, and other individuals. Caseworkers will engage with the child, mother, father, extended family, primary caregiver, professionals working with the family, and other team members for the purpose of building an authentic and collaborative working relationship. Supervisors will educate, model, and coach caseworkers in the KCAs of engagement.

This section provides information about how to engage through a trauma lens, general practice guidance related to the KCAs, detailed practice guidance for caseworkers and supervisors, a summary of key requirements, a summary of relevant policy, and additional resources that support the implementation of effective engagement practice with children and families.

2. Practice through a Trauma Lens: Focus on Engagement

Utilization of a trauma-informed approach to engagement with children, families, and other individuals will assist in the application of the KCAs and improve overall practice. The essential elements below were identified as critical to effective engagement. The explanations of each Essential Element were taken directly from "Guidelines for Applying a Trauma Lens to a Child Welfare Practice Model" (Chadwick Trauma-Informed Systems Project [CTISP], 2013):

> **Essential Element: Maximize Physical and Psychological Safety for Children and Families**
> While child welfare has always had a focus on the physical safety of the child, a trauma-informed child welfare system must go further and recognize that psychological safety of both the child and his/her family is extraordinarily important to the child's and family's long-term recovery and social and emotional well-being. Psychological safety is a sense of safety, or the ability to feel safe, within one's self and safe from external harm. This type of safety has direct implications for physical safety and permanence, and is critical for functioning as well as physical and emotional growth.
>
> A lack of psychological safety can impact a child's and family's interactions with all other individuals, including those trying to help them, and can lead to a variety of maladaptive strategies for coping with the anxiety associated with feeling unsafe. These survival strategies may include high-risk behaviors, such as substance abuse and self-mutilation. The child (and his/her siblings) may continue to feel psychologically unsafe long after the physical threat has been removed or he/she has been relocated to a physically safe environment, such as a relative's or foster parents' home. The child's parent(s) may feel psychologically unsafe for a number of reasons including his/her own possible history of

trauma, or the uncertainty regarding his/her child's well-being that emerges following removal.

Even after the child and/or parent gains some degree of security, a trigger such as a person, place, or event may unexpectedly remind him/her of the trauma and draw his/her attention back to intense and disturbing memories that overwhelm his/her ability to cope again. Other times, a seemingly innocent event or maybe a smell, sound, touch, taste, or particular scene may act as a trigger and be a subconscious reminder of the trauma that produces a physical response due to the body's biochemical system reacting as if the trauma was happening again.

A trauma-informed child welfare system understands that these pressures may help to explain a child's or parent's behavior and can use this knowledge to help him/her better manage triggers and to feel safe. (CTISP, 2013)

Essential Element: Enhance the Well-Being and Resilience of Those Working in the System

Working within the child welfare system can be a dangerous business and professionals in the workforce may be confronted with threats or violence in their daily work. Adding to these stressors, many workers experience secondary traumatic stress reactions, which are physical and emotional stress responses to working with a highly traumatized population. When working with children who have experienced maltreatment, parents who have acted in abusive or neglectful ways, and systems that do not always meet the needs of families, feelings of helplessness, anger, and fear are common. A trauma-informed system must acknowledge the impact of primary and secondary trauma on the workforce and develop organizational strategies to enhance resilience in the individual members of it. (CTISP, 2013)

The following Trauma-informed Practice Strategies (TIPS) were identified as critical to effectively operationalize engagement skills through a trauma-informed lens:

Utilize Trauma Knowledge

- Continually consider the impact of trauma on children, youth, parents, team members, workers, supervisors and relationships during agency intervention.
- Consider the impact of potentially traumatic events when making decisions and plans.
- Connect behaviors, emotions, school problems, and relational/attachment difficulties to the impact of traumatic events.
- Reframe trauma history as what has happened versus what is wrong with the person.

3. Practice Guide for Caseworkers: Engagement

Practice Guide for Caseworkers	
Engagement	
MITEAM COMPETENCY	Engagement is a series of intentional interventions that work together in an integrated way to successfully establish a relationship with children, parents and other individuals. Caseworkers will engage with the child, mother, father, extended family, primary caregiver, professionals working with the family and other team members for the purpose of building an authentic and collaborative working relationship.

FIDELITY MEASURES	**Observation:**
	• Treats individual(s) with respect.
	• Treats individual(s) with empathy.
	• Uses verbal responses that are consistent with body language.
	• Acknowledges his/her authority and the disproportionate amount of power in the relationship.
	• Helps the individual(s) identify people who are supportive.
	• Addresses reasons for reluctance to including specific team members.
	• Assists the family with navigating agency systems and processes.
	• Discusses with the family the success of the child(ren)/youth beyond case closure.
	• Provides trauma education to the individual(s).
	• Provides feedback to the individual(s).
	• Asks for feedback from the individual(s).
	Documentation:
	• A team that provides support to the child(ren)/youth and family has been formed.
	Interview:
	• The individual(s) was able to identify helpful activities of the worker.
	• The individual(s) feels understood by the worker.
	• The individual(s) feels respected by the worker.
	• The individual(s) reports the worker acknowledged the unique culture of the family/household.
	In Supervision:
	• The worker was able to identify:
	  ○ What is most important to the individual/family.
	  ○ How frame of reference is managed.
	  ○ Positive supports for the individual(s).
	• The worker identifies own team members that support their professional development.
	• The worker exchanges feedback with the supervisor.

POLICY REQUIREMENTS	• Interview all family members separately in cases involving domestic violence or if suspected. For more complete domestic violence practice guidance, see the Domestic Violence Practice Guide. • Whenever possible ensure children/youth and parents have a voice in decisions that affect them. • Treat families with dignity and respect. • Actively partner with family teams to identify needs and plan interventions to protect children and support families. • Identify and provide notice that a child is in foster care (beginning prior to removal and continues until legal permanency for the child is achieved) to all adult relatives including, but not limited to, maternal and paternal grandparents, maternal and paternal aunts, maternal and paternal uncles, adult siblings of the child and any other relative identified by the parent or child. (FOM 722-3B) • Continue to seek, identify and notify family members that a relation is in foster care until a child has achieved legal permanency.

HOW TO USE YOUR SUPERVISOR	• Schedule regular case conference time with your supervisor to discuss your cases each month. • Report to the scheduled conference on time with appropriate case files. • Identify ahead of time areas of concern and questions regarding specific cases to be discussed during supervisory meetings. • Seek supervisor's assistance in real time as needed. Ask your supervisor to model and/or observe areas of practice where you need assistance and provide feedback on your performance. • Examine the quality and intensity of engagement efforts and how they affect specific case results. • Explore opportunities and strategies for improving interaction with the parent, child, providers and extended family members. • Evaluate engagement efforts and potential next steps to further promote engagement. • Discuss specific barriers to engagement and explore alternative engagement strategies. • Identify examples of your use of genuineness, empathy and respect and discuss their impact on developing productive working relationships. • Identify how the relationships with family members may be triggering secondary traumatic stress reactions between children and parents. • Discuss examples of demonstrated cultural sensitivity and awareness and their impact on engagement efforts. • Review documentation of engagement efforts and identify ways to improve documentation to better reflect actual practice. • Discuss possible safety issues that may arise and plan for how best to engage families without compromising family safety and/or worker safety.

KEY CASEWORKER ACTIVITIES	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE TECHNIQUES
KCA 1 ENGAGEMENT ***Create an environment of empathy, genuineness and empowerment that supports a family entering into a helping relationship and actively working toward change.***	From the point of initial contact with the family to permanency and / or case closure.	• Create an environment of empathy, genuineness, respect and competency to engage children and the families. See DPG_caseworker_core_conditions_empathy. • Thoughtfully plan and prepare for engaging with children, parents, and providers. Set behavioral goals for each interaction and then reflect on your ability to engage in the way you wanted to after each encounter. Note areas needing improvement. • Plan for sufficient time to meet with children and parents. Make them feel that they are your priority and important. • Be aware of family work schedules, transportation availability, child's school/extra-curricular schedule and other commitments when scheduling appointments. • Recognize children and parents as the expert on their own history, needs and strengths. • Set clear expectations for children and parents about the child welfare process, your role and authority, and specifically how you plan on helping them achieve safety, permanency and well-being. • Set and reinforce clear expectations and define non-negotiables with children and parents. See DPG_non_negotiables. • Recognize and acknowledge your authority and the disproportionate amount of power you have in the relationship. • Use full disclosure to discuss sensitive topics with families. See DPG_use_full_disclosure. • Listen to what children and parents are saying and reflect your understanding in an empathic manner. • Take time to obtain the family's "back story" in addition to its "front story" (the information in the referral). • Ask parents, caregivers and children privately about past traumatic experiences. • Use clear, common language. Using jargon is a form of disrespect.

		• Check to make sure children and parents understand what is happening. Take responsibility if they do not understand and find additional ways to explain and support their understanding. • Use every contact with children and parents as engagement opportunities. See DPG_use_interviews. • Identify factors (tribal/cultural/racial/ethnic/generational/educational) that may inform your approach to engagement and the family's response to engagement efforts. Get advice from knowledgeable sources on how to adjust your strategy to be most effective. • When developing your engagement strategy, determine how the presence of domestic violence, substance abuse, mental health issues, within the family should impact your approach. • Do what you say you are going to do when you say you are going to do it. Be available and dependable. • Use effective age-appropriate techniques to engage children and youth in case planning and decisions. • Be open to new information and ideas about families and their ability to change. Do not let pre-conceived ideas impact your judgment and decision-making.
KCA 2 ENGAGEMENT ***Search for and engage parents, family members and other persons from the child or youth's community in the family team process.***	From the point of initial contact with the family to permanency and/or case closure.	• Conduct diligent searches for family supports early and often throughout the life of a case. See DPG_diligent_searches. • Involve the parents and children in identifying family, friends and other members of their formal and informal support network who might be able to provide assistance to the family. • Assess any potential safety threat related to locating and contacting a parent who is not currently actively involved in the family. • Discuss the range of roles and forms of assistance that the family's connections may be able to provide. Explain the range of ways in which they can help this family; such as supervising visits, inviting the child or youth and his or her parents to events together, spending time with the child or youth, providing transportation or emotional/spiritual support. • Explain to children, family members and other identified supports the purpose of their involvement and how it will help the family. • Ask identified family and friends how they would feel comfortable helping the family. Prepare family resources for their involvement. Agree upon what, how and why they will be providing support and what to do if they are challenged to fulfill their role. Clarify boundaries by explaining what each resource can and cannot do. Ensure that each family resource understands its roles, expectations and responsibilities.

4. Detailed Practice Guidance

a. Create an environment of empathy, genuineness, respect and competency to engage children and the families.

Background*:*

A caseworker must be able to: 1) find family members who can provide support and permanency for the children and youth; and 2) develop a helping relationship with children and their families in order to support them in changing the circumstances which contributed to the risk of maltreatment and/or a child's safety. The ability of the caseworker to find family members and the quality of the caseworker's relationship to them directly impacts the family's success.

The most important ingredient in developing a helping relationship with children and their families is a caseworker's presence and authenticity. If a family member can perceive that these are present, he or she will respond better and be more willing to truly engage. In a professional helping relationship, it is the responsibility of the caseworker to find a way to understand the family's perspective, especially when it may be difficult to fully comprehend the motivations for their actions or decisions. By engaging with children, youth and their family members with empathy, genuineness, respect, and competency, it is possible to create an environment in which the family is in control and takes ownership in the conversation. By taking family members off the defensive and providing them the opportunity to become invested in the discussion, there is an opportunity to shift the role of the caseworker from being an enforcer of rules to becoming a strong support for the family.

The relationship between the caseworkers and the family begins with their first contact and continues to develop with every interaction. Good relationships do not just happen; they must be built and nurtured. The relationship will be a result of the caseworker's commitment to helping the children and family, his or her ability to relate effectively on an interpersonal level, and the children and family's willingness to be open and risk relating to the caseworker. Empathy, genuineness, respect and competency provide a framework for engaging with children, youth and their families and establish a foundation needed to make real, lasting progress with and on behalf of them.

Policy Requirements:

PSM 711-1: Whenever possible, extended family should be engaged to assist parents to take adequate care of their children. When appropriately assessed, planned for and supported, extended family support and care is a child welfare service that reflects the principles of child centered, family focused casework practice.

PSM 722-1: CPS must consider family strengths and evaluate the potential for treatment of underlying factors to reduce risk and assist the family to care adequately for the child. The caseworker must attempt to engage the family in services. The plan for services should be developed in consultation with the family and network of supports.

Detailed Practice Guidance:

Caseworkers demonstrate respect when they hold the following values and beliefs:

- All human beings are worthy.
- We are unique.
- We have the right to self-determination and to make our own choices.
- We can change.

Caseworkers demonstrate empathy when they:

- Ask and are willing to listen to a child or parent's traumatic history.
- Recognize a child or parent's experience, feelings and nonverbal communication.
- Communicate, with words, their understanding of this experience.
- Create a climate where family members are open, willing, and able to explore real issues and problems.
- Respond to concrete needs quickly.
- Validate the feelings of others.
- Convey acceptance and an understanding of their emotional experience.
- Understand and are aware of pressures imposed upon the family.

Caseworkers demonstrate genuineness when they:

- Act in accordance with how they feel or believe.
- Make sure non-verbal behavior, voice tone and verbal responses match or are congruent.
- Communicate honestly, genuinely, respectfully and with acceptance.

Caseworkers demonstrate competency when they:

- Recognize how traumatic experiences can change familial perceptions.
- Listen actively.
- Show commitment to the goals identified by the child and family.
- Follow through with any promises.
- Are open-minded.
- Are knowledgeable.
- Provide and welcome feedback.

b. Conduct diligent searches for family members and other support persons and engage them.

Background:

Children and youth of all ages, no matter their needs or circumstances, desire and deserve a loving and lifelong connection to family and other support persons. When children move from their own home to foster care, they may lose touch with everything they know–the people who share their memories of first steps, first words, how they looked, the rituals and traditions that have become important to them and any sense of history. The loss of these experiences and shared history can add to the child's traumatic experiences. Without connection to family, they are missing an anchor that family and other support persons can provide. Many times, they have not only lost their parents, but also brothers, sisters, grandparents, aunts, uncles, cousins. As children grow and develop, relatedness with others and a sense of identity begins to form–which is most often rooted in family identity. This relatedness is critical in building their resiliency as research indicates that experiences of relatedness are the primary factors in overcoming adversity in one's life.[2]

Caseworkers should engage identified relatives and other support persons to explore how each of the persons can provide support to a child. This may mean participating on the family team, taking the child to church events on a regular basis, helping to create natural opportunities for children to spend time with their parents or serving as a placement resource for a child, and assisting in safety-planning. Relative placements can provide for a child's safety, continuity of care and permanency. Relatives and other support persons can play a pivotal role in reunification. Relative placements often help preserve a child's relationships, culture and environment, which are essential for a child's overall well-being.

It is important to note that just because relatives and other support persons are available and willing, it is still imperative to assess whether the placement is in the child's best interest. Being trauma-informed demands that caseworkers thoroughly evaluate the potential traumatic impact to children if placed with relatives who may not have protected them from harm, colluded with parents in the harm, disparages a parent or caregiver to the child or interferes with the relationship between the child and caregiver, or may not be able to ensure the physical and psychological safety of the children given their own histories.

Policy Requirements:

FOM 722-6: Throughout the case, the foster care worker must continue to seek, identify and notify relatives until legal permanency for the child is achieved. Caseworkers must access a series of search tools when attempting to locate relatives, including; statewide Bridges inquiry, Secretary of State inquiry, search of telephone books, U.S. Post Office address search, Friend of the Court inquiry, check with county clerk's office for vital statistics, contact last place of

[2] Masten (2010)

employment, follow up on leads provided by friends and relatives, legal publication and the Federal Parent Locator Service.

FOM 722-9: Caseworkers must identify, locate and notify absent parents.

Detailed Practice Guidance:

- Locate and contact absent mothers and fathers as soon as possible within the life of the case.
- Conduct a comprehensive assessment to identify as many family members and fictive kin as possible for the child or young person, including those adults who can or have in the past been a key supporter of the child or parents.
- Interview the child, private or public staff persons, family members and other significant adults in the child's life to identify all known family members or other support persons.
- Conduct a comprehensive case file review to identify all family members or other support persons who are referenced (i.e. names of foster parents from a previous custody episode or grandmother of a close friend).
- Contact all persons who have been identified through a phone call, home visit, certified letter or any other appropriate means to enlist their support.
- Develop a detailed and comprehensive eco-map and genogram.
- Prepare family members and other key supporters to help make important decisions and support the child through making commitments to them.
- Engage the identified family members and others who care about the child to become a part of the family team. Team members will continue to search for and engage family members and other key supporters throughout the life of the case.
- Decisions on relative placement must consider the trauma the child has experienced, how the relative placement will potentially minimize or exacerbate the child's previous trauma, and the extent to which the relative can provide the physical and psychological safety necessary for the child to recover from his or her trauma.

c. Assess approach to engagement when domestic violence is a concern.

Background:

Child maltreatment and domestic violence often co-exist within families, with estimates ranging from 30-60% of child welfare cases.[3] Children can be harmed by a domestic violence perpetrator's behavior in a number of ways, from being physically harmed, to being exposed to the perpetrator's abuse, to disrupting housing, to not being medically-up-to date due to a perpetrator's control of the insurance card. The research also suggests that domestic violence

[3] See https://www.childwelfare.gov/topics/systemwide/domviolence/impact/children-youth/

perpetrators are more likely than other parents to physically or sexually abuse their children.[4] The impact of a perpetrator's abusive behaviors can affect children socially, developmentally, physically, and emotionally, even if a child is not physically harmed.

Because of the high rates of domestic violence on the child welfare caseload and its correlation with degradation of child and family functioning,[5] caseworkers should approach their casework from a domestic violence-informed perspective. This should include screening for domestic violence in all cases, even if domestic violence is not the presenting issue, and continuing to assess for coercive control, as the case remains open.[6]

Engagement of families when domestic violence is present must include special considerations for safety of the adult survivor, the children and the caseworker. Caseworkers should always interview family members separately, and be conscious of how information is documented in the case record so that it does not compromise or negatively impact safety.

It is also important to be carefully plan when engaging and interviewing perpetrators of domestic violence. Engagement includes actively seeking out perpetrators to interview; setting goals for interviewing; assessing for willingness to work with child welfare and/or services; assessing for ability to talk about his/her behaviors and the impact of those behaviors on the children, and assessing for danger. Caseworkers should review the case record, as well as any law enforcement, criminal history, and existing orders of protection before interviewing and discuss any worker safety and family safety concerns with their supervisor, and plan accordingly.

During interviews, caseworkers should be conscious of not confusing engagement with collusion.[7] Holding perpetrators to high standards as parents, keeping them visible throughout the life of the case, and clearly documenting behaviors and the impact on the children is key to obtaining safe outcomes for children.[8]

Effective engagement of adult survivors of domestic violence begins with the first meeting. In introducing yourself and the reason for the referral, caseworkers should be mindful in not

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[4] See http://www.lundybancroft.com/articles/the-connection-between-batterers-and-child-sexual-abuse-perpetrators

[5] Journal of Family Violence, Vol. 18, No. 1, February 2003 (°C 2003) Effects of Family Violence on Child Behavior and Health During Early Childhood. Diana J. English, David B. Marshall, and Angela J. Stewart

[6] See Domestic Violence Addendum for Domestic Violence Investigations Protocol

[7] See Domestic Violence Addendum for "How Not to Collude with Domestic Violence Perpetrators"

[8] See Domestic Violence Addendum for "Documentation Schema"

holding survivors responsible for the perpetrator's behaviors, or characterizing the violence as a relationship or couple's issue: "*I'm here because we received a report from the police concerning your partner. I'd like to talk with you about what happened and how we can work together to keep your children safe."* In order to best partner with survivors, caseworkers should ask questions beyond the current incident and beyond physical abuse, including asking questions about controlling behaviors, jealousy or possessiveness, emotional or verbal abuse, undermining of parenting, etc.

As the vast majority of adult survivors have actively engaged in activities to promote the safety, stability and well-being of their children, effective engagement should include questions related to what the survivor has tried in the past to keep themselves and the children safe, as well as what has worked and what has not worked. Not only does this help you assess for strengths and protective capacities, but it also gives you the opportunity to validate the survivor's efforts and create a more effective safety plan[9].

Interviewing and engaging children in domestic violence cases can sometimes be challenging as children may not have the language to talk about what has happened or may be fearful of getting a parent in trouble or of being removed from their home. Children may also have not directly witnessed the incident, but still have been adversely impacted by it, for instance they may be fearful or anxious when they see physical injuries on the adult survivor following an incident. Additionally, children often have complex feelings about the perpetrator and adult survivor and may present as saying they love and miss the perpetrator and are angry at the survivor for calling the police. Caseworkers should use trauma-informed interviewing techniques, including getting down to a child's level when talking with children, telling them it's not their fault, and asking questions beyond the current incident, including questions regarding daily routines, what kinds of activities they do together as a family, and questions related to their relationship with the perpetrator.[10] Depending on the child's age and developmental level, you may also want to actively involve children in safety planning discussions with the adult survivor.

Policy Requirements:

PSM 712-6: To the extent safe and possible, caseworkers should engage families to provide safety within their own family without being punitive to the adult survivor of domestic violence. Caseworkers should assist the family in safety planning. CPS should use all applicable laws and policies to hold the abusive partner accountable. CPS must conduct a minimum of a preliminary investigation on complaints alleging domestic violence.

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[9] See Domestic Violence Addendum for "Survivor's Strengths and Safety Planning"

[10] See Domestic Violence Addendum for "Domestic Violence Investigations Protocol"

To the extent safe and possible, caseworkers should engage all family members to provide safety within their own family and should make every effort to engage and intervene with the perpetrator and partner with the adult survivor by identifying and validating strengths and building on the survivor's safety planning efforts. CPS should use all applicable laws, policies, and community partners such as courts, law enforcement, probation, parole, and service providers to hold the perpetrator accountable and support him/her in changing behaviors. CPS must conduct a minimum of a preliminary investigation on complaints alleging domestic violence.

Detailed Practice Guidance:

Several issues should be considered when engaging families where domestic violence is a concern and there are threats to the safety and well-being of a child:

- Use a perpetrator pattern-based definition of domestic violence:
  A domestic violence perpetrator is as a parent or caregiver who engages in a pattern of coercive control against one or more intimate partners. Domestic violence perpetrators often directly involve, target, and adversely impact the children. These behaviors can negatively impact child, and family functioning and may continue after the end of a relationship, or when a couple no longer lives together.
- Educate yourself on appropriate services, such as Batterer Intervention Programs (BIPs) and interventions available in your service area for perpetrators of domestic violence. Share information with providers regarding the perpetrator's pattern of behaviors, and your concerns regarding child safety.
- Educate yourself on the community resources available to support adult and child survivors in your service area, including understanding services they do and do not provide, as well as confidentiality policies. Recognize and assess the traumatic impact to children within the family exposed to domestic violence.
- Screen for domestic violence in all cases, regardless if domestic violence is a part of the initial intake.
    - Review and determine if domestic violence allegations are part of the initial intake.
    - If allegations are not part of the initial intake, interview the family members separately about coercive control and abusive behaviors.
    - Contact the police to see if they have responded to reports of domestic violence at the family member's address.
    - Review if there are any current orders of protection (civil or criminal) in effect and if they include the children.
    - Conduct criminal record reviews and educate yourself on charges related to domestic violence. Information gleaned from the criminal record is extremely helpful for the investigator to have prior to making a home visit in order to plan for both worker safety and family safety.

  - Use record reviews to assess whether any of the family members have a history of domestic violence perpetration in other CPS or criminal cases. This information may help you assess worker and family safety.
- Plan for your safety and the safety of the adult and child survivors.
  - Discuss with your supervisor how best to interview and engage the perpetrator, including your goals for the interview.
  - Discuss with your supervisor any safety concerns regarding interviewing the perpetrator, including worker safety concerns and concerns for the adult or child survivors and plan accordingly.
  - Do not argue. If a perpetrator is unable or unwilling to talk about his/her behaviors and how they relate to the safety of the children, bring the interview to a close.
  - Assess for the perpetrator's willingness to work with you and/or ongoing services to change his/her behavior.
- Engage with the adult survivor and child to plan for their safety.
  - Consider the safety of adult and child survivors when organizing, structuring and conducting interviews and meetings; make accommodations for needed security and check in with adult survivors regarding interviewing the perpetrator and any concerns she/he may have. You may also want to check in with the adult survivor after your interview with the perpetrator, especially if he/she became escalated.
  - Ask the adult survivor about her/his history of efforts to keep themselves and the children safe and her/his current concerns regarding the perpetrator's behaviors.
  - Know that as perpetrators often change their behaviors in response to system interventions, adult survivors may change their safety planning efforts. Understand that safety planning is dynamic and continue to check in with adult survivors about their safety efforts throughout the life of the case.
  - Discuss with your supervisor how best to include documentation involving safety planning in the case record so that is not disclosed to the perpetrator or negatively impacts child/adult survivor safety.
  - Talk with the adult survivor about the option of separate case plans, separate safety plans, separate family team meetings, and separate court hearings. Review any current orders of protection. Discuss with your supervisor before proceeding with a family team meeting in any case involving current or past domestic violence.
  - As age/developmentally appropriate, answer questions children may have regarding the process and what may happen, as well as including them in safety-planning discussions with the adult survivor.
  - Use a trauma-informed approach when interviewing adult survivors and children, especially if you are interviewing immediately after a traumatic incident.
  - Ask the adult survivor about how she/he is talking with the children about the perpetrator and the perpetrator's behaviors. Assist the survivor with safe, child-centered language if needed: *Your father loves and misses you very much, but right now he needs some help to be a safer dad.*

d. Use interviews with children and families as engagement opportunities.

Background*:*

There are many interviewing techniques that can be used as engagement tools for caseworkers to utilize as they work with the children and families involved with the formal child welfare system.

Solution-focused interviewing is one strength-based technique that caseworkers can use to engage children and parents in process and decision-making of their case. It assumes that parents can and should be part of the solution and encourages parents to be more participatory and, therefore, more invested in the outcomes. It allows parents to be heard, draws upon their strengths and empowers them to be more active in making changes they believe they need in their lives. Instead of focusing on past mistakes, solution focused interviewing helps people focus on future positive change. Solution-focused questions help to keep the individual involved in assessing his or her situation and in creating the solution, which is much better than being assigned a solution by the caseworker. Solution-focused questions can be used to gather information and build a relationship with the family by identifying the solutions that the family member wants in his or her life.

Insoo Kim Berg and Steve deShazer identified several basic tenets for a solution-focused approach to therapy, which can be applied to the use of solution-focused questions in the child welfare setting. Those tenets include: 1) focusing on family strengths instead of family problem; 2) remembering family members are the experts on their own families; 3) using the family's language; 4) listening for what the family might want to be different; 5) accepting what the family wants as valid and reasonable; and 6) listening for who and what are really important to the family.

Policy Requirements:

PSM 711-1: Caseworkers should seek the opinions of and gather input from all family members. The following tools are available to workers when interviewing families: MDHHS-189- Eco-Map; MDHHS 202-PSF-Personal Inventory; and the MDHHS 204-Family Portrait to assist in determining the family's strengths and needs.

Detailed Practice Guidance:

Prior to interviewing children and family members, it is important to decide what information is needed and how to best gather that information. Part of the preparation process is to examine existing resources such as the case record, prior CPS history, criminal history, current orders of protection, and other assessments to determine what information is unclear or unknown and, therefore, what is still needed. Prior to the interview, take time to consider how to gather the

information needed as well as any safety considerations that may need to be taken into account, such as in domestic violence cases.

- Help rephrase or reflect back the content and feelings that were heard and experienced to the child or family member. *It sounds like you are feeling stressed out. You seem pleased about getting your certificate.*
- Communicate through short phrases and body language that you are listening and following what is being said. *Of course. Can you tell me more?*
- Invite parents and children to communicate past traumatic events. Sometimes people have events happen to them when they are younger that significantly impact their ongoing development. Talking these through can help.
- Help a person change his or her frame of reference so that a problem, for example, can be approached in a more accurate, clear way.
- Help a child or family member develop an understanding or awareness of his or her feelings, thoughts and behaviors.
- Acknowledge the difficulty of the child or family member's situation and seek to help him or her discover strengths and resources of which she or he may not have been aware. *I imagine your children really keep you busy. What seems to help you manage your day?*
- Example of a domestic violence alternative for talking to adult survivors: *"I see all of the things you are doing on a daily basis to promote the safety and well-being of your children, despite your partner's behaviors."*
- Help the child or family member identify periods of time in his or her life when the current issues or concerns did not occur and under what circumstances they were not occurring. *Are there times when this issue does not happen or has not seemed as serious?*
- Help the child or family member assess how they are doing in certain areas (i.e. self-esteem, self-confidence, prioritization of issues). *On a scale of 1-10, with 10 meaning you have every confidence that this issue can be solved and 1 means no confidence at all, how much would you say it can be solved?*
- Help the child or family member create a vivid image or vision of what life could be like when the issue is solved. *What is your hope for the future in providing for your family?*

e. Use full disclosure to discuss sensitive topics with families.

Background*:*

Caseworkers often find it very difficult to have emotionally charged conversations with parents about the future of their children and family. These conversations are at the core of casework practice–our ability to keep children safe and families together relies on the ability of caseworkers to have timely, transparent discussions at the right time and in the right way. Full disclosure depends upon the use of the basic engagement skills of respect, genuineness and empathy while being honest in each conversation with the family. Sometimes caseworkers can avoid having these discussions because they can trigger secondary traumatic stress reactions.

Caseworkers can minimize the impact by recognizing their own anxiety, bias or judgment, physical symptoms and emotional disengagement as signs of secondary traumatic stress.

Considering the significant consequences and implications of decisions and actions taken in child welfare proceedings, caseworkers must be fully transparent in their communication with families. The caseworker and the family team are making decisions that have the potential for life changing consequences. Full disclosure–telling the whole truth about a matter which one should know in making an important decision–is essential.

In addition to being transparent in terms of what they communicate to families, it is just as important for caseworkers to be honest and professional in how they communicate with families. The way in which a caseworker talks to the family, both in the words he or she uses and the level of detail he or she provides, can have a huge impact on the relationship between the caseworker and the family. How you say something is as important as what you say. In child welfare practice, it can be the difference between timely permanency and a lengthy stay in care.

Concurrent permanency planning is one example of an area of practice that requires full disclosure of information with parents to be successful. Caseworkers must be open and honest with parents and tell them directly what their parental rights and responsibilities are and what is expected of them by when to achieve reunification, what the consequences of their actions or inactions in meeting the objectives or timelines of the case plan for reunification are, and tell them what the alternative permanency plan is if they do not meet expectations for reunification. With full disclosure, parents are fully aware of the alternative permanency plan for their child. Parents should be told that the concurrent plan is not an attempt to undermine their efforts to reunify with their child, but rather the alternative plan for permanency if reunification is not successful timely.

Another difficult and sensitive discussion to have with parents is the need to change a child's permanency goal from reunification to another permanency plan. It is important that you are clear, honest and direct. You must maintain a non-defensive approach and help them focus on what is in the best interest of their child. Here is an example of how you might open a conversation with a parent about a goal change:

"I have told you from the beginning that I would always be straight with you. Your children have been in foster care for 10 months now and they need to be in a permanent home so that they can have a happy, healthy life. I know you want that for them. I also know that you have struggled to do the things you know you need to do to be able to keep your kids safe in your home. I think it is time for us to talk about their permanency, as I do not believe that you are going to be able to parent your child in a safe manner in the future. Can we talk about a place, other than your home, for your children to live in to give them the home they need. What do you think?"

Violence in the family is often another emotionally charged topic for family members and workers. Caseworkers need to consider the different approaches needed with talking to victims and perpetrators of violence. While a direct, non-judgmental, behavioral focus is helpful with all family members, it is important to clarify to victims of violence that the agency does not see them as responsible for the violent behavior of other family members, and to validate their strengths around safety planning for themselves and their children. An example of this might be:

"I'm here because we got a call about your partner being arrested for assaulting you. We're here because we're concerned that his/her behavior and choices are negatively affecting you and the children."

When talking to someone alleged to be a perpetrator of violence, be aware of your own feelings, biases and attitudes about what they've been alleged to have done. As with victims of violence, maintain a non-judgmental approach, exploring their own understanding of their behavior, its impact on the family and how it fits with their vision of themselves as parent. Conversations with your supervisor before and after discussions with family members about violence can be extremely helpful in feeling comfortable with this sensitive topic.

Policy Requirements:

FOM 722-7A: Full disclosure is the process of open and honest communication between the caseworker and all parties (i.e. parents, relatives, foster parents). The caseworker must ensure full disclosure with the parties by having open communication regarding CPS and foster care cases.

Detailed Practice Guidance:

- Prepare for sensitive, open conversations.
  - Consider your purpose and what you hope to accomplish from the conversation with a child or family member.
  - Make sure you enter the conversation in a supportive frame of mind and a positive attitude.
  - Consider the assumptions you are making about a child or family member's intentions.
  - Acknowledge to yourself how painful and difficult these conversations can be. Assess your own issues, biases, fears and/or secondary traumatic stress triggers as you prepare for the conversation.

- Have sensitive, open conversations.
  - Cultivate an attitude of curiosity and discovery.
  - Watch their body language.
  - Be aware of your own body language.
  - Let the child or family member talk until he or she is finished.

  - Pay attention to how you are feeling. Do not take the information personally.
  - Acknowledge what you have heard. Try to understand what they are saying so well you could articulate it for them. Remember acknowledgement does not mean agreement.
  - Make your position clear, taking into account what you have heard.
  - Brainstorm options with the child or family member.

- Take extra care when conversations become emotionally charged or heated.
  - Acknowledge their emotional pain, feelings of helplessness and fears.
  - Empathize with their situation.
  - Listen to the person's frustration.
  - Understand how they perceive the situation.
  - Avoid arguing or defending previous actions.
  - Avoid threatening body language (i.e. do not stand with arms crossed).
  - Restate common goals.
  - Use a calm voice and simple statements.
  - Be aware of your own emotions changing as the conversation intensifies.
  - Get assistance from someone who is neutral and can help change the dynamics.

f. Set expectations and define non-negotiables during the family team process.

Background:

When parents and family members are confronted with the reality of their involvement with the child welfare system, they often experience many emotions, including anger, sadness, embarrassment, and most of all, fear of the unknown and uncertainty of their situation.

We have all experienced stressful situations that impact our ability to think and act in ways we typically would when not stressed. It is especially hard for parents to actively engage when they are preoccupied and worried about what might happen next. Additionally, for parents with previous child welfare experiences, being involved again can trigger significant traumatic stress that can bring about highly intense emotions in parents and children. This happens for several reasons. It is for this reason that expectations related to decision-making and timeframes must be identified or communicated to families in a way they can understand and accept.

As a caseworker, you are responsible for setting clear child welfare system expectations for the family, including those related to their involvement in case decision-making and planning. Parents should be encouraged to make decisions for their own families with the understanding there will be some parameters around these decisions. For example, while a domestic violence perpetrator will be expected to change the behaviors creating risk and safety concerns for the family, he can be engaged for input about how best he can accomplish those changes. Caseworkers also need to provide parents a clear picture of the rules, constraints and timeframes that influence what decisions get made, by whom and when. Issues related to child safety, court orders suspending visitation, mandatory drug screens, interviews with children alone or at school, and orders or protection are examples of non-negotiable items that should be clearly communicated with family members. There is an inherent tension between the rights of parental decision-making and caseworker mandates to ensure child safety.

Policy Requirements:

FOM 722-6B: Children and families should understand what is negotiable and what is not negotiable when making decisions as a part of the family team meeting process.

Detailed Practice Guidance:

- Prepare family members for the discussion. Be upfront and patient from the start.
  - Take a deep breath and be aware of your own thoughts, emotions and potential triggers prior to the discussion.
  - Outline all areas in which you are hoping the family member will take the lead to make important decisions.
  - Lay out areas that are not up for negotiation, including if you feel like anyone's safety is being compromised.

  - Ask the family member to tell you what he or she understands about the areas that are not up for negotiation.
  - Get assistance from someone who is neutral and can help change the dynamics.

- Provide context.
  - Explain why this area is important and why it is not up for negotiation.
  - Help family members prioritize the decisions they need to be making.
  - Acknowledge the tension between parental decision-making and caseworker mandates.

- Encourage questions.
  - Encourage children, parents, and extended family members to raise questions and concerns.

- Stay connected and supportive.
  - Remember that people respond to communications very differently, even when they're hearing the same information. By recognizing what parents and children are possibly thinking and experiencing emotionally, you can anticipate their reactions and better understand how to deliver messages.

g. Practice cultural awareness when engaging children and their families.

Background:

Racial and ethnic identity formation is an important part of human development and is a part of our overall identity formation. It is influenced by childhood and school-age experiences. Racial and ethnic identity comes to the forefront during adolescence and continues throughout our lifetime.[11]

Cultural awareness is also an important part of engaging and working with children and families involved in the child welfare system. Cultural awareness involves the values, norms and traditions that affect how individuals of a particular group perceive, think, interact, behave, and make judgments about their world.

Talking about culture, race, ethnicity, power and privilege can be uncomfortable considering the impacts of racism, oppression, prejudice, and stereotypes. These discussions are necessary if we want to assist youth to develop their racial and ethnic identity and to also move towards a society that works against oppression and racism.[12]

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[11] Casey Family Programs (2005). *Knowing Who You Are: Helping youth in care develop their racial and ethnic identity.*

[12] Ibid.

Cultural awareness work can and should be integrated into day-to-day practice. It is not something that can be adequately addressed in one or two visits or conversations. We need to look at it in the context of every aspect of each individual's life–where he or she lives, how it affects him or her in the community and school system, connections to birth and extended family, access to mentors and role models, the messages they may be hearing, etc.[13]

Policy Requirements:

FOM 722-2: Services from child placing agencies are available to all children, regardless of the religious orientation of the child or parent. The agency must not require a child to attend church services or to follow specific religious training. The agency will attempt to fulfill parental wishes whenever possible, while taking into consideration the child's feelings and desires. If there is disagreement between the parents and child, parental wishes prevail.

Foster parents/caregivers are expected to take into consideration the child's religious preference, especially when the child has established a pattern of religious belief and practice. Foster parents/caregivers assume the responsibility for providing opportunities for religious education and attendance at religious services in accordance with the religious preference of the child and/or parent(s).

School programs, whether public or private, must be accredited. If a child is allowed to attend a private school, the school's philosophy must not be contrary to the child's or the family's beliefs, customs, culture, values and practices. Parental permission is required for a temporary court ward to attend private school.

NAA 205: For American Indian/Alaska Native children, active efforts are **required** throughout all aspects of case service planning. Active efforts are more intensive than reasonable efforts and require the foster care worker to thoroughly assist the family in accessing and participating in necessary services that are culturally appropriate, remedial, and rehabilitative in nature.

When working with American Indian children, please refer to the Native American Affairs Manual (NAA). Casework service **requires** the engagement of the family in development of the service plan. This engagement must include an open conversation between all parents/guardians and the foster care worker in: discussing needs and strengths, establishing the service plan and reaching an understanding of what is required to meet the goals of the service plan.

[13] Ibid.

FOM 722-8: The child and parent(s) must be asked about their religious affiliation, participation, attendance, special dietary requirements, grooming, dress, or makeup requirements.

Native American Affairs Manual: When working with American Indian children, please reference **http://www.mfia.state.mi.us/olmweb/ex/NA/Public/NAA/000.pdf.**

Detailed Practice Guidance:

- Self-Reflection.
  - Define your own cultural, family beliefs and values.[14]
  - Define your own personal culture/identity: ethnicity, age, experience, education, socio-economic status, gender, sexual orientation, religion, etc.[15]
  - Are you aware of your own personal biases and assumptions about people with different values than yours?[16]
  - Challenge yourself in not automatically identifying your own values as the "norm".[17]
  - Develop skills for talking about race and ethnicity, addressing racism and discrimination, and integrate into day-to-day practice.[18]

- Awareness.
  - Questions such as "Who am I?" and "Where do I belong?" may be particularly difficult for youth who have been removed from their biological families.[19]
  - Youth who are transitioning out of care need support in building a positive sense of self and a deeper understanding of their identity. Identity may reflect racial and ethnic background, spirituality, sexual orientation, and values.[20]

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[14] California Health Advocates (2007). *Are you practicing cultural humility? – The key to success in cultural competence.*

[15] Ibid.

[16] Ibid.

[17] Ibid.

[18] Casey Family Programs (2005). *Knowing Who You are: Helping youth in care develop their racial and ethnic identity.*

[19] Child Welfare Information Gateway (2013). *Helping Youth Transition to Adulthood: Guidance for Foster Parents.*

[20] Ibid.

- Many lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth face neglect or abuse from their families of origin because of their sexual orientation or gender identity.[21]
- Youth with disabilities who are also in the foster care system are one of the most vulnerable populations in the United States, yet little attention is focused on the unique challenges they face as they negotiate their way through multiple systems to adulthood.[22]
- Be aware that different cultures/ethnicities may have very different views on what is considered appropriate discipline of a child, a "clean" home, hierarchy of power within the household and what constitutes domestic violence.
- Be aware that recent immigrants may not have an understanding of federal or state laws, or the role of child welfare. Be prepared to explain and or share resources to help educate and inform.
- In some cultures/ethnicities, willingness to admit to, or seek treatment for substance abuse and/or mental health needs, is considered shameful or weak. Be culturally sensitive when addressing these topics.
- Ensure that you are providing active efforts to any child that is Native American, as outlined in the Indian Child Welfare Act and the Michigan Indian Family Preservation Act.

- Engagement.
  - Ask the child and parent how they identify themselves (i.e. race, ethnicity, socioeconomic status).
  - Identify cultural practices that may be based on religious beliefs, such as the avoidance of certain foods or the wearing of traditional clothing.
  - Determine what type of environment the child identified as most comfortable and familiar prior to entering care.
  - Ask the child and parent if they identify with a physical or mental condition that limits their movements, senses or activities.
  - Incorporate when working with Native American families the Indian culture in planning for services and evaluating the effectiveness of services to meet the cultural needs of the child(ren) and family. (NAA205–MDHHS Policy)

- Action.
  - Provide the child and/or parent with community resources or support groups that will help support their identified needs. This can include, but is not limited to:
    - LGBTQ support groups and activities.

[21] The National Resource Center for Youth Development. *LGBTQ Youth in Care: Information and Resources.*

[22] The National Council on Disability (2008). *Youth with Disabilities in the Foster Care System: Barriers to Success and Proposed Policy Solutions.*

    - Churches and other religious locations and activities that will allow the individual to maintain her/her religious preference.
    - Disability and mental health support groups and employment resources, including information on Social Security disability.
- Discuss relevant information with foster parent/caregiver. Ensure that the child is a part of this conversation to assist in placement acclimation.
- When addressing LGBTQ topics, be mindful that this is a very sensitive topic. Only disclose information when given permission by the individual.
- When working with Native American families, utilize tribal representatives in all areas of case planning, including family team meetings.

5. Practice Guide for Supervisors: Engagement

Practice Guide for Supervisors	
Engagement	
MITEAM COMPETENCY	Engagement is a series of intentional interventions that work together in an integrated way to successfully establish a relationship with children, parents and other individuals. Caseworkers will engage with the child, mother, father, extended family, primary caregiver, professionals working with the family and other team members for the purpose of building an authentic and collaborative working relationship. Supervisors will educate, model and coach caseworkers in the Key Caseworker Activities of engagement.

FIDELITY MEASURES	**Observation:**
	• Treats individual(s) with respect.
	• Treats individual(s) with empathy.
	• Uses verbal responses that are consistent with body language.
	• Acknowledges his/her authority and the disproportionate amount of power in the relationship.
	• Helps the individual(s) identify people who are supportive.
	• Addresses reasons for reluctance to including specific team members.
	• Assists the family with navigating agency systems and processes.
	• Discusses with the family the success of the child(ren)/youth beyond case closure.
	• Provides trauma education to the individual(s).
	• Provides feedback to the individual(s).
	• Asks for feedback from the individual(s).
	Documentation:
	• A team that provides support to the child(ren)/youth and family has been formed.
	Interview:
	• The individual(s) was able to identify helpful activities of the worker.
	• The individual(s) feels understood by the worker.
	• The individual(s) feels respected by the worker.
	• The individual(s) reports the worker acknowledged the unique culture of the family/household.
	In Supervision:
	• The worker was able to identify:
	  ○ What is most important to the individual/family.
	  ○ How frame of reference is managed.
	  ○ Positive supports for the individual(s).
	• The worker identifies own team members that support their professional development.
	• The worker exchanges feedback with the supervisor.

POLICY REQUIREMENTS	• Ensure children/youth and families have a voice in decisions that affect them. • Treat parents with dignity and respect and, whenever possible, include them in the decisions that affect them and their children. • Actively partner with family teams to identify needs and plan interventions to protect children and support families. • Identify and provide notice that a child is in foster care (within 30 calendar days of removal) to all adult relatives including, but not limited to, maternal and paternal grandparents, maternal and paternal aunts, maternal and paternal uncles, adult siblings of the child and any other relative identified by the parent or child. • Continue to seek, identify and notify relatives that a relation is in foster care until a child has achieved legal permanency.

KEY CASEWORKER ACTIVITIES	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE TECHNIQUES
KCA 1 ENGAGEMENT ***Create an environment of empathy, genuineness, respect and empowerment that supports a family entering into a helping relationship and actively working toward change.***	From the point of initial contact with the family to permanency and / or case closure.	• Educate, model and coach caseworkers on their approach for connecting with each family that demonstrates the core conditions of helping and supports engaging the parents and children in a productive working relationship. • Educate, model and coach in critical engagement activities, such as home visits, family team meetings and interviews. • Educate, model and coach caseworkers in identifying bias, judgment, and thinking errors that may impact engagement, assessment, and interventions. • Educate, model and coach the caseworker on effectively using the practice of full disclosure. Speak honestly about what is happening related to the child and family's involvement in the child welfare system. This is a building block in developing a healthy relationship. • Educate, model and coach caseworkers on how and when to use open-ended, solution-focused questions. The supervisor should provide constructive feedback regarding the type and wording of questions posed. • Evaluate caseworker awareness of cultural issues that may be present. • Explore the caseworkers' findings regarding tribal affiliations and Indian heritage. The supervisor should model behavior of dependability, availability and consistency. • Educate, model and coach caseworkers to use age and culturally-appropriate engagement techniques and tools to create opportunities for developing emotional safety and mutual honesty. Review and monitor the casework of the worker. The supervisor should provide the structure, tools and organization that will enable the worker to perform necessary work. The supervisor should be fully aware of areas of strength and areas of need of the worker and should provide training, teaching, education and mentoring as needed.
KCA 2 ENGAGEMENT ***Search for and engage parents, family members and other support persons from the child's community in the family team process.***	From the point of initial contact with the family to permanency and/or case closure.	• Review caseworker activities to identify family members and persons from the child's community who are willing to support the child and family and provide feedback to improve caseworker performance to successfully search and engage family connections. Consider any potential safety threats involved in engagement of family members, especially a parent who is not currently involved in the life of the family. • Educate, model and coach caseworkers on how to engage parents, child, community supports, and extended family in the family team meeting process. Provide immediate, behavioral feedback. • Review with the worker his or her ongoing diligent search efforts. What is working, what is not? Provide feedback on how to improve results. What additional effort can be made? What leads can be followed? Has the child/youth been a part of identifying possible family/child/youth support? • Review documentation of engagement efforts and identify ways to improve documentation to better reflect actual practice.

6. Additional Resources to Support Effective Engagement

The following resources provide information regarding proven approaches, promising practices, guidance and tools for engaging family members to foster meaningful inclusion and participation in all aspects of case planning, implementation, and service delivery.

//www.webworks2go.com/PreService/Solution_Focused_Techniques.pdf. (May, 2007) An excerpt from "Building Solutions in Child Welfare (Partnerships for Safety)" by Insoo Kim Berg. This set of exploratory questions is utilized by the Minnesota Department of Human Services' Child Welfare Training System as an approach for family engagement.

//www.aifs.gov.au/cfca/pubs/practice/a144436/. "***The Application of Motivational Interviewing Techniques for Engaging 'Resistant" Families'. Maria Iannos and Greg Antcliff. Published by the Australian Institute of Family Studies, May 2013.*** This publication provides information relevant to engaging families through motivational techniques that yield an understanding of the where the family is in the "change" process based on the stages of change model put forth by DiClemente and Prochaska.

//qsw.sagepub.com. This link provides access to an online forum, Qualitative Social Work which provides abstracts for articles and resource information in the area of qualitative research and evaluation of practice. One article, "Strengthening Social Worker-Client Relationships in Child Protective Services", is available through subscription. The search feature enables access to various articles and studies based on topic and issues.

//www.hunter.cuny.edu/socwork/nrcfcpp/info_services/assessment.html. This link provides access to a study conducted by Chapin Hall in 2009 entitled, "Identifying, Interviewing, and Intervening: Fathers and the Illinois Child Welfare System." The study indicates that early identification and engagement of fathers more frequently led to reunification for children in care.

***De Jong, P. and Berg, I.K. (2002). *Interviewing for solutions*.** This book contains information regarding interviewing techniques based on experiences with solution-based therapy. The authors illustrate effective methods for engaging individuals in identifying strengths and solutions as a method for achieving desired changes in their life circumstances.

//centerforchildwelfare.fmhi.usf.edu/preservice/participantguides/Intro%20to%20Interviewing%20Participant%20Guide.pdf. These materials are part of the Child Welfare Pre-Service Training Curriculum that was produced by the Florida International University for the Florida Department of Children and Families, Office of Family Safety. This portion of the curriculum focuses on the core conditions of helping, basic interviewing skills and strategies to engage families in the assessment and case planning process.

//www.cebc4cw.org/program/solution-based-casework/detailed. This link accesses information from the California Evidence-Based Clearinghouse for Child Welfare which provides information about research concerning innovative child welfare programs and practices in the state of California. There is a directory of programs and articles with a range of topics/issues relevant to working with families involved with the child welfare system.

//www.childwelfare.gov/famcentered/engaging/. This link to the Child Welfare Information Gateway provides a great deal of resource information regarding examples and models for engaging fathers, paternal relatives and children and youth in various states. There are bulletins and publications regarding key practice principles and additional links to toolkits to promote family engagement.

Rockymore, Maxie. "A Practice Guide for Working with African American Families in the Child Welfare System". February, 2008. This publication provides a perspective on understanding and engaging African-American families who are involved with the child welfare system. The author is affiliated with the University of Minnesota. The article focuses on the identification of the strengths and cultural experiences of African-American families in order to promote their engagement and participation in service planning.

"Strategies to Increase Birth Parent Engagement, Partnership, and Leadership in the Child Welfare System: A Review" (July 2012) Casey Family Services. //www.casey.org/resources/. This link provides access to a resource library page with a directory to search numerous publications, including the article referenced above, which features best practices and effective models for engaging families in a collaborative relationship to make appropriate decisions regarding the care of their children.

//www.childwelfare.gov/outofhome/family_finding/search_statelocal.cfm. This site is a link to the Child Welfare Information Gateway and includes several examples of state and local programs and practices for searching for noncustodial parents and relatives.

www.practicenotes.org. ***"Bringing Absent Relatives into the Picture", Volume 14, Number 1, April 2009.*** This website is supported by the Children's Services of the North Carolina Division of Social Services and the Family and Children's Resources Program. This article highlights briefly and succinctly helpful tips and suggestions for searching diligently for relatives and underscores the key benefits for children.

Patterson, Grenny, McMillan, Switzler, Crucial Conversations: Tools for Talking When Stakes are High (New York: McGraw Hill, 2012), 3-4, 101-102. This book provides skills on how to conduct a conversation and discussion between two or more people in crucial times in which; (1) stakes are high, (2) opinions vary and (3) emotions run strong. The concepts are relevant for the supervisory relationship as well as the relationship between the department and individual family members being served.

California Health Advocates (2007). "*Are you practicing cultural humility? The key to success in cultural competence."*

Casey Family Programs (2005). "*Knowing Who You Are: Helping youth in care develop their racial and ethnic identity".*

Child Welfare Information Gateway (2013). "*Helping Youth Transition to Adulthood: Guidance for Foster Parents."*

The National Council on Disability (2008). "*Youth with Disabilities in the Foster Care System: Barriers to Success and Proposed Policy Solutions.*"

Bancroft, Lundy, Jay G Silverman, and Daniel Ritchie. *The batterer as parent: Addressing the impact of domestic violence on family dynamics*. SAGE Publications, Incorporated, 2011.

Groves, Betsy McAlister. *Children who see too much: Lessons from the child witness to violence project*. Beacon Press, 2003.

B. Competency Two: Teaming

1. Overview of Teaming

Teaming is a collective effort that necessitates a team approach. Caseworkers will form a team comprised of the important people in the child and family's lives that meet, talk and plan together. Caseworkers will ensure team functioning by making sure the team has the ability and cultural competence to design effective services and supports, adjust as may be needed and use collaborative problem-solving. Supervisors will educate, model and coach caseworkers in effective teaming practices such as team formation, coordination, and facilitation to ensure proper team functioning.

This teaming section provides general practice guidance related to the KCAs, detailed practice guidance for caseworkers and supervisors, a summary of key requirements, summary of relevant policy and additional resources that support the implementation of effective teaming practice with children and families.

2. Practice through a Trauma Lens: Focus on Teaming

Utilization of a trauma-informed approach to teaming with children, families, and other individuals will assist in the application of the KCAs and improve overall practice. The essential elements below were identified as critical to effective teaming. The explanations of each essential element were taken directly from "Guidelines for Applying a Trauma Lens to a Child Welfare Practice Model" (Chadwick Trauma-Informed Systems Project [CTISP], 2013):

> **Essential Element: Partner with Youth and Family**
> Youth and family members who have experienced traumatic events often feel like powerless pawns in the system, reinforcing feelings of powerlessness felt at the time of the trauma. Treating youth and families as partners by providing them with choices and a voice in their care plays a pivotal role in helping them to reclaim the power that was taken away from them during the trauma and tap into their own resilience. Youth and family members who have been involved in the child welfare system have a unique perspective and can also serve as partners by providing valuable feedback on how the system can better address trauma among children and families. These partnerships should occur at all levels of the organization, as youth and families can help shape trauma-informed practices and policies (CTISP, 2013).
>
> **Essential Element: Partner with Agencies and Systems that Interact with Children and Families**
> No one agency can function alone, and in a trauma-informed system, child welfare must reach out and coordinate with other systems so they too can view and work with the child and family through a trauma lens. This partnering includes:

- Teaming with law enforcement to minimize the number of front-end interviews a child must experience.
- Working with mental health agencies to ensure therapists are trained in specialized trauma assessment and evidence-based or evidence-informed trauma treatments.
- Coordination with schools, the courts, and attorneys.

Such coordination is necessary to prevent one part of the system undoing the good trauma-informed work of another part of the system (CTISP, 2013).

The following Trauma-informed Practice Strategies (TIPS) were identified as critical to effectively operationalize teaming skills through a trauma-informed lens:

Address Trauma:

- Build Resiliency in children, families, family team members, and self through building Trauma-Informed case plans that:
  - Promote mastery/competency.
  - Promote ability to develop and build relationships.
  - Promote ability to regulate emotion and behavior.
  - Foster development of self-esteem.
- Refer for evidence based/evidence supported trauma intervention when appropriate.

Educate about Trauma

- Proactively Transfer trauma knowledge through ongoing conversations that build understanding from the first interaction to the last. May include discussion around:
  - What trauma is.
  - What can be traumatic to a child or an adult.
  - How trauma changes the brain.
  - How trauma impacts people differently.
  - The impact and symptoms of trauma.
  - What resiliency is.
  - How resiliency works to treat trauma.
  - How resiliency can be built.
  - How resiliency can impact long-term view.

3. Practice Guide for Caseworkers: Teaming

Practice Guide for Caseworkers	
Teaming	
MITEAM COMPETENCY	Teaming is a collective effort that necessitates a team approach. Caseworkers will form a team comprised of the important people in the child and family's life that meets, talks and plans together. Caseworkers will ensure team functioning by making sure the team has the ability and cultural competence to design effective services and supports, adjust as may be needed and use collaborative problem-solving.

FIDELITY MEASURES	**Observation**:
	• Helps the individual(s) identify people who are supportive.
	• Addresses reasons for reluctance to including specific team members.
	• Prepares the family team members (informal and formal) for participation on the team.
	• Facilitates teaming.
	• Accesses skilled team members (formal and informal) to serve family's goal.
	• Asks the individual(s) what the team members (informal or formal) have done to provide support.
	• When developing or adjusting the plan, asks for team member's input.
	Documentation:
	• A team that provides support to the child(ren)/youth and family has been formed.
	• The worker prepares the family team members (informal or formal) for participation on the team.
	• The family's suggestions and comments are documented in the case file.
	• The team member's suggestions and comments are documented in the case file.
	• Documentation indicates the worker maintained contact with the family and support persons between in-person meetings.
	• The family's team meets within the required timeframes (FOM 722-6B).
	• There is evidence in the documentation that the team implements specific safety activities to address safety concerns of the child(ren)/youth.
	• There is evidence in the documentation that the team addresses specific permanency plans.
	• There is evidence in the documentation that the team addresses specific issues of well-being for the child(ren)/youth.
	Interview:
	• The individual(s) was able to identify helpful activities of the worker.
	• The individual(s) reports the worker acknowledged the unique culture of the family/household.
	• The individual(s) described specific examples where his/her input was utilized in decision-making.
	• The individual(s) reports the work includes informal resources as support.
	In Supervision:
	• The worker was able to identify:
	  ○ How the parent participates in the process of change.
	  ○ Positive supports for the individual(s).
	  ○ What progress has been made so the family's team is taking ownership of the case planning process and fully participating in the shared decision-making.
	  ○ How he/she educates the family about the importance of teaming.
	  ○ How committed the family's team is in supporting the family's plan.

POLICY REQUIREMENTS	• Youth 16 and older must have a discharge meeting 90 days before dismissal or 30 days after an unplanned court discharge. • Semi-annual permanency meetings must begin at 14 years old and occur once every six months for the purpose of discussing permanency goals/plans and identifying supportive adults. (Meetings must be facilitated by someone other than the assigned caseworker if youth is in Young Adult Voluntary Foster Care.) • For incarcerated parents, caseworker must provide and document notice of the FTM by mail or telephone, contact the facility where the parent(s) is(are) incarcerated and request parent participation in the meeting, provide a copy of the 1105, and request signature and return of the document. • For incarcerated parents, caseworkers must provide notification of court intervention, change in permanency goal and return home family team meetings. • All children age 11 or older should be invited to FTMs unless it is determined that it would be harmful to a child's safety or well-being. • Initial FTM pre-meeting discussions must occur in person. Subsequent discussions may occur over the phone. • During FTM pre-meeting discussions, caseworkers must discuss the purpose of the FTM, confidentiality, family story, strengths, proposed participants, non-negotiables and family needs. They must also provide the family with a Pre-Meeting Discussion brochure (MMDHHS-PUB-1160) if they have not received one.
HOW TO USE YOUR SUPERVISOR	Schedule, prepare and actively participate in regular case conferences with your supervisor to discuss: • Strategies for identifying the appropriate individuals to be part of the family team. • Barriers to identifying, recruiting and engaging the appropriate individuals in the family team process and meetings. • Ways to use team members as key supporters for the family in order to achieve positive outcomes. • Completed teaming activities, the outcome of that effort, pending activities and possible next steps to support the development and utilization of the family team. • Whether to hold separate or joint family team meetings in domestic violence cases, and how best to plan for safety for the adult and child survivor, prior, during, and after the team.

KEY CASEWORKER ACTIVITIES	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE TECHNIQUES
KCA 3 TEAMING **FORMATION** ***Form a family team.***	From initial contact to permanency or case closure.	• Discuss with child/youth, parents and family who they want to be members of their team. • Involve both parents (including non-custodial parents) and their extended families and relations unless there are identified safety concerns. • Ask members of the family team what resources and/or supports they may be able and willing to provide to the child and parent.

		• Help the family identify individuals beyond their immediate family network who can or have supported them in the past. Team membership can include: the child, parents, caregivers, family members, fictive kin, community support worker, guardian, key interveners, teacher and any other persons invited by the child and family. Professionals providing treatment and other service providers should also be included. • Identify and understand any reluctance to include relevant participants, particularly absent parents. Address reasons for reluctance and make needed adjustments to the team and process. • Recruit the persons who have been identified to become members of the family team. • Seek commitments from those people identified to participate as members of the family team. • Help the parent and child understand the importance of having motivated, qualified persons on the team and actively participating. • Form a family team and ensure the ongoing coordination and functioning of the team. See DPG_form_a_family_team.
KCA 4 **TEAMING** **COORDINATION** ***Prepare members of the family team for participation on the team and for upcoming decisions that will be made.***	From initial contact to permanency or case closure.	• Provide the family with a general orientation to the teaming and the Family Team Meeting (FTM) processes. The overview should provide the family with information they need to know so that they can prepare to take ownership of the case planning process and fully participate in the FTM. • Prepare family members to tell their own story describing their current needs, strengths and level of functioning. Team members should be prepared to explain what happened to bring them to the attention of MDHHS. Their strengths need to be contextualized with their potential trauma history identifying how those strengths can assist the parent and child in recovering from the impact of past trauma and how they will prevent future maltreatment and keep their children safe moving forward. • Prepare the family and other identified team members for having an open and honest discussion. Discuss confidentiality and privacy rights and other considerations. • Create an agenda for the meeting with input from the team. Ask the family and other team members what they hope to accomplish at the meeting. • Ask parents and other team members to suggest ground rules they feel may be helpful in the meeting and throughout the teaming process. • Set a convenient time and location for meetings for team members. • Identify and address cultural and linguistic needs of the team, including the need for an interpreter or for additional or customized supports.
KCA 5 **TEAMING** **FUNCTIONING** ***Ensure members of the team meet and participate in shared decision-making on a regular basis.***	From initial contact to permanency or case closure.	• Convene and facilitate formal family team meetings to ensure team members are engaged in important decisions. See DPG_convene_facilitate_mtgs. • Keep team members informed and engaged in the teaming process. Set up an email list for members of the family team. Send regular updates. • Prepare members of the team for upcoming decisions that will be made. • Ensure the team meets often enough (i.e. in person, phone) to make informed decisions and fully support the family. • Identify ways to support the team's participation in team meetings and decision-making (e.g. provide transportation to meetings/appointments; supervise visits; attend family team meetings and court hearings with the parents; mentor the parent in the areas needing improvement (i.e. parent/child attachment/bonding, organizational skills, home maintenance, budgeting, or other life skills). • Acknowledge the parents' care for their children as their motivation to participate in the system to regain custody. • Encourage caregivers to understand and address the impact of trauma on the child or youth. See DPG_caregivers_impact_of_trauma.

4. Detailed Practice Guidance

a. Form a family team and work together until safety and permanency are achieved and the case is closed.

Background*:*

The teaming process is central to supporting children and parents. Caseworkers are responsible for engaging all of the persons identified as important supporters by the child and parent. Once these persons have been engaged, the next step is to begin the process of bringing these persons together to form a functioning team. Members of the team need to feel confident that no major decisions about removal, placement, services, or permanency will be made without their involvement and consent and that they will have the information needed to weigh in on these decisions.

It is important for caseworkers to recognize effective teaming practice and assess their own ability to support high-quality teaming to help families achieve safety, permanency and well-being.

A team is a group of motivated, qualified people, including informal supporters a parent or youth may invite, who bring skills and knowledge appropriate to the needs of the focus child, youth or family. Caseworkers are responsible for helping youth and their family members identify potential team members, recruit these persons and seek their commitment to participate as members of the team. The team must have the ability to plan, organize and execute effectively for and with the child and family, given the level of complexity and cultural background involved.

Team members meet and participate in a shared decision-making process on an ongoing basis. Team decisions should reflect effective family-centered problem solving that supports meeting the short-term and long-term goals of the child and family. Well-functioning teams have a working relationship with the child and family and with each other.

Team members should be prepared in advance of meetings for upcoming decisions and activities. It is important to check in with individual team members to ensure appropriate follow up on commitments made to the child and family and the broader team. Team members should be involved in the assessment, planning and implementation of interventions for and with the child and family.

Policy Requirements:

FOM 722-6B: Child welfare staff, parents, caretakers, foster parents, children and youth, along with extended family, friends, neighbors, community-based service providers, community representatives or other professionals involved with the family, should be a part of the family

team. The team should work together to create a plan for safety, placement and permanency tailored to the individual needs of each child. This process provides a forum to share ideas and opinions and stresses the importance of the family's perspective and involvement. In addition, this process encourages full participation of all participants, honest communication and promotes dignity and respect.

Detailed Practice Guidance:

- Use the team for planning and guiding service delivery.
- Meet the family's linguistic and cultural needs through identification of the right members of the team.
- Help the child and parents identify the right team members for their family.
- Ensure the child and parents are satisfied with the functioning of the team.
- Ensure team members understand the needs of the child and family.
- In domestic violence cases, safety is paramount. Whether there are separate or joint meetings, any team members should be carefully selected so as not to compromise ongoing safety or hold adult survivors accountable for perpetrator's behaviors. Safety planning should happen throughout the process. Review information to determine if information gathered from the adult and child survivors can be presented safely to the perpetrator. Look for third party sources, e.g. police report, prior documented CPS history, PPO statements and the perpetrator's own statements as additional or alternative sources of information. Ensure that concerns about the domestic violence perpetrator's behavior are expressed as the agency's concerns instead of a "he said, she said." Partnership with the adult survivor means giving him/her input into how issues of safety and confidentiality are approached.
- Set goals as a team and ensure these reflect the values and aspirations of the child and family for a better life.
- Acknowledge the challenges inherent in the teaming process.
- Meet (face-to-face and/or electronically) often enough to support shared decision-making, but a least as often as policy requires, at a pace that maintains awareness of the child and family situation and provides timely, appropriate services in response to emergent needs or problems.
- Ensure team members commit to and ensure dependable delivery of services and resources for the child and family. All members of the team are kept fully informed of progress being made and of the implementation of planned services.
- Ensure team actions and decisions follow a pattern of consistent and effective problem solving and results.
- Ensure team leadership has sufficient ability and authority to press accountable parties to meet requirements and commitments of service provision responsibilities and also advocate for additional needed resources.
- Ensure all involved parties have a common understanding of the plan and related requirements.

- Build consensus among members on outcomes and requirements for case closure. Respect dissent as necessary and valuable in the team process.
- Ensure all team members have and use the same information.
- Build accountability among team members for achieving desired outcomes.
- Set goals for attaining independence from the service system and case closure.
- Develop a mechanism for identifying emerging problems and initiating appropriate responses and adjustments in the planning and implementation processes.

b. Convene and facilitate formal family team meetings to ensure team members are engaged in important decisions.

Background:

MDHHS is committed to the goal of forming a team of motivated and committed persons who have the skill, personal interest and time to plan for safety, permanency, and well-being of each family served by MDHHS. Working together naturally over time–in formal meetings, staying in touch by phone calls, email, coordinating service planning, providing transportation, rethinking strategies–team members support the child and family in achieving important goals.

To build, prepare and maintain a functioning family team, caseworkers will need to devote a considerable amount of time to coordinating the efforts of the team. The caseworker or other designated lead persons will need to ensure team members, for example: understand important decisions that need to be made and are prepared to make them; bring the team together to make informed, integrated decisions; facilitate formal meetings; develop plans that reflect team member decisions; measure and share results of service referrals and services that have been provided and hold members accountable for the commitments they have made to the team. The caseworker must also make sure that the child's safety is never compromised by any decisions the team makes.

Convening and facilitating formal Family Team Meetings (FTMs) is one critical part of this process of ensuring that team members meet and participate in shared decision-making on a regular basis. Caseworkers are responsible for convening FTMs prior to removing children and youth from their own families, to develop plans, establish permanency goals, change permanency goals, help preserve placements, and develop transition plans to adulthood. Each of these areas requires attention and effort on the part of the caseworker throughout the FTM process. MiTEAM Specialists, supervisors and other persons are available to assist caseworkers in this process as may be needed. It is important that caseworkers acquire and use skills and practices that support effective teaming as they convene and facilitate formal family team meetings.

Policy Requirements:

FOM 722-6B: Caseworkers must encourage parents and children to identify and invite supports. The caseworker must coordinate efforts to invite all participants to the meeting. Pre-meeting discussions should be held to establish a supportive environment that allows the youth and parent to prepare for an active role in planning and facilitating the FTM.

Detailed Practice Guidance:

Below is detailed teaming guidance that supports caseworker practice before, during and after FTMs.

Before the family team meeting:

- Help parents and children identify and recruit relatives, friends and community supports to be part of the team.
- Prepare parents, children and team members to understand the purpose of the family team meeting, their role, what is expected of them, and strategies to help them effectively participate in the meeting.
- Prepare parents, children and team members for upcoming decisions, the criteria that will be used to make decisions and potential consequences for their decisions within the context of the child welfare system.
- Motivate, encourage and support team members to view family team meetings as a helpful, positive forum for supporting goal achievement. Respect diversity of views and dissent.
- Engage family and team members in the development of the meeting agenda.
- Use the family team meeting preparation tool DHS-1107, A Caseworker's Guide to Pre-Meeting Discussions & Family Team Meetings.
- In cases where domestic violence has been a factor (or alleged to have been) in the family functioning (even when it's not the reason for the current referral), determine with the adult survivor and supervisor whether there should be separate or joint meetings and team members understand the safety concerns, are supportive, and understand the importance of confidentiality, especially regarding safety planning information.

During the family team meeting:

- Welcome and introduce all members of the team.
- Help members of the team develop meeting ground rules and support their adherence during the meeting.
- Create a safe and predictable meeting environment so that team members can focus on the important tasks at hand. Acknowledge the group process may feel intimidating to some members.
- Actively encourage families and team members to contribute to the conversation and weigh in on important facts of the case, family strengths, needs, and circumstances, and the consequences of decisions made.

- Encourage consensus-building.
- Focus the activity and discussion of the family team meeting on family-centered planning that will support and create the conditions needed to achieve the identified permanency goal.
- Brainstorm ideas for supporting child safety and family stability.
- Outline the team's next steps and ensure understanding, accountability among team members.
- In domestic violence cases, ensure the physical and emotional safety of adult and child survivors to talk openly, and share hopes and fears. Be prepared to set limits for the domestic violence perpetrator, and to keep them focus on their own behavior and plan.

After the family team meeting:

- Follow up on commitments made by team members to determine if team members have questions or need assistance to fulfill their obligations and to ensure accountability within the team.
- Support an ongoing working relationship among team members by coordinating communication and activities between family team meetings.
- Bring the team back together as changes in circumstances and needs change.
- Discuss with the family team members their experience during the FTM and ways that it can be improved for future meetings.
- In domestic violence cases, check in with the adult survivor as to any safety concerns.

c. Team with parents and caregivers to help them understand and address the impact of trauma on their child.

Background*:*

Child maltreatment most often results in child trauma. A common definition of trauma is an overwhelming event that renders a person powerless, takes away physical and psychological safety and can have an ongoing harmful effect on perception of self, others and development.[23] Traumatic stress can change the physiology of the brain, especially in children.[24] In the past 20

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[23] Terr, L. *Too Scared to Cry.* Harper and Row, 1990. Source: Google Scholar

[24] Ford, Julien D., 2001-2012, Developer of Target Treatment Model. Trauma Affect Regulation: Guide for Education and Therapy. *Advanced Trauma Solutions, Inc.* Source: SAMSHA Grant Literature Citation

Ford, J. D., Fraleigh, L.A., Albert, D.B., & Connor, D. F. (2010). Child abuse and autonomic nervous system hyporesponsivity among psychiatrically impaired children. *Child Abuse & Neglect*, 34(7). Source: Google Scholar

Siegel. D., & Hartzell, M. (2003). *Parenting from the inside-out: How a deeper self-understanding can help you raise children who thrive*. New York, NY: Jeremy P. Tarcher/Putnam. Source: Google Scholar

years research on child trauma[25] has revealed that child maltreatment is very likely to be traumatic to children likely resulting in compromised functioning in multiple developmental areas for children.[26] Children who have experienced chronic maltreatment since early

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Siegel, D.J. (2010). *Mindsight: The new science of personal transformation.* New York, NY: Bantam Books. Source: Google Scholar

Ford, T. J., Taylor, E., & Warner-Rogers, J. (2000). Sustained release methylphenidate. Child Psychology and Psychiatry, 5, 108–114. Source: ACF Grant Literature Citation

Ford, Julian D., et al. "Child Maltreatment, Other Trauma Exposure, and Posttraumatic Symptomatology among Children with Oppositional Defiant and Attention Deficit Hyperactivity Disorders." Child maltreatment 5.3 (2000): 205-17. Source: ACF Grant Literature Citation

Putnam, Frank W. "The Impact of Trauma on Child Development." Juvenile & Family Court Journal 57.1 (2006): 1-11.

Source: ACF Grant Literature Citation

[25] DeBellis, M., & Thomas, L. (2003). Biologic findings of post-traumatic stress disorder and child maltreatment. Current Psychiatry Reports, vol. 5, 108-117. Source: ACF Grant Literature Citation

Perry, B.D., (1999), *The neurodevelopmental impact of violence in childhood*. Source: SAMHSA Grant Literature Citation

Perry, B. D. (2006). Applying principles of neurodevelopment to clinical work with maltreated and traumatized children: The neurosequential model of therapeutics. In N. B. Webb (Ed.), Working with traumatized youth in child welfare (pp. 27-52). New York: The Guilford Press. Source: SAMHSA Grant Literature Citation

Perry, B. D., & Szalavitz, M. (2007). The boy who was raised as a dog: And other stories from a child psychiatrist's notebook: What traumatized children can teach us about loss, love and healing. New York: Basic Books. Source: SAMHSA Grant Literature

Herman, J. L., Perry, C. J., & van der Kolk, B. A. (1989). Childhood trauma in borderline personality disorder. American Journal of Psychiatry, 146(4), 490-495. Source SAMHSA Grant Literature

van der Kolk, B. A. (2005). Developmental trauma disorder: Towards a rational diagnosis for children with complex trauma histories. Psychiatric Annuals, 35(5), 401-408. Source: SAMHSA Grant Literature Citation

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S. & Spinazzola, J. (2005) Disorders of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma. Journal of Traumatic Stress, 18(5), October 2005, 389–399. Source: SAMHSA Grant Literature Citation

[26] Cook, A. Blaustein, M., et al. (2003). *Complex trauma in children and adolescents*. White paper from the National Child Traumatic Stress Network, Complex Trauma Task Force. Retrieved April 29, 2011, from http://www.nctsnet.org/nctsn_assets/pdfs/edu_materials/complextrauma_all.pdf. Source: Google Scholar

childhood are likely to have experienced a number of different types of traumatic events. This phenomenon is defined as complex trauma.[27] Research indicates that children in foster care average between four and five different types of trauma, which does not take into account how many times each type of trauma may have occurred. [28] Becoming trauma-informed directs caseworkers to respond not just to the events of maltreatment but to the ongoing psychological impact from trauma to a child's development and well-being.

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[27]van der Kolk, B. A. (2005). Developmental trauma disorder: Towards a rational diagnosis for children with complex trauma histories. Psychiatric Annuals, 35(5), 401-408. Source: ACF Grant Literature Citation

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S.,& Spinazzola, J. (2005) Disorders of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma. Journal of Traumatic Stress, 18(5), October 2005, 389–399. Source: ACF Grant Literature Citation

Ford, Julian D., et al. "Child Maltreatment, Other Trauma Exposure, and Posttraumatic Symptomatology among Children with Oppositional Defiant and Attention Deficit Hyperactivity Disorders." Child maltreatment 5.3 (2000): 205-17. Source: ACF Grant Literature Citation

Ford, Julien D., 2001-2012, Developer of Target Treatment Model. Trauma Affect Regulation: Guide for Education and Therapy. Advanced Trauma Solutions, Inc. Source: ACF Grant Literature Citation.

Kagan, Jerome; Klein, Robert E. (2012), Cross-cultural perspectives on early development. American Psychologist Vol 28: 11, Nov 1973, p947-961. Source SAMHSA Grant Literature Citation

Kagan, Richard, NREPP; (SAMHSA's) National Registry of Evidence-Based Programs and Practices. Real Life Heroes, December 2007. Source SAMHSA Grant Literature Citation

Kagan, R., Douglas, A., Hornik, J., & Kratz, S. (In Press). Real life heroes pilot study: Evaluation of a treatment model for children with traumatic stress. Journal of Child and Adolescent Trauma 1(1). Source: ACF Grant Literature Citation

[28] Briggs, E. (2012). Factors impacting the completion of trauma focused treatment: What can make a difference, Traumatology. Source: SAMHSA Grant Literature Citation

Henry, J., Sloane, M., & Black-Pond, C. (2007). Neurobiology and neurodevelopmental impact on childhood traumatic stress and prenatal alcohol exposure. Language, Speech, and Hearing Services in Schools, 38(2), 99-108. Source: ACF Grant Literature Citation

Henry, J., Richardson, M., Black-Pond, C., Sloane, M., Atchison, B., & Hyter, Y. (2012). A grassroots prototype for trauma-informed child welfare system change. *Child Welfare*, *90*(6), 169-186. Source: ACF Grant Literature Citation

Henry, Black-Pond, Richardson (2011). Trauma-informed Court Report. Source: SAMHSA Grant Literature Citation

Henry, J., Richardson, M., Black-Pond, C., Sloane, M., Atchison, B., & Hyter, Y. (2012). A grassroots prototype for trauma-informed child welfare system change. *Child Welfare*, *90*(6), 169-186. Source: SAMHSA Grant Literature Citation

Caseworkers have not been consistently trained to provide an understanding of trauma to parents and their children. Utilizing a trauma perspective in child welfare is a change that caseworkers, supervisors, and administrators may not be comfortable with yet. Even so, the research on the value of identifying and addressing trauma for improving outcomes for children in child welfare is definitive.[29]

Equipping caseworkers with trauma knowledge to communicate to parents and children an understanding of trauma is the first step in becoming trauma-informed. Caseworkers are likely to initially resist educating parents and children about trauma. This is primarily due to: a) caseworkers do not feel confident in communicating to children, parents and caregivers about trauma; b) caseworker perceptions that "trauma" is a clinical term and, therefore, not for caseworkers to discuss with parents, caregivers and children; c) a fear that talking about trauma with parents, caregivers and children will trigger further traumatic stress in a child and further deteriorate mental health. Caseworkers also are often not trained to engage perpetrators of

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[29] Cohen, JA., Mannirinno, AP., Deblinger E., (2006). Treating Trauma and Traumatic Grief in Children and Adolescents. New York: The Guilford Press. Source: SAMHSA Grant Literature Citation

Cohen, J. A., Mannarino, A. P. & Knudsen, K. (2005). Treating sexually abused children: One year follow-up of a randomized controlled trial. *Child Abuse and Neglect, 29,* 135-145. Source: ACF Grant Literature Citation

Kagan, Jerome; Klein, Robert E. (2012), Cross-cultural perspectives on early development. American Psychologist Vol 28: 11, Nov 1973, p947-961. Source SAMHSA Grant Literature Citation

Kagan, Richard, NREPP; (SAMHSA's) National Registry of Evidence-Based Programs and Practices. Real Life Heroes, December 2007. Source SAMHSA Grant Literature Citation

Kagan, R., Douglas, A., Hornik, J., & Kratz, S. (In Press). Real life heroes pilot study: Evaluation of a treatment model for children with traumatic stress. Journal of Child and Adolescent Trauma 1(1). Source: ACF Grant Literature Citation

Perry, B.D., (1999), *The neurodevelopmental impact of violence in childhood*. Source: SAMHSA Grant Literature Citation

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Perry, B. D., & Szalavitz, M. (2007). The boy who was raised as a dog: And other stories from a child psychiatrist's notebook: What traumatized children can teach us about loss, love and healing. New York: Basic Books. Source: SAMHSA Grant Literature

Herman, J. L., Perry, C. J., & van der Kolk, B. A. (1989). Childhood trauma in borderline personality disorder. American Journal of Psychiatry, 146(4), 490-495. Source SAMHSA Grant Literature

violence and abuse about the trauma created by their behaviors. Additionally caseworkers can struggle to talk with non-offending parents in non-blaming way about the trauma their children have experienced from another parent or caregiver. These concerns and challenges are understandable but can be minimized through trauma training and consultation. Caseworkers are capable of communicating to parents, caregivers and children about what trauma is and how it could affect them. Talking about trauma is not "clinical," but rather a recognition of real experiences, such as "pain," "sadness," or "feeling overwhelmed." Naming trauma does not trigger a psychological deterioration, but provides language to normalize a child's, parent's or caregiver's experiences. Trauma-informed conversations also involve maintaining a focus on any immediate safety concerns for any family member.

It's also important to remember that trauma symptoms may be just one of the factors effecting child and family functioning when domestic violence is source of the trauma symptoms. Domestic violence perpetrator's behaviors can often lead to trauma symptoms. They can also be associated with other factors that may exacerbate trauma symptoms, or interfere with treatment. A domestic violence perpetrator's violence may scare children and it also may lead to eviction, which may create of cascade of other disruptions in the family functioning. These disruptions may lead to disconnection from family, school or treatment providers. These changes may exacerbate symptoms. Similarly, a domestic violence perpetrator may actively interfere with family members receiving treatment for trauma. All these factors need to be accounted for in working from a trauma and domestic violence-informed perspective.

Though licensed foster homes in Michigan receive trauma training, when communicating with parents and caregivers it is important to understand that there may be explanations as to why they may not initially be interested in learning about trauma. Parents and caregivers are not likely to understand what trauma means to their children's development and behaviors for several reasons:

- No language for trauma. They do not understand what trauma is and what it can do to development.
- Parent and/or caregiver fear that learning about their child's trauma will trigger guilt and/or shame for their role in their child's trauma.
- Fear that if their child or youth has been traumatized, the child or youth will not be able to recover from the trauma.
- Parents' and caregivers' own trauma that is unresolved. Parents and/or caregivers can be fearful that identifying and addressing their child's trauma will emotionally overwhelm them because of their own trauma as a child.

When parents and caregivers do understand trauma, they are more likely to recognize their child's behaviors as trauma-induced. Parents and caregivers want to help their children, but they often do not know how. Knowing that the child's behaviors are rooted in his or her own trauma history can help reduce parent and caregiver stress. They can realize that the child's behaviors are occurring, not because there is something wrong with the child or that the child is "bad", but rather that their children are reacting in normal ways to abnormal stress that

continues to be replayed in their brains. Providing caregivers with a basic knowledge of trauma can significantly alter negative perceptions of the child and their behaviors.

Talking to perpetrators of violence about their children's trauma is a challenging and important task. The casework needs to first to determine the safest environment to conduct the conversation and assess the safety of sharing information from other family members. The caseworker needs to be clear about the purpose of the conversation, e.g. developing a case plan, informing the perpetrator of the decision to file a neglect petition, engagement and assessment around motivation to change, getting the perpetrator to support trauma treatment for the children etc. Once these factors have been considered the caseworker will be appropriately prepared to discuss with the perpetrator of violence trauma concerns related to the children.

It also important to remember that some adults who are survivors of childhood trauma are also perpetrators of violence against other family members. It is important to keep safety and behavior change at the center of their case plan even as you might provide them with support and resources for their own trauma history. Any referrals made for trauma treatment for a perpetrator of violence must include information about the concerns related to their perpetration of violence as well as information about their own trauma history.

Policy Requirement*:*

There are no applicable policy requirements.

Detailed Practice Guidance:

- Ask parents and caregivers what they think the impact could be on the child or youth given what the child experienced (i.e. neglect, physical abuse, sexual abuse, etc.) or witnessed (i.e. domestic violence[30], parental substance abuse, etc.).
- Provide a simple definition of trauma to parents and caregivers. Help them understand that sometimes overwhelming events can happen to children and adults that take away safety and create powerlessness. The impact keeps affecting them. They may think about the event all the time. They may fear it happening again, become nervous all the time, have trouble sleeping or play or act out what happened to them.
- Screen for trauma utilizing trauma screening tools. Once the trauma screening has occurred, share the results with parents and caregivers to help them understand the connection between what has happened to the child and the behaviors. Be careful not

[30] In domestic violence cases, caseworker should ask this question of both the perpetrator and the adult survivor, although he/she should be mindful with adult survivors so as not to blame them, or hold them responsible, for the perpetrator's behaviors.

to blame the non-offending parent for the behavior of the perpetrating parent or caregiver.

- Communicate to parents, caregivers and their children hope for the future. Tell them that people can recover from trauma. Children can heal from trauma. They can learn to calm their body and brain when they get scared. They can change what they think about the experience and themselves. Telling their own story often times gives them power over it. It is most often essential to trauma recovery for a child to participate in trauma therapy.
- Inform parents and caregivers that children and adults who experience trauma may have behavior changes. Explain to them that trauma can affect learning in school, attention and listening, because these persons may be on high alert for danger. Children and adults who have experienced trauma have a much harder time trusting other persons and are more likely to be more aggressive and/or withdraw from other persons to protect themselves. Here is an example:
  My role is to be your caseworker. This means that I want to build a relationship with you. This relationship is valuable to me and hopefully it will be to you as well. I realize that given all that has happened to you, you may not trust me, and that is understandable and acceptable. I most want you to be safe with me, meaning that you can talk to me and I will listen. I will be honest with you even when I may have to tell you information that may be difficult and/or painful for you to hear. You deserve to know what is happening in court and what my recommendations are.
- Discuss resiliency with parents, caregivers and children. When children have positive personal relationships, experiences being successful, good self-esteem, and can manage their emotions, they are much more likely to get over the trauma and/or difficult experiences. Many times parents and caregivers are the key people to help a child overcome the effects of trauma.
- Ask parents and caregivers if they have experienced trauma. If they have, help them understand that this may be affecting their own parenting style. If it is affecting their parenting, they can recover.
- Be a broker for trauma services.
- Obtain a comprehensive trauma assessment, by a professional trained in childhood trauma, that identifies the impact of trauma to a child's development and functioning from which trauma-informed resiliency based case-planning can occur.
- Know what clinicians in the area are trained in evidence-based trauma treatment so that children who are traumatized can receive trauma treatment.

5. Practice Guide for Supervisors: Teaming

Practice Guide for Supervisors	
Teaming	
MITEAM COMPETENCY	Teaming is a collective effort that necessitates a team approach. Caseworkers will form a team comprised of the important people in the child and family's life that meets, talks and plans together. Caseworkers will ensure team functioning by making sure the team has the ability and cultural competence to design effective services and supports, adjust as may be needed and use collaborative problem-solving. Supervisors will educate, model and coach caseworkers in effective teaming practices such as team formation, coordination and facilitation to ensure proper team functioning.

FIDELITY MEASURES	**Observation**:
	• Helps the individual(s) identify people who are supportive.
	• Addresses reasons for reluctance to including specific team members.
	• Prepares the family team members (informal and formal) for participation on the team.
	• Facilitates teaming.
	• Accesses skilled team members (formal and informal) to serve family's goal.
	• Asks the individual(s) what the team members (informal or formal) have done to provide support.
	• When developing or adjusting the plan, asks for team member's input.
	Documentation:
	• A team that provides support to the child(ren)/youth and family has been formed.
	• The worker prepares the family team members (informal or formal) for participation on the team.
	• The family's suggestions and comments are documented in the case file.
	• The team member's suggestions and comments are documented in the case file.
	• Documentation indicates the worker maintained contact with the family and support persons between in-person meetings.
	• The family's team meets within the required timeframes (FOM 722-6B).
	• There is evidence in the documentation that the team implements specific safety activities to address safety concerns of the child(ren)/youth.
	• There is evidence in the documentation that the team addresses specific permanency plans.
	• There is evidence in the documentation that the team addresses specific issues of well-being for the child(ren)/youth.
	Interview:
	• The individual(s) was able to identify helpful activities of the worker.
	• The individual(s) reports the worker acknowledged the unique culture of the family/household.
	• The individual(s) described specific examples where his/her input was utilized in decision-making.
	• The individual(s) reports the work includes informal resources as support.
	In Supervision:
	• The worker was able to identify:
	  ○ How the parent participates in the process of change.
	  ○ Positive supports for the individual(s).
	  ○ What progress has been made so the family's team is taking ownership of the case planning process and fully participating in the shared decision-making.
	  ○ How he/she educates the family about the importance of teaming.
	  ○ How committed the family's team is in supporting the family's plan.

POLICY REQUIREMENTS	• Older Youth: Youth 16 and older must have a 90-day discharge meeting within 90 days before dismissal or 30 days after an unplanned court discharge. Semi-annual meetings must begin at 14 years of age occurring once every 6 months for the purpose of discussing permanency goals and identifying supportive adults. (Meetings must be facilitated by someone other than the assigned caseworker if youth is in Young Adult Voluntary Foster Care.) • Incarcerated Parent Participation: Caseworker must provide and document notice of the FTM by mail or telephone, contact the facility and request parent participation, and provide a copy of the 1105 and request signature and return of the document. Must provide notification for court intervention, change in permanency goal and return home FTM's. • Youth and Child Participation: All children age 11 or older should be invited to family team meetings unless it is determined that it would be harmful to a child's safety or well-being. • Pre-Meeting Discussion: The initial meeting must occur in person using the Pre-Meeting Discussion brochure (MMDHHS-PUB 1160); subsequent meetings may occur over the phone. The caseworker must discuss the purpose of the FTM, confidentiality, family story, strengths, proposed participants, non-negotiables and family needs.

KEY CASEWORKERS ACTIVITIES	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE TECHNIQUES
KCA 3 TEAMING **FORMATION** ***Form a family team.***	From initial contact to permanency or case closure.	• Set clear expectations for how to identify family team members from both maternal and paternal families, friends, teachers and community supports and provide tools, support and guidance necessary for their success. • Educate, model and coach caseworkers regarding whether to hold separate or joint meetings in domestic violence cases, as well as how to plan for safety throughout the teaming process. • Educate, model and coach caseworkers on how to approach potential family team members, discuss the role and benefits of their inclusion on the team, identify possible additional team members, and explore how they could possibly support the family and child safety. • Observe and provide feedback to caseworkers on how well they identify and resolve reluctance on the part of families to identify familial and community resources who could potentially support family reunification. • Review case notes and provide feedback to caseworkers on the success of their efforts to identify all possible family team members. • Educate, model and coach caseworkers on strategies to successfully obtain commitments from family and community resources to support parents and children. • Encourage the identification and addition of members to the family team throughout the life of a case.

KCA 4 **TEAMING** **COORDINATION** ***Prepare members of the family team for participation on the team and for upcoming decisions that will be made.***	From initial contact to permanency or case closure.	• Educate, model and coach caseworkers on the approach and content necessary to prepare members to effectively support family goals and decisions. • Observe, evaluate and provide feedback to caseworkers on their effectiveness in preparing members for their participation on the family team. • Help caseworkers process the personal and professional challenges in facilitating meetings and the challenges of difficult interactions. • Educate, model and coach caseworkers to support teams to build on recognize past trauma that may be impacting family functioning, family strengths and remain family-focused. • Educate, model and coach caseworkers to set expectations with members regarding the purpose of the family team process, their role in the process, how the process works, their participation and non-negotiable aspects of the process. • Educate, model and coach caseworkers on how best to describe and explain to family team members the decisions that will need to be made and how they will be made throughout the life of the case. • Educate, model and coach the caseworker how to talk with parents, children and other family members about adding or changing a permanency goal and other sensitive issues using full disclosure. • Review and provide feedback on plans for children/youth preparation and participation in the family team meeting process.
KCA 5 **TEAMING** **FUNCTIONING** ***Ensure members of the team meet and participate in shared decision-making on a regular basis.***	From initial contact to permanency or case closure.	• Monitor the timely and regular convening of family team meetings across the caseloads of caseworkers and provide feedback to improve performance. • Educate, model and coach caseworkers to facilitate FTMs to comply with both the requirements and intent of the meetings. • Educate, model and coach caseworkers to facilitate shared decision-making among team members and how to respect diversity of opinion and dissent. • Assist caseworkers in educating parents on the impact of trauma on their child.

6. Additional Resources to Support Effective Teaming

Effective teams are able to support families by working collaboratively to develop a plan of care and protection to achieve child safety, permanency, and well-being. The family team meeting process is a central path for utilizing a team of individuals to offer support, services and resources to achieve positive outcomes.

www.childwelfare.gov/management/reform/soc/communicate/initiative/soctoolkits/resources/NV_CaseManagementTrainingFacilitator.pdf. This link to the Child Welfare Information Gateway provides access to a guide for facilitating coordination of services among stakeholders and community partners and outlines strategies for addressing a range of dynamics and issues/priorities for case planning.

www.dcfs.state.la.us**.** The website for the Louisiana Department of Children and Family Services provides a search engine for key child welfare case planning activities. By entering family team meetings, a basic and family-friendly guide is available to describe the purpose and outline of a team meeting along with an explanation of the roles of the agency and family in the process.

www.hunter.cuny.edu/socwork/nrcfpp/info_services/family-group-conferencing.html. This link on the website of the National Child Welfare Resource Center for Organizational Improvement provides numerous articles regarding family team meetings and family group conferencing. The Child Welfare Policy and Practice Group has developed a guide for child and family planning teams that is referenced in several of the state models cited, having been utilized by the state of Indiana and New Jersey recently.

www.naswma.org/displaycommon.cfm?an=1&subarticlenbr=520. This article on the website of the National Association of Social Workers in Massachusetts focuses on de-escalation techniques in potentially explosive situations that can be applied to facilitation and management of volatile dynamics within a family team meeting.

www.threeriverscap.org/sites/default/files/081810de-escalationtraining.pdf. This link provides a PowerPoint presentation, *De-escalating people in Crisis. Nonviolent verbal intervention,* which was developed by Russ Turner, People Incorporated, August 2010, and published on the website of Three Rivers Community Action, a nonprofit social service organization based in Minnesota. The materials are applicable to managing the group dynamics within a family team meeting or other settings such as visits, court proceedings, etc.

http://info.MDHHS.state.nc.us/olm/manuals/dss/csm-55/man/CSVII.htm. The link to the website for the North Carolina Department of Health and Human Services provides access to its online policy and practice guides for holding a child and family team meeting. The materials provide helpful information about applying family-centered practice principles to these

activities and highlight the critical role of child and family team meetings throughout the life of the case.

http://www.futureswithoutviolence.org/family-team-conferences-in-domestic-violence-cases/.
Written by Lucy Salcido Carter, M.A., J.D., this is a link to a practice guide for family team conferencing when domestic violence is present.

C. Competency Three: Assessment

(Case Planning, Case Plan Implementation, and Placement Planning)

1. Overview of Assessment

Assessment is an ongoing process of information gathering, analysis, and collaborative decision-making that includes parents, family members, children, caregivers, and professionals as partners. A comprehensive family assessment is a compilation of evaluations used to design plans and provide children and parents services that focus on safety, permanency, and well-being. Assessing the potential impact of traumatic stress on children and caregivers is a part of this process so that it can be addressed in case planning.

The assessment process is used by caseworkers to develop a shared understanding or long-term view by all team members of the goals and outcomes that are necessary for the child to exit the child welfare system safely and permanently. The planning process defines clearly the outcomes necessary for exiting the system.

As a part of the assessment process, caseworkers must engage the team in the process of planning for safety, permanency and well-being, document and implement the plan. The placement process is a part of the planning process. It is the methodology to ensure identification of the most appropriate, least restrictive placement consistent with the child's need to maintain connections to family and friends, receive assistance with any special needs and stay in the same school when appropriate. It requires that the caseworker and supervisor keep the team focused on the primary concerns that led to the family involvement in the child welfare system and create linkages between the identified needs, desired changes, and use of family strengths to meet case planning goals. Caseworkers must then track plan implementation to ensure it is being implemented with the necessary people, intensity and quality to determine whether services and supports are meeting the needs identified in the plan. Caseworkers should work with the team to adjust the plan if supports and services are not meeting the needs of the child, youth or family. Supervisors will educate, coach and model KCAs in assessment, planning, implementing, and tracking practices.

This assessment section provides general practice guidance regarding the KCAs, detailed practice guidance for caseworkers and supervisors, a summary of key requirements, summary of relevant policy, and additional resources that support the implementation of effective practice with children and families.

2. Practice through a Trauma Lens: Focus on Assessment

Utilization of a trauma-informed approach to assessment with children, families, and other individuals will assist in the application of the KCAs and improve overall practice. The essential elements below were identified as critical to effective assessment. The explanation of the

essential element was taken directly from "Guidelines for Applying a Trauma Lens to a Child Welfare Practice Model" (Chadwick Trauma-Informed Systems Project [CTISP], 2013).

Essential Element: Identify Trauma Related Needs

The child welfare workforce should be educated on trauma and how it affects an individual at any stage of development and intersects with his/her culture. The system should screen everyone for traumatic history and traumatic stress responses which would assist the workers in understanding a child's and family's history and potential triggers and in creating a trauma-informed case plan. For those who screen positive for trauma, a thorough trauma-focused assessment by a properly trained mental health provider can identify a child's or parent's reactions and how his/her behaviors are connected to the traumatic experience and help guide subsequent treatment and intervention efforts (CTISP, 2013).

The following Trauma-informed Practice Strategies (TIPS) were identified as critical to effectively operationalize assessment skills through a trauma-informed lens:

Identify Trauma:

- Continually assess/screen for potentially traumatic/secondary traumatic events and potential trauma as a result of agency involvement.

- Refer for further trauma assessment when necessary as indicated by preliminary assessment/screen.

3. Practice Guide for Caseworkers: Assessment

Practice Guide for Caseworkers	
Assessment	
MITEAM COMPETENCY	Assessment is an ongoing process of information gathering, analysis and collaborative decision-making that includes parents, children, extended family members, caregivers and professionals as partners. A comprehensive family assessment is a compilation of evaluations used to design plans and provide children and parents services that focus on safety, permanency and well-being.
FIDELITY MEASURES	**Observation:** • Acknowledges his/her authority and the disproportionate amount of power in the relationship. • Helps the individual(s) identify people who are supportive. • Prepares the family team members (informal or formal) for participation on the team. • Facilitates teaming. • Accesses skilled team members (formal and informal) to serve the family's goal. • Asks the individual(s) what the team member(s) (informal or formal) have done to provide support. • Evaluates strengths. • Evaluates needs. • Asks the individual(s) about events experienced by primary/key family members that are potentially traumatic. • Requests individual(s) input regarding the effectiveness of services. • When developing or adjusting the plan, asks for team member's input. • Asks individual(s) their perspective on the parent's ability to keep the child(ren)/youth safe. • If child(ren)/youth is not residing with custodial parent: Asks individual(s) their perspective on the caregiver's ability to keep the child(ren)/youth safe. • If child(ren)/youth is not residing with custodial parent: Inquires about the caregiver's perspective on the impact of traumatic events on the child. • Inquires about the individual(s) perspective on the safety of all family/household members (both physical and psychological). **Documentation:** • A team that provides support to the child(ren)/youth and family has been formed. • The worker prepares the family team members (informal or formal) for participation on the team. • The family's suggestions and comments are documented in the case file. • The team member's suggestions and comments are documented in the case file. • Documentation indicates the worker maintained contact with the family and support persons between in-person meetings. • The family's team meets within the required timeframes (FOM 722-6B). • There is evidence in the documentation that the team implements specific safety activities to address safety concerns of the child(ren)/youth. • There is evidence in the documentation that the team addresses specific permanency plans. • There is evidence in the documentation that the team addresses specific issues of well-being for the child(ren)/youth. • The history of the family's involvement with MDHHS is thoroughly reviewed and outlined in the case file. • The case file contained documentation of a trauma screening for the child(ren)/youth.

	• The case file contained documentation of completion of a mental health screening as noted on the child's well child exam form. • The worker documented a thorough assessment of the family's circumstances. **Interview:** • The individual(s) was able to identify helpful activities of the worker. • The individual(s) reports being satisfied with services offered and/or referred. • The individual(s) reports the worker acknowledged the unique culture of the family/household. • The individual(s) described specific examples where his/her input was utilized in decision making. • The individual(s) reports the worker provided education on how early traumatic experiences may impact parenting. **In Supervision**: • The worker was able to identify: o What is most important to the individual/family. o How trauma has potentially impacted each individual. o How trauma is addressed in the case plan. o How the parent participates in the process of change. o Positive supports for the individual. o What progress has been made so the family's team is taking ownership of the case planning process and participating in the shared decision-making. o How he/she educates the family about the importance of teaming. o How committed the family team is to supporting the family's plan.
POLICY REQUIREMENTS	• Conduct a thorough inquiry of family background; focusing equal attention on the mother and father's history. • Follow the Forensic Interviewing Protocol (MDHHS Pub 779) when interviewing children. • Complete a CPS safety assessment as early as possible in MiSACWIS following the initial face-to-face, but no later than the initial disposition. Update or complete new assessments as required. • Complete the initial family assessment of needs and strengths (FANS-CPS) and a child assessment of needs and strengths (CANS–CPS) in cases where a preponderance of evidence of child abuse and neglect exists. • Determine likely hardship to the child if he or she were to be separated from his or her parents or caregivers. • Schedule a medical examination of alleged victims and any other children residing in the household as appropriate (PSM 713-4). • Complete a Risk Assessment (PSM 713-11) as required. • Complete a Risk Re-Assessment (MDHHS 258) as required. • Complete Foster Care Family Assessment/Reassessment of Needs and Strengths (MDHHS145) and age appropriate Foster Care Child Assessment of Needs and Strengths, (MDHHS-432, 433, 434, 435), initially by the 31st day after the child is removed and 90 days thereafter. Each child must be screened for educational needs within 30 calendar days of entry into foster care.

	• Complete the Foster Care Reunification Assessment (MDHHS-147). • Complete the Foster Care Safety Assessment (MDHHS-149). • Use family team meeting process to assess progress. • Determine recommendations for court. Assess the benefits and risks of a child remaining out of home and continuing in placement, returning home with monitoring or closing the case and terminating court jurisdiction. • Complete the Child Adoption Assessment (MDHHS-1927) within 45 calendar days of case acceptance. • Complete the Child Adoption Assessment Addendum (MDHHS-606) on an annual basis if the child has not been placed for adoption and when there is a change in placement or other significant event. • Complete Preliminary Adoptive Family Assessment (MDHHS-1926) to assess prospective adoptive families. • Complete the Initial Foster Home/Adoption Evaluation (BCAL-3130) on interested family once it has been determined adoption with the prospective family is in the child's best interest. • Complete the Adoptive Family Assessment Addendum (MDHHS-612) for approval of adoption when a specific child has been identified for a family.
HOW TO USE YOUR SUPERVISOR	Schedule, prepare and actively participate in regular case conferences with your supervisor to discuss: • Information and findings collected from formal risk and safety assessments and evaluations as well as informal interviews and analysis of the information collected as it relates to the child's safety, permanency and the child and family well-being and child welfare practice and intervention. • How assessment findings can inform the development of the case plan that centers of building resiliency and what decisions need to be made. • Specific barriers and their solution to involving the family in the assessment process.

KEY CASEWORKER ACTIVITIES	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE TECHNIQUES
KCA 6 ASSESSMENT ***Utilize formal and informal assessment techniques to collect information.***	Ongoing.	• Conduct safety and risk assessments to help understand the extent to which children and youth are safe and the types of services that may be needed to support them. See DPG_conduct_safety_assessments. • Reduce the trauma of the initial investigation and assessment. See DPG_reduce_trauma_initial_investigation. • Request and review prior substantiations, services, court documents, school reports, police reports, medical and mental health evaluations

		and other historical case information, including Soundex, Bridges, ICHAT and LEIN to inform assessment findings. • Assess for the presence of patterns coercive control and domestic violence in every case regardless of the presenting allegations. • Explore American Indian heritage by asking the child and family questions about American Indian affiliation. • Talk with relatives, noncustodial parents, other relevant caregivers, collaterals, school staff, service providers or other support people to collect information about the families current and past functioning. • As needed, refer for additional evaluations (i.e. psychological, trauma assessment, psychiatric, substance abuse, urinalysis testing, FASD pre-screening, early on, etc.) to gather relevant information on the strengths, traumatization, needs, risks, underlying issues, and future goals of the child and family. • Observe and note conditions in the home, attitudes and behaviors of the child and parent, relationships and interactions between each family member and their interactions with the caseworker to inform safety and risk determinations. • Assess the impact of the caregiver's behavior and decisions on child and family functioning. • Explore the child, parent and caregiver's connections with other individuals that may affect future case planning. • Complete trauma screening. • Explore through conversation and observation: ○ Parents' developmental expectations of children. ○ Parents' empathy of children's needs. ○ Parents' belief in the use of corporal punishment as a means of discipline. ○ Parents' roles with child. ○ Extent to which parents' are flexible or demand strict obedience to their demands. • Explore the presence of parental protective capacities and resiliency. Assess their ability to be reliably activated to protect their children by talking with team members and parents and observing parental behavior. Consider whether one parent is impeding, undermining or interfering with another parent's protective efforts. • Gather information on the child and family relationships/dynamics using eco-maps and genograms.
KCA 7 ASSESSMENT ***Collaborate with team members to identify child and family strengths, trauma and needs.***	• Prior to developing case plan. • At all caseworker visits with family members. • At assessment updates and prior to 90 day case plan updates.	• Meet with the team to discuss the purpose of assessment, what information is beneficial and how the information will be used. • Review initial safety/risk assessment and discuss strengths, past traumatization, safety concerns, and risk issues to be included in the assessment. Ask for the parent's input and perspective about the initial assessment. • Ask children/youth to identify family strengths and needs in accordance with their developmental and intellectual capacity. • Solicit parent's input on each member's strengths, needs and ways to address past traumatization. • Acknowledge and document the parent's perspective of strengths, needs and assessment findings. Identify and build on mutually agreed upon strengths and needs. • Have open, honest and respectful dialogue around the department's findings and assessment findings with team members.

KCA 8 **ASSESSMENT** ***Organize and analyze all of the information that is collected to develop a comprehensive family assessment.***	• Prior to developing case plan. • When assessments and case plans are updated. • As new information is discovered.	• Develop a comprehensive family assessment in partnership with the parents, children, youth, extended family members, and other support persons and use this information to inform planning. See DPG_develop_comprehensive_fam_assessmt. • Organize and analyze the information that was collected to determine areas of strength and need. • Brainstorm and formulate ideas about possible underlying causes for safety and risk issues, if the causes are unknown. • Determine the prognosis for change by evaluating the parent's readiness to change. Be able to articulate and justify this reasoning. • Determine the following if the family has prior history: ○ Patterns in abuse history for both the victim and the parent(s). ○ Parental compliance, participation and benefit of prior services. ○ Identification of relatives or significant others that could be used as a support system to the child or as possible placement. • Apply critical thinking skills to support the gathering and synthesizing of information which will support effective decision making. [31] • When domestic violence is a concern, use a perpetrator pattern based approach to formulate the concerns about child and family functioning.

[31] In domestic violence cases, assessment of danger and risk should stem from the perpetrator's pattern of coercive control and abusive behaviors and the risk the perpetrator poses to the children and not the adult survivor's decision making, i.e. if she/he chooses to stay or leave the relationship.

KCA 9 ASSESSMENT ***Update comprehensive family assessment on a regular basis and prior to case closure.***	• At least every 90 days. • Prior to updating case plan. • Whenever family or individual circumstances change substantially.	• Assessing and gathering of information are ongoing processes that occur during each contact with the child, parents and caregivers (including appropriate non-custodial parents) and both informal and formal supports. The results from the assessment process are documented in the various tools, which are used by MDHHS staff including safety and risk assessments, FANS and CANS. • Assess for coercive control and domestic violence. • Regularly meet with parents, family and team members to observe and discuss changes in strengths and needs relative to parenting capacity and identify emerging issues that may need assessing. [32] • Track and make referrals for ongoing periodic screenings and assessments, EPSDT, and follow-up assessment activities for other screenings/evaluations, re-testing for educational status, re-evaluation of mental health issues. • Make prompt and clearly defined referrals for additional or updated specialized evaluations needed as circumstances change or new needs emerge. • Obtain copies of new/updated screenings/evaluations and use in revising plans and goals. • Make direct contacts with providers of assessments/evaluations (with family's consent) to evaluate progress, identify needs and clarify recommendations. • Update the FANS/CANS tools whenever there is a major change in the child and/or family's circumstances or a placement disrupts but at a minimum at least every 90 days prior to the updating of the case plan. • Gather information from child, family, caregivers, and service providers on progress in achieving goals and correcting past trauma and other underlying issues contributing to needs. • Meet with child, parents and caregivers to discuss readiness and preparation for proposed case closure. Ensure the discussion with the child is developmentally-appropriate and sensitive to his or her individualized needs. • Identify presenting safety/risk issues and future risk of harm in the foreseeable future relating to the child's living situation and responsible caregivers. • Obtain needed supports and make referrals for services that can ensure the safety and stability of the child and family when the case is closed. • Provide documents to the child, parents and/or caregiver regarding health, education, identification and entitlements to services that can assist in the future. • Utilize skills of crucial conversations.

[32] In domestic violence cases, every effort should be made to keep the perpetrator visible throughout the life of the case, even if the relationship has ended and/or the perpetrator does not reside in the home. This includes meeting with the perpetrator, observing the perpetrator on visits with the children, etc.

4. Detailed Practice Guidance

a. Conduct safety and risk assessments.

First conduct safety assessments to understand the extent to which children and families are safe, and determine the actions and/or services needed to assure safety. Secondly, conduct risk assessments to estimate the risk of future harm to children in the household and to determine the need for ongoing services and plan for case closure.

Background*:*

Ensuring child safety is at the core of child welfare practice. Safety and risk assessment tools are available to assist caseworkers in determining the current and future safety and risk of a child. Appropriate utilization of these tools is essential for every caseworker throughout the life of a case. Safety and risk assessments are designed to support casework practice and decisions.

Safety assessments are utilized to assist workers in clarifying current identifiable concerns and immediate threats to child and family safety. The purpose of a safety assessment is to:

- Assess the present or imminent danger to all children in the family and all household members listed on the complaint.
- Ensure that major aspects of danger are considered in every investigation to ensure child safety.
- Determine whether to initiate or maintain a protective intervention(s) when danger or a threat of danger is identified.
- Ensure reasonable efforts to help keep families together and prevent a removal have been made.

When critically thinking about the safety of the child and family, the caseworker evaluates:

- The current concerns and inquiries about the extent of maltreatment.
- The circumstances surrounding the maltreatment.
- The protective capacities of the caregiver.

This critical thinking process also requires the caseworker to assess:

- The caregiver's perception of the situation.
- The child's level of vulnerability.
- The conditions that indicate impending danger to the child or youth.

This tool helps caseworkers create a clear picture of the current concerns and the steps that need to be taken to ensure child safety. The utilization of informal and formal techniques to assess safety is a continuous process throughout the life of a case.

Caseworkers should work with the parents and child as well as family members and family supports to develop an immediate, realistic and effective safety plan whenever needed.

Whenever safety issues are identified, the caseworker must work with the child and family in the development of and participation in a safety plan. The plan must be specific to the immediate safety concerns, realistic in its goals and possible for the family to achieve. If safety concerns are identified and a safety plan cannot be realistically established or supported by the family, other alternatives to address child safety must be considered.

Unlike safety assessments, risk assessments are utilized by workers at the conclusion of an investigation. The risk assessment determines risk of future harm to the children in the family. The risk assessment calculates risk based on response to the abuse and neglect scales (regardless of the initial allegations). Risk levels are intensive, high, moderate or low, based on the scoring by the worker. Overrides (both mandatory and discretionary) are allowed to ensure that risk is accurately reflected.

A risk assessment helps to determine the degree to which key risk factors are present in a family situation that increase the likelihood of future maltreatment. It does not predict when or how serious the harm may be, but rather the likelihood that harm will occur.[33] A risk assessment, based on an examination of risk factors, attempts to address whether the harm may continue and whether the harm is acute or chronic in nature.

Caseworkers are charged with assessing risk on an ongoing basis in order to minimize the risk of future harm to the child. The skill of critical thinking will help structure the caseworkers thinking when developing a plan for future intervention and change within a family.

Policy Requirements:

PSM 711-4: Risk Assessment in conjunction with the Structured Decision-Making Tool will determine the category dispositions for CPS investigations.

PSM 713-1: At initial CPS face-to-face contacts, safety factors and protective interventions are to be assessed. A safety assessment must be completed as early as possible in MiSACWIS. CPS workers must be mindful of the safety factors in the safety assessment throughout the investigation, complete a new safety assessment for any of the key decision points (listed in PSM 713-1) and update the safety assessment narrative to reflect what child safety planning occurred.

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[33] Brittain, C. & Hunt, D., *Helping in Child Protective Services: A Competency-Based Casework Handbook,* American Humane Association (2004).

PSM 713-11: The risk assessment determines the level of risk of future harm to the children in the family. Interviews with the family should be structured to allow the worker to discuss all risk and safety issues with the caretakers and complete the risk assessment following the conclusion of contacts with the family. Risk levels are intensive, high, moderate, or low, based on the scoring of the scale.

FOM 722-9B: This policy outlines the role of the caseworker in helping to identify protective interventions to address identified safety issues, address any immediate danger and enable longer range services to be provided to the child while keeping the family intact.

FOM 921: It is a requirement for all local offices to meet all expectations outlined in Children's Foster Care Manual 922 regarding the assessment and certification of foster families regarding foster family home certification (R400.12301 through R400.12317).

ADM 300: Child adoption assessments obtain historical information on the child (i.e. medicals, psychological) in order to match a child who is available for adoption with a family whose abilities to parent suited to the child's needs and characteristics.

ADM 500: Preliminary Adoptive Family Assessment is to be used to document information and/or assess a prospective adoptive family that expresses an interest in a child for the purposes of adoption.

Detailed Practice Guidance:

- Gather sufficient and reliable information from a variety of sources. This should include information on the type, frequency and circumstances surrounding maltreatment occurrences, potential trauma that may have occurred as well as strengths that indicate the protective factors available within the child's family.
    - Interview children, parents, members of the family team and community members. In order to obtain the most accurate information, make every effort to interview family members separately, especially in domestic violence cases.
    - Gather and evaluate information from all contacts related to safety and risk concerns.
    - Gather and evaluate parental history related to their health, mental health, employment, alcohol and drug use, family relationships, history of violent and abusive behaviors towards current and former partners, general outlook on life and outlook on their role as a parent and education.
    - Use MiSACWIS to review and evaluate past history.

- Evaluate the information gathered and apply the criteria (i.e. definitions) for each factor to determine the presence or absence of the safety or risk factors in the child's life.

- When domestic violence is a concern, formulate the safety and/or risk concern from a perpetrator pattern perspective, e.g., what the perpetrator did to impact child and family functioning.

- Consider the extent to which safety factors identified pose a threat to the child's safety, but do not present immediate danger of serious harm to the child, the impact of the presence of multiple safety factors and the degree to which the presence of safety factors increase the level of danger to a child. Additionally, the potential traumatic impact from past maltreatment should be identified and evaluated.

- Use critical thinking skills.
  - Analyze information that has been obtained.
  - Assess the accuracy of information obtained.
  - Understand current strengths and barriers.

- Consider the following sequential steps for arriving at the safety decision:
  - Identify the behaviors and conditions that increase concern for the child's safety and consider how they affect each child in the family. It is important to recognize that psychological safety is an important consideration.
  - Identify the behaviors or conditions (i.e. strengths, resiliencies, resources) that may protect the child.
  - Evaluate the family's willingness to accept and ability to use the intervention or service at the level needed to protect the child.

- Make a safety decision.
  - **Safe:** Children are safe; no safety factors exist.
  - **Safe with services:** At least one safety factor is indicated, and at least one protecting intervention has been put into place.
  - **Unsafe:** At least one safety factor is indicated and the only possible protecting intervention is the removal of the child from the family.

- Determine the level of risk.
  - **Category I** indicates intensive risk of future harm to the child. A court petition is required, as CPS has determined that there is a preponderance of evidence of child abuse or neglect.
  - **Category II** indicates a high or intensive risk of future harm to the child and determination that there is a preponderance of evidence of child abuse or neglect identified by the risk assessment.
  - **Category III** indicates a low or moderate risk of future harm to the child as identified by the structured decision-making tool and risk assessment. There is a preponderance of evidence of child abuse or neglect.

- **Category IV** indicates low risk of future harm to the child and there is not a preponderance of evidence.
- **Category V** indicates no evidence of child abuse and/or neglect.

b. Reduce the trauma of the initial investigation and assessment.

Background:

Children who have been maltreated have experienced significant trauma. Often, their family is also in crisis.

During the initial assessment and investigation, caseworkers, by their actions and interactions with children and parents, have the ability to help mitigate the ways a child can be re-traumatized through this process. This requires caseworkers to be sensitive to the child and parent's past and current experiences in order to secure the safety of the child, promote change and minimize further trauma. The caseworker needs to recognize that these family crises are often precipitated by traumatic life events that often seriously compromise the ability of adults to safely parent their child.

The first contact with parents and children is often at the onset of investigation, when crisis, confusion and emotion are at their height. A caseworker's actions and words during this stage play a significant role in how effectively they are able to engage children and parents in creating changes necessary to ensure safety, permanency and well-being, while minimizing the effects of the trauma they are experiencing.

Policy Requirements:

PSM 722-6B: CPS must meet face-to-face with the family in order to begin the establishment of a supportive environment that allows the parent, child and/or caregiver to play an active role in case planning. CPS must encourage parents and youth to invite support persons to the FTM. A pre-meeting must be held prior to holding an FTM. It is best practice for the caseworker to have this discussion at the home during the initial investigation.

PSM 711-1: Whenever possible, extended family should be engaged to assist parents to take adequate care of their children. When appropriately assessed, planned for and supported, extended family support and care is a child welfare service that reflects the principles of child-centered, family-focused casework practice.

PSM 722-1: CPS must consider family strengths and evaluate potential for treatment of underlying factors to reduce risk and assist the family to care adequately for the child. CPS must attempt to engage the family in services. The plan for services should be developed in consultation with the family and network of supports.

Detailed Practice Guidance:

The steps outline how caseworkers can reduce the trauma of investigation, removal and initial out-of-home placement.[34]

- Plan ahead as much as possible for investigations, assessments and possible removals; reduce the element of surprise. Create a trauma-informed removal plan in preparation for potential child removal to reduce the potential traumatic effects that removal can precipitate.
    - Slow down; plan out investigations and removals.
    - Let the family know an assessment and investigation are going on and that removal is a possibility. Communicate clearly and openly the department's role.
    - Involve the child and parent during the exploration of the allegations to gain their perceptions of the allegations.
    - Work with the child and parents to identify support persons who might be placement resources. Find out the persons who the child knows and feels physically and psychologically safe to be around.
    - Collaborate with other agencies, especially law enforcement.
    - If possible, identify a placement before removal.
    - If there is no other alternative and the child needs to wait at the MDHHS office while a placement is found, find a comfortable place for him or her to wait, away from phone conversations with prospective placements (to avoid hearing rejections). Provide the child with something to do (i.e. color, read a book) and have someone available to spend time with the child.

- Focus on child and parent strengths and resources, family plans for building protective factors and past and present actions to protect the children.

- In cases where domestic violence is a concern, express to the adult survivor concern for the safety and well-being of the adult survivor and the children, and desire to partner with the survivor around his/her safety and the safety of the children. Explain the agency's position on the perpetrator's behavior being the source of the safety and risk concerns.

- Remain calm and focused during the investigation, assessment and removal and engage parents in helping and supporting the child.
    - Remain calm. Move slowly.
    - Respect the parent's anger by acknowledging it, which will often defuse it. Calm the parent to help reassure the child.

[34] These steps were taken from, "Reducing the Trauma of Investigation, Removal and Initial Out-of-Home Placement Project" (2008-09) conducted by Portland State University, Center for Improvement of Child and Family Services, funded through the Children's Justice Act Task Force at the Oregon Department of Human Services.

  - Separate children from the chaos of arrest, interrogation or resistance on the part of the parents. Tell the child what is happening. Reframe the parent's anger as sadness to the child.
  - Let the parent put the child into the car seat, say goodbye.
  - Gather photographs, letters or other items (i.e. a child's blanket or favorite toy) that may help the child feel connected to his or her parents.

- Provide sensory comfort, familiarity and help with settling in.
  - Ask the parents for ideas on how they can best support their children through this process.
  - Use icebreaker meetings to bring the foster parents and biological parents together to exchange information about the child and the child's living situation.
  - Arrange for the first visit that the child will have with his or her parents and siblings as soon as possible.

- Empathize, connect and try to understand the parent's and child's perspective.
  - Listen carefully to the experiences expressed by the child and parent to make sure they know they have been heard and understood.
  - Demonstrate sensitivity and empathy regarding the anxiety experienced by the children and parents. Acknowledge their feelings and the difficulty of what they are going through.
  - Acknowledge their love for each other.

- Provide information and reassurance to parents and children.
  - Explain what is happening to the parent(s). Tell them where their child is going and when they will see him or her again.
  - Explain what is happening to the child on a level he or she can understand. Tell children where they are going, who will be there and, if known, when they will see their parents again. Write out (when the child is able to read) what will happen next so that the child has a visual understanding of what to expect. Draw for younger children 3-6 years of age what is going to happen next so that they have a visual picture.
  - Assure children that it is not their fault.
  - Keep promises.
  - Contact the child by phone the next day to see how he or she is doing.
  - Have a physical contact with the child by either the CPS or foster care worker as soon as possible.

- Support child and family relationships and connections.
  - Develop a visitation plan to ensure time together. The plan should include visits with siblings not in the same placement.
  - Identify ways the child and parent can maintain contacts in addition to visits (i.e. phone, email, texting).

- Notify the child's school or daycare provider so it can be supportive.

- Provide services aimed at healing, well-being and building resiliency as soon as possible, including trauma-informed services.

- Make sure that the parents and child have someone to talk to about what is happening.

c. Develop a comprehensive child and family assessment in partnership with the children, family members and other support persons.

Background:

> *The family is our refuge and our springboard; nourished on it, we can advance to new horizons. In every conceivable manner, the family is link to our past, bridge to our future.*
> *- Alex Haley*

A caseworker's role in the assessment process is to enter the world of children and parents to understand what led to the breakdown in the families' ability and/or willingness to keep their children safe. The caseworker must be able to clearly communicate this understanding to all involved. A comprehensive child and family assessment provides caseworkers with a forum to compile collected information, evaluations and the rationale behind their interpretations of the circumstances and decisions. The comprehensive child and family assessment process offers a big picture view of the significant factors that impact a child's safety, permanency and well-being. Strengths, needs, current and previous and current trauma, protective capacity, motivation for change and underlying causes that may have precipitated a need for child welfare-related services will all be explored and identified. The intersection of issues such as substance abuse, mental health issues, and domestic violence must be explored and understood. A broad understanding of these significant factors allows the family team to design individualized interventions and case plans aimed at helping families achieve reunification. The hope is that through this process caseworkers can help children and youth maintain connections to their family; their refuge, springboard, link to the past and bridge to the future.

The caseworker's ability to engage the child, parent and caregivers is crucial to obtaining accurate and valuable information. Caseworkers must understand that children, parents and caregivers desire connection and shared power. Caseworkers must convey to the family team that their active involvement is desired in the assessment process. The family team is the vehicle that will drive their success and caseworkers must recognize family members as the experts on their own families. Caseworkers must also be willing to dig deep to gather needed information. This can occur through interviews with family members, contact with supporters and research. To obtain meaningful and relevant information, caseworkers must develop effective interviewing techniques. Asking crucial questions will lead the caseworker to an enhanced understanding of what occurred and what is needed. Continuous case mining and

research are also essential to corroborate and enhance understanding. The comprehensive child and family assessment is a dynamic, living process that evolves over the life of the case.

Caseworkers must complete all assessment tools (i.e., safety, risk, FANS/CANS) in the specified timeframes. Caseworkers must also utilize community resources or service providers to gain additional information and insight into the family's circumstances. Caseworkers must communicate with these resources and providers to ensure an accurate understanding of the information that is being provided. If the caseworker disagrees with the other professionals involved, he or she must discuss concerns with the family team and clearly document this in the comprehensive family assessment. The completed tools and outside evaluations will be brought together to enrich the team's understanding about the circumstances that led to protective services and what is needed to rectify those conditions.

The comprehensive child and family assessment will help uncover the underlying issues that precipitated the protective intervention and provide deeper insight into what is needed to set the child, parents and caregivers up for future success. If interventions are tailored around surface issues or the main focus is the incident that brought the family to the department's attention and the underlying issues are not addressed, it is far less likely the intervention will have a positive impact on the child and parent. The assessment is not just a collection of facts; it includes rationale behind the caseworker's perspective. The caseworker must be able to utilize critical thinking skills in order to analyze and re-examine information. The comprehensive child and family assessment also requires caseworkers to recognize patterns of behavior over time in the broad context of needs and strength. Each family is unique in the way these factors affect its ability to protect individual members. Caseworkers need to be careful not to have preconceived ideas and then look for information to confirm these notions.

Policy Requirements:

PSM 713-1: Conduct a thorough inquiry of family background.

PSM713-1: Assess safety to determine if there is imminent danger. Be mindful of the safety factors in the safety assessment tool throughout the investigation, complete a new safety assessment tool at key decision points and update the safety assessment tool narrative to reflect what child safety planning occurred.

PSM713-11: Determine the level of risk of future harm for each child. Risk levels are intensive, high, moderate, or low, based on the scoring of the scale.

PSM 713-12: The family assessment of needs and strengths tool is used to identify areas where the family needs to focus in order to reduce risk of future child abuse or neglect.

PSM 713-13: A child assessment of needs and strengths is used to identify the physical, social and emotional characteristics of the child and how his or her strengths and needs impact the

family's functioning. The tool is also used to determine the effects the neglect or abuse has had on the child.

FOM 722-6: Review all current and past CPS and foster care records. Evaluate patterns in abuse history for the victim and parents. Assess parental compliance, participation and benefit of prior services and if relatives or significant others could be used as supports in case planning.

FOM 722-6: Feedback from professionals working with the family must be obtained and incorporated in each service plan. Information obtained during visits with the children must be used to complete the Child Assessment of Needs and Strengths Tool. The foster care worker must request information from the team prior to completing these tools.

FOM 722-8A: Foster care workers must engage the family in a discussion of the family's needs and strengths prior to completing the family assessment of needs and strengths tool. This tool systematically identifies critical family needs that are barriers to reunification and provides a foundation to design effective service interventions. The tool must be completed for all households that have a legal right to the child or children in care.

FOM 722-8B: Foster care workers must complete a child assessment of needs and strengths tool for all children in care. There are different tools based on the age and developmental stage of the child. These tools are used to evaluate and prioritize the needs and strengths of each child.

FOM 722-9A: Foster care workers must complete the Reunification Assessment Tool for all cases where the children have a permanency goal of return home. The purpose is to structure critical case management decisions. This tool monitors critical case factors in goal achievement, structures case reviews and is intended to help to expedite permanency. The tool measures compliance with parenting time and progress in resolving the primary barriers identified in the family assessment of needs and strengths.

FOM 722-9B: The Foster Care Safety Assessment Tool is used to assess if a child is in immediate danger of physical harm and determine if there is a protecting intervention available that could provide appropriate protection to keep the family intact.

ADM 300: The purpose of the Child Adoption Assessment Tool is to provide an accurate and full description of the child. It is used to ensure the most appropriate placements, develop recruitment plans when a family is not identified, provide a reliable source of history and assess the need for adoption medical subsidy application.

ADM 500: The Preliminary Adoption Family Assessment Tool is used to assess prospective adoptive families that express interest in a child for the purposes of adoption

ADM510: The Adoptive Family Assessment Addendum Tool must be completed when an Initial Foster Home/Adoption Evaluation was utilized to document that a family was appropriate to be licensed, however, there was not a specific child identified at the time that the family had expressed interest in adopting. The addendum tool assesses if the family can meet the needs of the identified child.

Detailed Practice Guidance:

The comprehensive child and family assessment process begins with the first contact with the child, family and potential caregivers, and continues until case closure. It is important throughout to use critical thinking skills to reflect on what is being learned and what it means for the child and family. Here are important steps in this process.[35]

- Conduct Research.
  - Review prior substantiations, services, court documents, current orders of protection, school reports, medical and mental health evaluations and other historical case information, including Soundex, Bridges, ICHAT, and LEIN. Remember to inquire about any other names that the household members may have used in the past.
  - During the CPS investigation, explore the extent to which a child is at imminent risk of harm. Explore parents' perspective and willingness to cooperate as well as their ability and willingness to change. Search for appropriate alternatives to removal by considering safety plans, if the perpetrator is willing to leave the home or the need for a court order.

- Involve the child, parent and caregiver.
  - Talk to the child, parent, and potential caregivers about the assessment process and how it drives case planning. Ensure conversation with the child is age and developmentally appropriate.
  - Ask about and listen to the parents' (and child when appropriate) perceptions of why they are involved with child welfare, what they might fear and what they can expect to gain from services.
  - Utilize Readiness for Change (see Resources Section) and Stages of Change[36] (see Resources Section) to determine where family members are in accepting the reality of

[35]These steps are based on the *Comprehensive Family Assessment Guidelines for Child Welfare* developed through the National Resource Center for Family-Centered Practice, a service of the Children's Bureau.

[36]Stages of Change: Pre-contemplation: Initial resistance to change. Contemplation: A family member becomes aware of the problem but has not yet made an effort to change. Preparation: A family member is intending to take some action to change. Action: A family member changes his or her behavior and/or environment. Maintenance: Family members work to prevent relapse and maintain the gains they have made during the change process.

their situation and their willingness to change. Remember initial resistance and denial are normal reactions in the change process.
  - Utilize Motivational Interviewing to engage with the children, parents and caregivers to collect valuable information.
  - Use the 21 Not Knowing Skills to seek information, engage the family and work towards solutions.
  - Follow the Forensic Interviewing Protocol.
  - Acknowledge differences and find mutual purpose.
  - Partner with the adult survivor of domestic violence to build upon safety planning efforts and support child safety, stability and healing from trauma.
  - Explore the sources of influence that impact behaviors of children, parents and caregivers.

- Utilize extended family, professionals, caregivers and supports to gather additional information and insight.
  - Obtain Releases of Information when appropriate.
  - Request and review medical, mental health, educational, police and other relevant reports.
  - Gather information during family team meetings.
  - Conduct a Fetal Alcohol Spectrum Disorder (FASD) pre-screening by observing the child and reviewing the child's medical history. Make a referral as needed for additional testing.
  - Refer for additional evaluations (i.e. psychological, psychiatric, substance abuse, urinalysis testing) to gather relevant information on the strengths, needs, trauma, risks, other underlying issues, and future goals.
  - Complete trauma screening to determine the need for additional services.
  - Complete education screening and evaluate the current educational plan.

- Identify strengths, needs and protective capacities of the parents and their support team.
  - Identify those positive qualities and resources within the family.
  - Identify the protective resiliency of the child.
  - Identify those patterns of parental behavior that have led to the need for protective interventions.
  - Identify the protective capacities and resiliency in the family that can directly contribute to the protection and development of the children. For example, this may mean:
    - There is the presence of a supportive extended family member willing and able to help.
    - There is the demonstrated ability of parents to accept responsibility for their behavior and willingness to change.
    - There is a strong family value placed on the role of parent and desire to do a good job.
    - The parents are very resilient.
    - There is a willingness and ability to meet the needs of the child or youth.

  - The physical and emotional health of parent or caregiver is strong.
  - Caregivers have the capacity to form and maintain healthy relationships.

- Utilize critical thinking skills to reflect.
  - Consider the critical questions that need to be answered and what decisions will be made using the information.
  - Determine the type, scope and depth of information that must be gathered to inform the decision.
  - Implement a variety of information-gathering strategies to access and record the needed information.
  - Analyze the information, examine in detail and formulate hypotheses about what the information reveals.
  - Test out hypotheses to assure a high degree of accuracy and consistency in the information.
  - Synthesize or integrate the information so it is congruent and allows accurate conclusions to be drawn.

- Develop a Comprehensive Family Assessment.
  The process of developing a comprehensive child and family assessment is a combination of using the caseworker's observations and interactions with family team members and the information gathered through the tools described below. The overall process is ongoing, even though the use of specific tools will occur at defined times as required by policy. The caseworker will be meeting with the child, parent and caregivers on an ongoing basis to gather information, observe interactions and share information to assure the family understands what is happening and family members' role in the assessment of their strengths and needs as well as the development of the case plan.
  - Continuously assess safety. When required, complete (MDHHS-1016) Safety Assessment. Always be observant, ask questions, and be aware of any possible safety concerns.
  - During the course of the CPS investigation, if safety factors remain the same, but the protecting intervention(s) and/or the safety decision changes, the assessment must be appropriately updated. However, if safety factors change, a new assessment must be completed.
  - Complete a CPS Risk Assessment (MDHHS257), as required.
  - Complete the CPS Family Assessment of Needs and Strengths (MDHHS259), as required.
  - Complete the CPS Child Assessment of Needs and Strengths, as required.
  - Determine the likely harm to the child if s/he were separated from the parent(s), guardian or custodian and the likely harm to the child if s/he were returned to the parent(s), guardian or custodian.
  - Complete FC Family Assessment/Reassessment of Needs and Strengths (MDHHS145) initially by the 31st day after the child is removed and 90 days thereafter.
  - Factors, such as the situations of parents, the foster home, relative caregivers, and the safety of the child, that might affect parenting time must be identified and evaluated.

- Complete the FC Family Assessment of Needs and Strengths (MDHHS-145).
- Complete the age-appropriate FC Child Assessment of Needs and Strengths, (MDHHS-432, 433, 434, and 435). Identify the top three need items (priority needs) for the child and up to three strengths.
- Assess the benefits and risks of a child remaining out of home and continuing in placement, returning home with monitoring or closing the case and terminating court jurisdiction.
- Evaluate the least restrictive placement setting.
- Complete the FC Reunification Assessment (MDHHS-147).
- Complete the FC Safety Assessment (MDHHS-149).
- Provide an accurate and full description of the child, including the child's special needs and history by completing the Child Adoption Assessment (MDHHS-1927) within 45 calendar days of case acceptance.
- Complete Preliminary Adoptive Family Assessment (MDHHS-1926) to document information and/or assess a prospective adoptive family that expresses an interest in a child for the purposes of adoption.
- Determines if it is in the child's best interests to be placed with a prospective adoptive family. If so, complete the Initial Foster Home/Adoption Evaluation (BCAL-3130) of the interested family.
- Complete the Adoptive Family Assessment Addendum (MDHHS-612) for approval of adoption when a specific child has been identified for a family.

5. Practice Guide for Supervisors: Assessment

Practice Guide for Supervisors	
Assessment	
MITEAM COMPETENCY	Assessment is an ongoing process of information gathering, analysis and collaborative decision-making that includes parents, children, caregivers, extended family members and professionals as partners. A comprehensive family assessment is a compilation of evaluations used to design plans and provide children and families services that focus on safety, permanency and well-being.
FIDELITY MEASURES	**Observation:** • Acknowledges his/her authority and the disproportionate amount of power in the relationship. • Helps the individual(s) identify people who are supportive. • Prepares the family team members (informal or formal) for participation on the team. • Facilitates teaming. • Accesses skilled team members (formal and informal) to serve the family's goal. • Asks the individual(s) what the team member(s) (informal or formal) have done to provide support. • Evaluates strengths. • Evaluates needs. • Asks the individual(s) about events experienced by primary/key family members that are potentially traumatic. • Requests individual(s) input regarding the effectiveness of services. • When developing or adjusting the plan, asks for team member's input. • Asks individual(s) their perspective on the parent's ability to keep the child(ren)/youth safe. • If child(ren)/youth is not residing with custodial parent: Asks individual(s) their perspective on the caregiver's ability to keep the child(ren)/youth safe. • If child(ren)/youth is not residing with custodial parent: Inquires about the caregiver's perspective on the impact of traumatic events on the child. • Inquires about the individual(s) perspective on the safety of all family/household members (both physical and psychological). **Documentation:** • A team that provides support to the child(ren)/youth and family has been formed. • The worker prepares the family team members (informal or formal) for participation on the team. • The family's suggestions and comments are documented in the case file. • The team member's suggestions and comments are documented in the case file. • Documentation indicates the worker maintained contact with the family and support persons between in-person meetings. • The family's team meets within the required timeframes (FOM 722-6B). • There is evidence in the documentation that the team implements specific safety activities to address safety concerns of the child(ren)/youth. • There is evidence in the documentation that the team addresses specific permanency plans. • There is evidence in the documentation that the team addresses specific issues of well-being for the child(ren)/youth. • The history of the family's involvement with MDHHS is thoroughly reviewed and outlined in the case file. • The case file contained documentation of a trauma screening for the child(ren)/youth.

	• The case file contained documentation of completion of a mental health screening as noted on the child's well child exam form. • The worker documented a thorough assessment of the family's circumstances. **Interview:** • The individual(s) was able to identify helpful activities of the worker. • The individual(s) reports being satisfied with services offered and/or referred. • The individual(s) reports the worker acknowledged the unique culture of the family/household. • The individual(s) described specific examples where his/her input was utilized in decision making. • The individual(s) reports the worker provided education on how early traumatic experiences may impact parenting. **In Supervision**: • The worker was able to identify: ○ What is most important to the individual/family. ○ How trauma has potentially impacted each individual. ○ How trauma is addressed in the case plan. ○ How the parent participates in the process of change. ○ Positive supports for the individual. ○ What progress has been made so the family's team is taking ownership of the case planning process and participating in the shared decision-making. ○ How he/she educates the family about the importance of teaming. ○ How committed the family team is to supporting the family's plan.
POLICY REQUIREMENTS	• Ensure that children and youth are empowered to participate in treatment plan development. • Ensure full-disclosure of the outcomes of the all assessment tools. • Utilize time to explore tactics that will enable caseworker's ability to relate all interactions as times to collect information, which helps in determination of safety/risk.

KEY CASEWORKER ACTIVITIES	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE TECHNIQUES
KCA 6 ASSESSMENT ***Utilize formal and informal assessment techniques to collect information.***	Throughout the life of the case.	• Observe caseworkers' collection of assessment information from interviews, home visits and phone contacts and provide feedback on strategies to improve performance. • Educate, model and coach caseworkers on how to analyze and synthesize assessments and reports to assess safety/risk threats, trauma, caretaker capacities, and child vulnerabilities to determine child welfare agency intervention and conditions necessary for permanency. • Monitor the initiation and progress of the comprehensive family assessment process for compliance with timelines, consistency with assessment procedures and principles and quality of content. • Coach the caseworker around assessing the impact of caregiver's domestic violence behavior on child and family functioning. • Coach the caseworker in screening for the presence of patterns coercive control and domestic violence in every case regardless of the presenting allegations.

KCA 7 ASSESSMENT ***Collaborate with team members to identify child and family strengths, trauma and needs.***	Throughout the life of the case.	• Educate, model and coach caseworkers on how to approach and talk with parents and children to identify strengths and needs. • Observe caseworker interactions with parents and families and provide feedback on their ability to collaborate, engage and identify strengths, trauma, resiliency and needs. • Identify and correct misunderstandings stemming from bias and/or judgment and any gaps in information needed for accurate assessment.
KCA 8 ASSESSMENT ***Organize and analyze all of the information that was collected to develop a comprehensive family assessment.***	Throughout the life of the case.	• Review documentation to assess caseworker analysis of information. Provide feedback on analysis assumptions and logic. • Monitor the caseworker's assessment of family history of maltreatment and patterns of abuse to ensure its completion, provide feedback on how to interpret and use this information to support assessment findings. • Educate, model, and coach caseworkers on how to discuss assessment findings with families in a way that supports collaboration, engagement, potential relationship-building and a clear link to services and goals. • Monitor completion of assessments for timeliness and quality and provide feedback to caseworkers on their performance. • Ensure that caseworkers are formulating risk and safety from a perpetrator pattern based approach in cases involving domestic violence.
KCA 9 ASSESSMENT ***Update comprehensive family assessment on a regular basis and prior to case closure.***	Throughout the life of the case.	• Monitor the completion and quality of assessment updates throughout the life of a case and provide feedback to caseworkers on ways to improve their timeliness and usefulness in making case decisions. • Educate, model, coach caseworkers to use reassessments to update case plans, make case decisions. Educate on skills of critical thinking. • Monitor and ensure caseworker completion of the appropriate tools within comprehensive family assessment process prior to case closure. • Educate, model and coach caseworkers to assess and prepare families for case closure to ensure long-lasting permanency. • Educate on the skill and utilization of Crucial Conversations.

6. Practice through a Trauma Lens: Focus on Case Planning

Utilization of a trauma-informed approach to case planning with children, families, and other individuals will assist in the application of the KCAs and improve overall practice. The essential elements below were identified as critical to effective case planning. The explanations of each Essential Element were taken directly from "Guidelines for Applying a Trauma Lens to a Child Welfare Practice Model" (Chadwick Trauma-Informed Systems Project [CTISP], 2013).

Essential Element: Enhance Child Well-Being and Resilience

A child's recovery from trauma often requires the right evidence-based or evidence informed mental health treatment, delivered by a skilled therapist, that helps the child reduce overwhelming emotion related to the trauma, cope with trauma triggers, and make new meaning of his/her trauma history. But to truly address the child's trauma and subsequent changes in his/her behavior, development, and relationships, the child needs the support of caring adults in his/her life. It is common for a trauma-exposed child to have significant symptoms that interfere with his/her ability to master developmental tasks, build and maintain relationships with caregivers and peers, succeed in school, and lead a productive and fulfilling life.

Case planning must focus on giving the child the tools to manage the lingering effects of trauma exposure and to help him/her build supportive relationships so that the child can take advantage of opportunities as he/she grows and matures. By helping him/her develop these skills in setting and build supportive relationships, mental health and child welfare professionals enhance the child's natural resilience (i.e. strength and ability to overcome adversity) (CTISP, 2013).

Essential Element: Enhance Family Well-Being and Resilience

Most birth families with whom child welfare interacts have also experienced trauma, including past childhood trauma, community violence, and domestic violence that may still be ongoing. Providing trauma-informed education and services, including evidence-based or evidence-informed mental health interventions as needed, to birth parents enhances their protective capacities, thereby increasing the resilience, safety, permanency, and well-being of the child. In addition, both birth and resource parents should also be offered training and support to help them manage secondary trauma related to caring for a child who has experienced trauma and his/her siblings (CTISP, 2013).

Essential Element: Partner with Youth and Family

Youth and family members who have experienced traumatic events often feel like powerless pawns in the system, reinforcing feelings of powerlessness felt at the time of the trauma. Treating youth and families as partners by providing them with choices and a voice in their care

plays a pivotal role in helping them to reclaim the power that was taken away from them during the trauma and tap into their own resilience. Youth and family members who have been involved in the child welfare system have a unique perspective and can also serve as partners by providing valuable feedback on how the system can better address trauma among children and families. These partnerships should occur at all levels of the organization, as youth and families can help shape trauma-informed practices and policies (CTISP, 2013).

Essential Element: Partner with Agencies and Systems that Interact with Children and Families

No one agency can function alone, and in a trauma-informed system, child welfare must reach out and coordinate with other systems so they too can view and work with the child and family through a trauma lens. This partnering includes:

- Teaming with law enforcement to minimize the number of front-end interviews a child must experience.
- Working with mental health agencies to ensure therapists are trained in specialized trauma assessment and evidence-based or evidence-informed trauma treatments.
- Coordination with schools, the courts, and attorneys.
- Coordination that is necessary to prevent one part of the system undoing the good trauma-informed work of another part of the system (CTISP, 2013).

The following Trauma-informed Practice Strategies (TIPS) were identified as critical effectively operationalize case planning skills through a trauma-informed lens:

Address Trauma:

Build Resiliency in children, families, family team members, and self through building Trauma-Informed case plans that:

- Promote mastery/competency.
- Promote ability to develop and build relationships.
- Promote ability to regulate emotion and behavior.
- Foster development of self-esteem.
- Refer for evidence based/evidence supported intervention, when appropriate.

7. Practice Guide for Caseworkers: Case Planning

Practice Guide for Caseworkers	
Case Planning	
MITEAM COMPETENCY	Case planning is a cooperative effort in which the caseworker, in partnership with the parents, children and other team members, develops a road map for moving a child to permanence promptly (as required) while at the same time addressing the child's safety and well-being needs. Effective assessments drive the case planning process.
FIDELITY MEASURES	**Observation:** • Acknowledges his/her authority and the disproportionate amount of power in the relationship. • Prepares the family team members (informal and formal) for participation on the team. • Facilitates teaming. • Accesses skilled team members (informal and formal) to serve family's goal. • Asks the individual(s) what the team member(s) have done to provide support. • Evaluates strengths. • Evaluates needs. • Asks the individual(s) about events experienced by primary/key family members that are potentially traumatic. • Requests individual(s) input regarding the effectiveness of services. • Asks the individual(s) how s/he can be of assistance to the family. • Inquires about the individual(s)'s perspective on the child(ren)/youth's safety (both physical and psychological). • Inquires about the individual(s)'s perspective on the child(ren)/youth's well-being (both physical and psychological). • When developing or adjusting the plan, asks for team members' input. • If a safety plan was created, both proactive and reactive steps were incorporated. • Asks individual(s) their perspective on the parent's ability to keep the child(ren)/youth safe. • If child(ren)/youth is not residing with custodial parent: Asks individual(s) their perspective on the caregiver's ability to keep the child(ren)/youth safe. • If child(ren)/youth is not residing with custodial parent: Inquires about the caregiver's perspective on the impact of traumatic events on the child. • Inquires about the individual(s) perspective on the safety of all family/household members (both physical and psychological). **Documentation:** • A team that provides support to the child(ren)/youth and family has been formed. The worker prepares the family team members for participation on the team. • The family's suggestions and comments are documented in the case file. • The team member's suggestions and comments are documented in the case file. • Documentation indicates the worker maintained contact with the family and support persons between in-person meetings. • The family's team meets within the required timeframes (FOM 722-6B). • There is evidence in the documentation that the team implements specific safety activities to address safety concerns of the child(ren)/youth. • There is evidence in the documentation that the team addresses specific permanency plans. • There is evidence in the documentation that the team addresses specific issues of well-being for the child(ren)/youth. • The parent's ability to keep the child(ren)/youth safe was documented.

	• The impact of trauma and resiliency on parent's ability to keep child(ren)/youth safe was documented. • The plan builds resiliency. • Plans are written in a behaviorally specific manner. • If a safety plan was created, it was written to include both proactive and reactive measures. • The team regularly reviewed the plan. • The (re)assessment of progress was written in a behaviorally specific manner. • There is evidence in the documentation that service providers were provided with clear and specific service needs for the family. **Interview:** • The individual(s) reports being satisfied with services offered and/or referred. • The individual(s) described specific examples of the worker acknowledging his/her success (however large or small). • The individual(s) described specific examples where his/her input was utilized in decision making. • The individual reports the worker includes informal resources as support. **In Supervision:** • The worker was able to identify: ○ What is most important to the individual/family. ○ How trauma is addressed in the case plan. ○ How the parent participates in the process of change. ○ How successes are acknowledged (however large or small). ○ How case has progressed and what to expect in next 90 days. ○ What progress has been made so the family's team is taking ownership of the case planning process and fully participating in the shared decision-making. ○ How he/she educates the family about the importance of teaming. ○ How committed the family's team is to supporting the family plan.
POLICY REQUIREMENTS	• Casework service requires the engagement of the parent in the development of the case plan. • Developing the case plan with parental involvement means making an attempt or effort to identify and locate absent parent/legal caregiver or putative fathers. • Parents must be encouraged to actively participate in developing the Parent Agency Treatment Plan and Service Agreement. • With parental input, develop a strength-based Service Agreement which focuses on the issues identified on the risk and needs and strengths assessments. • Help caregivers assess and be responsive to the needs of their children and youth. • Help parents identify goals, reduce risk to their child and help them provide adequate care for their child. • For American Indian children the worker must collaborate with a child's tribe within three days upon assignment of a CPS complaint for investigation or any case opening for children's services involving an American Indian child. The child's tribe will define the required "active efforts" for the department.
HOW TO USE YOUR SUPERVISOR	• Schedule, prepare and actively participate in regular case conferences with your supervisor to discuss: ○ Information from the FANS and CANS assessments, information in the case plan and other information gathered about the family with supervisor and how the information can inform the development of the case plan. ○ What has been completed, the outcome of that effort, pending activities and possible next steps to support the case planning process. ○ How to address specific barriers to involving the family in the case planning process and to verify that the plan is individualized to the family's specific strengths, needs and trauma needs of the family. ○ Whether separate case plans are needed for safety purposes.

KEY CASEWORKER ACTIVITIES	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE TECHNIQUES
KCA 10 **CASE PLANNING** ***Involve parents and other team members in the case planning process with a long-term view toward safety and permanency.***	• Within first 30 days of placement. • Every 90 days after initial case opening.	• Conduct diligent searches for extended family and parents who should participate in case plan and goal development. • Coordinate support needed to ensure family participation in case planning (e.g. transportation, flexible schedule, child care). • Include age/developmentally appropriate children in the planning process. • Utilize pre-meeting discussions to prepare family members to participate in case planning. • Encourage family members to identify their strengths, needs, types of services and service provider preferences that will promote safety, permanency and well-being. • Assess the effectiveness of services/case plan to create conditions that will support safety and permanency jointly with family team members and make necessary case plan revisions to support progress toward goals. • Involve family team members in determining the need to change case plan goal. • Develop, write and monitor a safety plan. See DPG_develop_write_safety_plan. • Develop, write and monitor a case plan. See DPG_develop_write_monitor_case_plan.
KCA 11 **CASE PLANNING** ***Link services to individual strengths, potential traumatic stress and specific needs of each relevant family member to the identified permanency goal or goals.***	• Assessment. • Prior to developing case plan. • Caseworker visits and FTMs. • When family's situation changes.	• Describe the conditions that must be created in the identified permanency resource in order to support achievement of the permanency goal and the skills/capacities needed by caregivers to create these conditions. Identify the services needed to support development of the capacities and conditions needed to safely parent. • Identify relevant cultural, tribal, background issues to be considered in mobilizing and structuring services. • Assess the strengths, needs and capacity of the caregivers to safely parent and align services to support needed skill development. • Continuously re-evaluate permanency goal, conditions needed to achieve permanency goal, caregiver capacity to create these conditions, and services to support needed skill development and ensure their alignment. • Use caseworker visits, family team meetings and other case planning meetings and activities to identify individual strengths and needs of children and families. • Match services to strengths and needs. • Review and use information from the parents, extended family members, assessment tools, historical case records, and reports from providers to inform the case planning process. • Review independent living needs to identify and match individual services. • Identify and address needs of all relevant family members, including non-custodial parents and children who are not the subject of maltreatment reports, in addition to target children and custodial parents. • Help the family identify needed services. See DPG_help_family_ID_services. • Identify services in collaboration with child and parent that will best meet identified needs. • Use re-assessments to re-evaluate strengths and needs of family members, based on changing circumstances, progress in achieving goals, emerging issues.

KCA 12 **CASE PLANNING** ***Develop plans that have behaviorally specific and achievable goals and action steps.***	• Within first 30 days of placement. • Every 90 days after initial case opening.	• Use information from the FANS and CANS assessments and other information gathered about the family to develop the case plan. • Ensure the desired outcome is a description of the change in behavior, which must be accomplished to assure the safety, permanency and well-being of the child. • Include clear descriptions of the goals, objectives and action steps/activities in the case plan. • Ensure objectives consist of a series of small steps needed to resolve the problems, which led to child maltreatment and departmental involvement. • Develop action steps to specify tasks that parents, service providers and caseworkers must do. • Include specific activities and behaviors to be assessed as part of the parenting time plan for all parents/caregivers including the non–custodial parents. • Identify how past trauma is being addressed for the parents and child. • Identify each goal and objective for the parent/child/youth, specific action steps/activities, time frame for achieving and expected outcome, including the discipline and child handling techniques, supervision of child, and activities to promote educational stability and success.
KCA 13 **CASE PLANNING** ***Use visits with the child and parent to make progress on goals and action steps.***	• Caseworker visits.	• Conduct visits with family members at required (or more) intervals to support goals. [37] • Visit privately with children to create a safe environment for them to share sensitive information regarding their needs and circumstances. • Discuss how the child's trauma may be exhibited through behaviors and emotions with foster parents and strategies for meeting needs.
KCA 14 **CASE PLANNING** ***Track progress on case plan implementation and adjust as needed.***	• Reassessment. • Case plan reviews. • Caseworker visits. • Case plan monitoring. • FTMs.	• Meet with the parent and child at required intervals or more frequently if necessary to support goals and determine if they are participating in the service(s) identified in the plan and if they feel the services are assisting them in making behavioral changes. • Review case plans at least quarterly for ongoing appropriateness of permanency goals outcomes, activities/steps and timeframes. • Develop case plans during FTMs, not in advance. • Review re-assessments, service reports and information from family team members to determine whether permanency goal and case plan modifications are warranted. • Have frequent contact with service providers to ensure individualized service delivery/ expected progress and identify needs for changes in services or method of delivery. • Convene FTMs to make needed changes to case plans in order to reflect individual strengths and needs and progress to goals. • Evaluate with family, caregivers, and service providers continuing responsiveness and relevance of current services, their effectiveness to achieve permanency goals.

[37] In domestic violence cases, every effort should be made to continue to meet with the perpetrator, even if he/she no longer resides in the home, especially if he/she is having regular visitation with the children.

8. Detailed Practice Guidance

a. Develop, write and monitor a safety plan.

Background:

Safety planning is critical for ongoing child protection when there is a known or potential threat of harm in the home, school or other setting in a child's life. Child safety is the primary and essential focus that informs and guides all decisions made from intake through case closure. Safety is the degree to which a child is free from abuse, neglect and exploitation by others in his or her place of residence, school and other daily settings. The child's parents or caregivers provide the attention, actions and supports and additionally possess the skills and knowledge necessary to protect the child from known and potential threats of harm in the home, school and other daily settings.

Safety plans are separate and distinct from the Parent Agency Treatment Plan/Service Agreement (PATP/SA), which address behavioral changes required over time. A safety plan is developed mutually by the caseworker and the parent through collaboration and shared responsibility. By engaging the parent to identify what family members see as their strengths, validating their contributions and including a discussion of their strengths in the safety planning process, the caseworker helps the family develop a realistic and achievable safety plan. An effective safety plan must be both proactive and reactive; to prevent harm from occurring and how to respond if and when problems occur.[38]

Proactive Steps:

- What will the individual, parent or caregiver do in order to prevent the harmful behavior from occurring and/or reduce the immediate risks?

Reactive Steps:

- What will the individual, parent or caregiver do if the problem, behavior or action occurs, despite having taken the proactive steps?

Efforts to implement the safety plan are monitored by the caseworker and identified family members to make sure these efforts are keeping the child safe. This monitoring occurs through regular contact with the family and those persons who have information about the child's

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[38] Caseworker should be aware that in domestic violence cases, domestic violence advocates use the term "safety planning" to describe their work with adult and child survivors to craft sometimes intricate plans for safety that may or may not include formal interventions such as law enforcement or the courts.

Caseworkers should also have separate safety planning with survivors and perpetrators in domestic violence cases and be mindful in a safety plan to not hold survivors responsible for the perpetrator's choices/behaviors.

safety, as well as those individuals who have an identified role in the safety plan. In addition to monitoring the effectiveness of the plan, the caseworker is continually assessing for new threats of serious harm or whether the current level of threats have changed. If the threat level has changed, it may be appropriate to reduce or increase the intrusiveness and restrictiveness of the safety plan.

Policy Requirements:

FOM 722-6B: The FTM is the primary forum for safety planning, collaborative service planning, service identification and assessing progress.

PSM 713-1: Safety assessments must be completed as early as possible following the initial face-to-face contact with the child and caregiver. Safety assessments are required at the following key decision points: prior to determining to remove a child; prior to determining intensive in-home services in lieu of removal; prior to determining whether to maintain out-of-home placement or return to home of removal; and when the status of safety factors change, such as when there is a change in family circumstances or information known about the family or a change in ability of protecting interventions to minimize safety factors.

PSM 714-4: A safety reassessment must be completed after every face-to-face visit with child victims. If safety factors are identified, the worker must develop and implement a safety plan.

Detailed Practice Guidance:

- Ensure that parents, caregivers and children (when appropriate) have a prominent role in developing the safety plan.
- Identify and utilize family strengths in the tasks and action steps in the safety plan.
- Define specific concerns and behaviors; the lethality of concerns and behaviors for all individuals involved, and consider how safety plans may be kept confidential, if required.
- Specify exactly who must be protected.
- Determine when the identified safety behavior occurs and specific circumstances that led to the behavior.
- Decide exactly who will carry out what in the plan.
- Identify specific action steps for participants to ensure each child's safety and reduce risk factors.
- Specific steps the caseworker will complete to monitor and revise the plan.
- Respect differing viewpoints without distortion, exaggeration or characterization.
- Organize thoughts and articulate them concisely and coherently.
- Suspend judgment in absence of sufficient evidence to support a decision.
- Document the safety plan using the MDHHS 1105. The intent is to provide an immediate plan to take away from a family team meeting (or other meeting) for all participating team members. Circumstances will dictate the specificity of each safety plan.

b. Develop, write (i.e. tasks, goals), and monitor the case plan.

Background:

The Parent Agency Treatment Plan/Service Agreement (PATP/SA) that is developed by the caseworker, parent, child and family team is a road map to safety, permanency and well-being. The family team must incorporate the child and family strengths, past trauma, other underlying needs and resiliency-centered protective factors identified in the comprehensive family assessment in the case plan. The reason that the child has come to the attention of the department must be addressed in the case plan. The caseworker must also recognize that the child and family strengths, needs and resources may change and the planning process must evolve over time. Discussing with the family its strengths and including those as part of the case plan makes families better able to view the case plan as realistic and achievable.

While it may seem easier for the caseworker to complete the PATP/SA with little or no input from the family and those around the family, it would be a disservice to the parents and children to approach case planning in this manner. If case plans are to be accurate and have an impact on the lives of the families, they must be done collaboratively and the information gathered during the assessment process must drive the case planning process and, ultimately, what is in the PATP/SA. The caseworker must view case planning as a dynamic process, with no plan being static.

Case planning has several key purposes including, but not limited to:

- Identifying strategies with the parent that will address the traumatic effects of maltreatment, the changes necessary to reduce risk and safety threats, how to build resiliency for the child and parent and how to help the child recover from past traumatic experiences.
- Providing a clear and specific guide (roadmap) for the caseworker and the parent for changing the behaviors and conditions that influence risk.
- Establishing a benchmark to measure the family's progress for achieving the desired outcomes.
- Developing a framework for case decision-making.

Case plans include a desired outcome, goal, objectives and action steps and must be written in a manner that is easily understood by every member of the team. The case plan and services must be individualized and created for the family and its specific strengths and needs.

The desired outcome is a statement of behavioral change needed. The desired outcome will be a description of the change in behavior, which must be accomplished to assure the safety, achieve permanency or enhance a child's well-being.

The goal is a statement of the specific changes needed to achieve the desired outcome. Goals should describe one or more of the problems or needs identified as part of the comprehensive family assessment. Goals should describe in observable and measurable terms exactly what change is desired. The result described by the goal generally represents the elimination of a need or problem which resulted in the department's involvement with the family. Case goals must be consistent with the desired outcome and support achievement of the permanency goal.

The objectives must be written to address all of the significant factors and problems identified as part of the assessment process which contribute to risk. They should be developed to support the enhancement of the family's strengths that can be called on to mitigate risk and address traumatic impact. Objectives must be time-limited and mutually agreed upon by the parent and the caseworker. Goals and objectives should be specific, measurable, attainable, results-oriented and time-limited.

Action steps are the specific actions that describe what identified individuals must do. Action steps within a well-written case plan should specify the exact steps each person must take toward achieving the desired outcome. Here is an example.

Desired Outcome*:* James will lead a healthy lifestyle free of substance abuse.

Goal*:* James will obtain a healthy lifestyle.

Objective*:* James will become sober within six months.

Action Steps*:*
1) James agrees to submit to random drug screens three times a week for six months.
2) James agrees to complete a substance abuse assessment within 30 days.
3) James agrees to participate in weekly individual and group counseling for the next 30 days.
4) James agrees to follow all recommendations for additional treatment as outlined by the assessment throughout the next six months.

DV Example:

Desired outcome: James will promote a safe environment for his children and partner free from violence and abuse.

Goal: James will demonstrate safe and non-violent or abusive behaviors towards his partner and children.

Objective: James will cease all physical abuse, emotional abuse, verbal abuse, and controlling behaviors towards his partner and children.

Action Steps:

1) James will agree to reside with his mother for the time being in order to reduce the children's exposure to his behaviors and abide by the current protective order.
2) James will participate in a family team meeting with his mother, brother, sister, pastor, cousin and boss in order to help identify steps to support him in ceasing his abusive behaviors and acknowledge how his behaviors have adversely impacted his children.
3) James will participate in an intake with a Batter Intervention Program and comply with any treatment recommendations. He will also sign a release for the BIP to communicate with this worker.
4) James will agree to abide by the current protective order in place and attend all scheduled criminal court dates.
5) James will continue to meet with this worker on a regular basis to discuss his progress towards ceasing his violent and abusive behaviors.
6) James will continue to provide financial support to his partner for the stability and well-being of the children.

Policy Requirements:

FOM 722-6: Families must be engaged in the development of their case plan including: discussing needs and strengths, developing the service plan and reaching an understanding of what is required to meet the goals of the service plan. The agreed-upon services provided to the family must facilitate movement toward identified goals.

FOM 722-8C: Parental participation is required in the development of parent/caretaker goals and objectives. Goals and objectives must be clear, measurable and designed to resolve the primary barriers for reunification identified in the MDHHS-145, Family Assessment of Needs and Strengths (FANS), and achieve the permanency goal.

PSM 714-1: The case plan must contain family input, be strength-based and address the needs identified in the safety and risk assessment.

Detailed Practice Guidance:

- Consider several important questions with members of the team:[39]

[39] *Child Protective Services: A Guide for Caseworkers,* 2003. Author(s): Office of Child Abuse and Neglect, Children's Bureau, DePanfilis, D., Salus, M.K.

  - What are the outcomes that, when achieved, will indicate that risk is reduced for the child and parent and that the traumatic effects of the maltreatment have been successfully addressed for the child?
  - What goals, objectives and action steps must be accomplished to achieve these outcomes?
  - What are the priorities among the outcomes, goals, objectives and action steps?
  - What interventions or services will best facilitate successful outcomes? Are the appropriate services available?
  - How and when will progress be evaluated?

- Use the family team meeting process to work with members of the team to develop a case plan.

- Monitor case plan implementation.
  - Utilize foster care and CPS visitation guides to direct conversation of face-to-face visits with parents and children.
  - Use FTM protocol to remember identified topics for specific FTM meetings.
  - Foster care reviews and court hearings should be utilized to provide feedback to courts and attorneys regarding progress or lack thereof.
  - Review with supervisor lingering issues, strategies and follow up steps to making case decisions.
  - Review progress reports, assessment findings and other written documentation.
  - Contact service providers and other members of the family team to discuss progress.

c. Parenting Time Planning: Parent-Child Visits

Background:

The Parenting Time Plan is not a document or process separate from the Case Plan. The Parenting Time Plan is a comprehensive and critical portion of the overall case plan that, if not completed appropriately, runs the risk of sabotaging the most well-intentioned case plan (Hyde, J. & Kammerer). Parent-child visitation is essential for a child's well-being while in foster care. The primary purposes of visitation is to maintain the parent-child attachment, reduce a child's sense of abandonment and to preserve their sense of belonging as part of a family. Supervised visitation further allows the agency to assess parental progress with the case service plan as it relates to basic parenting skills. A child needs to have frequent and regular contact with his/her parent(s), as this relationship is a critical aspect of normal child development. Parent-child visitation provides the court necessary information in determining reunification and permanency planning efforts. Maintaining family connections has life-long significance for a child. Visitation maintains their relationships with siblings and others who have a significant role in a child's life. When a child loses family connections, they also lose family history, medical history and cultural information. Visitation is considered the heart of reunification, but even

when reunification is not likely, parents, sibling and extended family continue to be important in children's lives.

The majority of children who come into care eventually exit the system to be reunited with their families. Placing focus on practices that involve the parents in their children's daily lives while in foster care makes reunification more likely and more expedient. Maintaining and growing the parent-child relationship is a key ingredient that supports positive permanency. Including parents in a way that is natural and replicates daily situations provides an opportunity for stronger, more lasting connections and creates a smoother transition for both parents and children when they are ready to return home. However, depending on the child's traumatic stress, contact with parents and siblings may trigger prior traumatic events that increase intrusive thoughts, re-enactment, avoidance and/or hyper-vigilance. Recognition and responsiveness to the triggering and subsequent child reactions are critical for the child's well-being. The role of the parent or sibling in the re-triggering must be determined in order to understand where support may be needed for the child as well as his or her parents.

Policy Requirements:

FOM 722-06I: Maintaining family contact and regular visitation is a service to children. Visits preserve a child's attachment to his or her parents, siblings, and other family members, and can lessen both the child's and the parent's anxiety about the child being placed in out-of-home care. A visit and contact plan must be created for each child in out of home care that meets his/her developmental and attachment needs and allows for frequent contact between the child and members of his or her family. This plan must be in the best interest of the child and must develop or enhance attachment with the child's family, including siblings.

FOM 722-8C: Identify the parenting time plan for all parents/caretakers and non-parent adults, if applicable. Identify under worker activities what the department will do to facilitate parenting time. Specify type, frequency, location, and duration of parenting time. If less than weekly, specify why and state how parenting time setting will assure a family friendly environment.

- If location is other than parental home, specify where and what conditions must exist for in-home visits to take place.
- If parenting time is supervised, specify by whom and what conditions must exist for unsupervised visits.
- If a court is limiting parenting time, specify why more frequent parenting time would be harmful to the child and what the parent must do to achieve at least weekly parenting time.
- If parent is limiting parenting time, indicate parent's reasons for wanting less frequent parenting time and project if and when frequency could be increased.
- Specify behaviorally specific activity expected of the parents during parenting time.
- Specify the requirements for the expansion of parenting time. Identify the circumstances for parenting time to progress in frequency and duration.

Developing the Parenting Time Plan

Assessment scores, parental engagement and comprehensive case planning will drive the development of the comprehensive parenting time plan. This planning process involves parental engagement at several case management stages throughout the life of the case. To ensure that the Parenting Time Plan is comprehensive and family/child specific be sure to consult your direct supervisor, policy manuals and additional resources for appropriate completion. Parenting Time plans that lack family-specific planning and comprehensive parental involvement could lead to delayed, poorly informed or inappropriate decisions related to child safety, permanency and well-being. The following outlines the basic tasks/behaviors/documentation that should occur when developing the Parenting Time Plan.

1. **Upon case assignment, review the case file for the following:**
   - Removal reasons and safety concerns that the parent(s) represent to the child. Safety concerns should have specific and clear evidence supporting them.
   - Known parenting skills/behavior deficits that parents can address in parenting time.
   - Known sources of parental support, resources and strengths.
   - Needs of the child that can be met through parenting time. Younger children will need to have contact with their parents often. Children may also be subject to behavioral issues related to limited or no contact with parents.
   - Services/providers that could be used to support parent-child contact and/or improvement in skills/behaviors related to parenting.
   - Current parent visitation schedule taking place for custodial and non-custodial parents. This will be a starting point for the development of a comprehensive parenting time plan.

2. **Pre-Meeting Discussion (FOM 722-06B)**
   - Meet with parents and orient them to the process of what parenting time is, their expectations, rights, responsibilities and how the parenting time plan will be developed.
   - Work with parents to identify potential sources of support that can be used to assist with implementing the parenting time plan.
   - Help parents understand the benefits of including current caregivers in the Family Team Meeting. Also help the parents understand the benefits of working with the caregivers and discuss setting up meeting.
   - Potential invitees to initial Family Team Meeting include the caregivers (foster parents/relative caregivers), family members, friends and service providers. These invitees should be prepared to participate in the meeting prior to the FTM so be prepared to have additional conversations with FTM members prior to the meeting. This will be primarily to orient members to the basics of the FTM and how they will participate.

3. **Initial Family Team Meeting (See MDHHS Family Team Meeting Protocol & FOM 722-06B).**
   - Efforts to engage and orient the group to the process of developing the parenting time plan must take place. Elements that must be included in the parenting time plan are:
     - Frequency, duration and location of parenting time visits.
     - Defined purpose for supervised parenting time (i.e. child safety, teaching parenting skills, to encourage continued parental responsibility, assessment of parent-child relationship/behaviors)
     - Specific safety risks requiring supervised parenting time and documented safety plan that alleviates that risk.
     - Clear plan for progression and expansion of parenting time including an increase in frequency, duration and decreasing levels of supervision.

   - Establish plans for an "icebreaker" meeting between parent(s) and caregiver(s) in order to set the stage for shared parenting responsibilities, exchange of critical child information and ongoing mentoring relationship.
   - Plan for ongoing parent-child contact and parental participation in additional activities including: medical/dental appointments, child education participation, extra-curricular activities. Contact plans should also include phone calls, emails, letters and/or video conferencing.

4. **Subsequent Family Team Meetings (See MDHHS Family Team Meeting Protocol & FOM 722-06B).**
   - Family Team Meetings should address all of the information and requirements from the initial FTM as well as review, assess and revision of the parenting time plan including a justification for expanding, maintaining or decreasing the parent-child contacts and visitation.

5. **MiSACWIS documentation of parenting time plan**

   - Describe behaviorally specific activities expected of the parent(s) during visitation (Visitation Plan).
     - Define the purpose of supervised visitation (to evaluate parenting skills, to encourage continued parental responsibility or child safety).
     - Indicate specific risks are present that require supervision and safety plans developed to mitigate risk.
     - Specify what is expected of the parent(s) during visitation to meet each child's individual needs.
     - If there are specific parental activities recommended from the service provider, include that information here.

- **Describe how the plan includes opportunities for parental participation in child's life activities (Visitation Plan).**
  - If this is not part of the plan, provide an explanation.
  - Document ways that the agency and caregiver will support the parent remaining in the parental role (i.e. participation in medical appointments, school conferences, etc.).
  - Document how appointments or activities will be communicated to the parents.
  - Document plans to maintain contact between the child and parents between visits (extracurricular activities, phone calls, text, email, etc.).

- **Describe how the agency is assisting parent(s) in meeting the objectives (Visitation Plan)**
  - Discuss what was done to prepare and support the parent(s), caregiver(s), and/or children prior to, during, and after the visitation to meet the intent of parenting time plan.

- **Describe the Relative/Foster Parent Responsibilities (Visitation Plan).**
  - Describe ways in which the foster parent/relative caregiver is supporting activities outlined in the visitation plan (i.e. transportation, supervision of parenting time, modeling, coaching parenting skills, etc.).

- **Explain how the visitation setting will assure a family friendly safe environment (Visitation Plan).**
  - Describe how the physical location is comfortable, accessible and familiar to both the parent(s) and child(ren).
  - Describe how the physical location provides for the basic needs of the parent(s) and child(ren) during visitation.
  - Does the physical location provide for the safety of the child(ren)?
  - Does the physical location promote and allow for normal family interaction?
  - Is the physical location similar to the parent(s) and child(ren) home conditions?

- **Summarize visitation restrictions including any court orders (Visitation Plan Details).**
  - Describe worker/agency limits or rules imposed (i.e. use of electronic devices, visitors, etc.)

- **Identify circumstances necessary to expand the frequency and duration of visitation (Visitation Plan Details).**
  - Specify in behaviorally specific terms, risk and safety concerns that must be reduced to move less restrictive oversight (unsupervised).

- **Describe parental compliance with visitation plan and quality of parent/child interactions during parenting time (Visitation Plan Details).**
  - Note: This question should be answered at the conclusion of the reporting period. This narrative should support the reason for the parenting time evaluation scoring.

6. Assessment/Evaluation of Parenting Time compliance

- **Family Assessment of Needs & Strengths (FANS) (FOM 722-08A)**

Completion of the FANS must be done within the first 30 days of a child being removed from the home and quarterly thereafter. Supporting justification must accompany the scoring of the assessment. When assessing parenting skills foster care worker should utilize multiple sources of information that include, but are not limited to:

- Service provider reports.
- Direct observations of parent-child interactions.
- Feedback regarding parental involvement with daily/routine child activities.
- Parental involvement with child case planning process.
- Other relevant sources of assessment information.

Assessment guidelines for parenting skills:

A. Strong Skills: Caretaker displays knowledge and understanding of parenting skills and is utilizing these skills with child(ren) on a daily basis. Parent shows an ability to identify positive traits in their children (recognize abilities, intelligence, social skills, etc.), encourages cooperation and a positive identification within the family.

B. Adequate skills: Caretaker displays adequate parenting patterns which are age-appropriate for the child in the areas of expectations, discipline, communication, protection, and nurturing. Caretaker has the basic knowledge and skills to parent.

C. Improvement needed: Improvement of basic parenting skills needed by caretaker. Caretaker has some unrealistic expectations, gaps in parenting skills, demonstrates poor knowledge of age-appropriate disciplinary methods, is ambivalent about parenting, and/or lacks knowledge of child development, which interferes with effective parenting. Includes:
   - Frequent parent/child conflict over discipline.
   - Children sometimes left unsupervised.
   - Parents sometimes inattentive to child's emotional needs or are rejecting.

- Any single preponderance of evidence referral for inappropriate discipline, violent behavior towards child(ren), lack of supervision, or failure to thrive (includes current).
- Parent lacks knowledge/needs assistance in dealing with special needs child(ren).
- Occasional parent/child role reversal.

D. Destructive/abusive parenting: Caretaker displays destructive/abusive parenting patterns. Based on available evidence, it appears that caretaker(s) uses extreme punishment, or that their actions are tantamount to emotional abuse/neglect or that caretaker has abdicated responsibility for supervision, protection, discipline and/or nurturance. Indicators include:
   - Two or more preponderance of evidence referrals for inappropriate discipline, violent behavior towards child(ren), lack of supervision, or failure to thrive (prior and current).
   - Caretaker makes it clear that child(ren) are not wanted in home. Discipline routinely involves use of an instrument (belt, board) or unusual deprivation (lock in cellar or closet).
   - Routine badgering and belittling of child(ren).
   - Caretaker discipline and control completely ineffective or caretaker makes no effort.
   - Caretaker unable to prevent abuse by others.
   - Caretaker contributes to child's delinquent involvement.
   - Prior termination of parental rights for sibling(s).
   - Persistent parent-child role reversal.
   - Caretaker refuses/unwilling to acknowledge that child has been sexually abused.

- **Overall Parenting Time Evaluation (Reunification Assessment) (FOM 722-09)**
  The Reunification Assessment is completed Updated Service Plans (USP). When scoring specific items ensure that scoring is supported by detailed narrative that utilizes observable behaviors.

  Assessment guidelines for overall parenting time evaluation:
   - Substantial: Maintained parenting time schedule and caretaker-child interaction is appropriate throughout all parenting time.
   - Partial: Generally maintained parenting time schedule. Notified agency if could not keep appointment. No major problems in caretaker behavior or caretaker-child interaction.
   - Poor: Failed to maintain parenting time schedule. Failed to notify agency if unable to keep appointment one or more times. There has been poor caretaker-child interaction and/or inappropriate caretaker behavior during

parenting time. Parenting time canceled due to caretaker behavior or the court has ordered no parenting time or the child refuses parenting time.
- Refused: Parent/Caretaker(s) refused to participate in the parenting time plan.

d. Help the family identify needed services.

Background:

Once a family's strengths, past traumas, needs and problems have been fully assessed and the Parent Agency Treatment Plan/Service Agreement (PATP/SA) has been developed with the parent's input, the caseworker must help children and parents identify and access service providers capable of assisting them in achieving the desired outcomes from the plan.

Efforts need to be made to ensure that a service provider (or the caseworker) is a good fit for the family. A creative aspect of child welfare practice is matching the family's identified needs with individualized and culturally appropriate services. Far too often, service providers named in case plans are chosen because the department regularly uses them or because they are the only provider within the community. Sometimes these providers can meet the family's needs and other times they are not able or willing. The caseworker must be an advocate for the correct services and be proactive to assure that the services are what the family needs. Service providers need to be willing to meet a family's unique needs and avoid cookie cutter service delivery. Services do not need to be formal and can often be delivered by the caseworker or other non-professional or informal supports. Services must be accessible to the parent and child both in location and hours of availability.

The referral for individualized (v. cookie cutter) services is tightly tied into the accurate assessment of families. For example in domestic violence cases, an adult domestic violence survivor may or may not benefit from being referred to domestic violence services. If the assessment indicates that she is aware of the impact on her children and is actively doing what a reasonable parent would be doing in her situation, sending her to services to "gain insight into the domestic violence" may not be useful and in fact be an undue burden and a barrier to success. Similarly, the referral of a domestic violence perpetrator to a batterer intervention program needs can be "individualized" by sharing with that program what the agency has learned about his pattern of behavior and the case goals for him. This why the perpetrator is more likely to benefit from the service and also the caseworker is likely to receive more meaningful reports from that program.

Once the appropriate services and provider have been identified, the caseworker will need to, with the parent and the family team, monitor the delivery and effectiveness of the services to determine the family's level of participation and whether the services are supporting the achievement of the case goals and desired outcomes.

If appropriate services to meet the parent's and child's identified needs are not available, the caseworker may need to engage his or her supervisor, county or statewide leadership or other community partners, to create additional service options for parents and children. If the family participates in the services, accomplishes the action steps and meets the goals of the case plan, then in most instances the department should be able to close the child welfare case.

Policy Requirements:

FOM 722-8C: The treatment plan and services agreement should be specific to the individual needs of the family and child(ren), express their viewpoints and be written in a manner easily understood by the family with expected outcomes clearly defined. The completed PATP should blend required formal services with family-centered decisions.

PSM 714-1: Caseworkers are responsible for developing the service agreement, working with the caretakers to assist them in learning new skills, improving the environment and evaluating the need for continued ongoing protective services.

Detailed Practice Guidance:

- Ask parents if they have ideas and preferences about specific services and service providers.
  - Will the service provider be culturally appropriate?
  - What skills are required of the service provider?
  - What factors enhance or prohibit the family's participation and cooperation with this provider?
- Consider with the family team several key questions regarding safety services.
  - What services will address the underlying conditions and contributing factors impacting the family's functioning?
  - What services will enhance the protective capacities and build resiliency for the family?
  - What services will prevent safety threats and mitigate the need for intervention in the future?
- Consider with the family team several key questions regarding permanency services.
  - What services will address the child's need for permanency in a timely manner?
  - Are the services being provided working toward permanency for the child?
- Consider with the family team several key questions regarding well-being services.
  - What services does the family need to assure its basic needs are being met?
  - Are the services for the parents different than those for the child?
  - Are the services being provided enhancing or stabilizing the child's well-being (i.e. health needs, educational needs, mental health needs)?
- Identify the most appropriate, accessible and culturally appropriate services within the family's community.
- Refer and prepare the child and parent to access and participate in the services.

- Prepare the service provider by sharing critical information such as a domestic violence perpetrator's pattern of behavior, concerns for child safety, reason for the services, identified strengths, trauma histories and needs.
- Utilize the family team meeting process to assure the delivery of and cooperation with identified services.
- Seek documentation or reports from the service providers regarding the family's progress; lack of completion or additional or other services which may be needed.
- Provide services to the parent through modeling and coaching appropriate ways to build relatedness, address traumatic stress, discipline children, play/interact with children and promote healthy child development.
- Assist the parent in learning and practicing effective ways to maintain the home, manage a budget and access needed community services.
- Accompany the parent and the child to appointments to provide support and learn ways to interact with the formal service delivery system.
- Assist the parent and child in advocating for their needs.

9. Practice Guide for Supervisors: Case Planning

Practice Guide for Supervisors	
Case Planning	
MITEAM COMPETENCY	Case planning is a cooperative effort in which the caseworker, in partnership with the parents, children and other team members, develops a road map for moving a child to permanence promptly (as required) while at the same time addressing the child's safety and well-being needs. Effective assessments drive the case planning process.
FIDELITY MEASURES	**Observation:** • Acknowledges his/her authority and the disproportionate amount of power in the relationship. • Prepares the family team members (informal and formal) for participation on the team. • Facilitates teaming. • Accesses skilled team members (informal and formal) to serve family's goal. • Asks the individual(s) what the team member(s) have done to provide support. • Evaluates strengths. • Evaluates needs. • Asks the individual(s) about events experienced by primary/key family members that are potentially traumatic. • Requests individual(s) input regarding the effectiveness of services. • Asks the individual(s) how s/he can be of assistance to the family. • Inquires about the individual(s)'s perspective on the child(ren)/youth's safety (both physical and psychological). • Inquires about the individual(s)'s perspective on the child(ren)/youth's well-being (both physical and psychological). • When developing or adjusting the plan, asks for team members' input. • If a safety plan was created, both proactive and reactive steps were incorporated. • Asks individual(s) their perspective on the parent's ability to keep the child(ren)/youth safe. • If child(ren)/youth is not residing with custodial parent: Asks individual(s) their perspective on the caregiver's ability to keep the child(ren)/youth safe. • If child(ren)/youth is not residing with custodial parent: Inquires about the caregiver's perspective on the impact of traumatic events on the child. • Inquires about the individual(s) perspective on the safety of all family/household members (both physical and psychological). **Documentation:** • A team that provides support to the child(ren)/youth and family has been formed. • The worker prepares the family team members for participation on the team. • The family's suggestions and comments are documented in the case file. • The team member's suggestions and comments are documented in the case file. • Documentation indicates the worker maintained contact with the family and support persons between in-person meetings. • The family's team meets within the required timeframes (FOM 722-6B). • There is evidence in the documentation that the team implements specific safety activities to address safety concerns of the child(ren)/youth. • There is evidence in the documentation that the team addresses specific permanency plans. • There is evidence in the documentation that the team addresses specific issues of well-being for the child(ren)/youth. • The parent's ability to keep the child(ren)/youth safe was documented.

	• The impact of trauma and resiliency on parent's ability to keep child(ren)/youth safe was documented. • The plan builds resiliency. • Plans are written in a behaviorally specific manner. • If a safety plan was created, it was written to include both proactive and reactive measures. • The team regularly reviewed the plan. • The (re)assessment of progress was written in a behaviorally specific manner. • There is evidence in the documentation that service providers were provided with clear and specific service needs for the family. **Interview:** • The individual(s) reports being satisfied with services offered and/or referred. • The individual(s) described specific examples of the worker acknowledging his/her success (however large or small). • The individual(s) described specific examples where his/her input was utilized in decision making. • The individual reports the worker includes informal resources as support. **In Supervision:** • The worker was able to identify: ○ What is most important to the individual/family. ○ How trauma is addressed in the case plan. ○ How the parent participates in the process of change. ○ How successes are acknowledged (however large or small). ○ How case has progressed and what to expect in next 90 days. ○ What progress has been made so the family's team is taking ownership of the case planning process and fully participating in the shared decision-making. ○ How he/she educates the family about the importance of teaming. ○ How committed the family's team is to supporting the family plan.
POLICY REQUIREMENTS	• Casework service requires engagement of the parents and children (when age appropriate) in development of the case plan. • Developing the case plan with parental involvement means making an attempt or effort to identify and locate absent parent/legal caregiver or putative fathers. • Parents must be encouraged to actively participate in developing the Parent Agency Treatment Plan and Service Agreement. • With family input, develop a strength-based Service Agreement which focuses on the issues identified on the risk and needs and strengths assessments. • Help parents assess and be responsive to the needs of their children and youth. • Help parents identify goals, reduce risk to their child and help them provide adequate care for their child. • For American Indian children the worker must collaborate with a child's tribe within three days upon assignment of a CPS complaint for investigation or any case opening for children's services involving an Indian child. The child's tribe will define the required "active efforts" for the department.

KEY CASEWORKERS ACTIVITIES	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE TECHNIQUES
KCA 10 **CASE PLANNING** ***Involve families and other team members in a case planning process with a long-term***	• Within first 30 days of placement. • Every 90 days after initial case opening.	• Observe practice and provide feedback to caseworkers on their ability to work with families to identify relevant family (including extended family, non-custodial parents) who should participate in case planning. • Review documentation to monitor caseworker's progress in the provision of services to support participation, (e.g. transportation, flexible schedule, child care) in case planning. Discuss findings and feedback in supervision with caseworkers.

view toward safety and permanency.		• Review documentation to determine the consistent inclusion of youth in foster care planning unless documented reasons not to. Discuss findings and feedback in supervision with caseworkers. • Educate, model and coach caseworkers on how to talk with family members and children to identify relatives, friends and others who may be supportive resources for the family. • Educate, model and coach caseworkers to encourage family members to identify strengths, their perceptions of needs and services that can address needs, preferences for service providers and to participate in goal setting and assessment of progress. • Educate, model and coach caseworkers to prepare family members to participate in case planning, (how to provide input, importance of plan). • Educate, model and coach caseworkers to arrive at case plan meetings knowledgeable of assessment information and the child and family's circumstances and needs. • Educate, model, and coach caseworkers to develop the case plan in the meeting, with the family, and not in advance. • Review case documentation to determine if families are involved in decision-making, as evidenced by signing of case plan, documentation of questions, concerns or requests, etc. Discuss findings and strategies for improving involvement in supervision with caseworkers.
KCA 11 **CASE PLANNING** ***Link services to individual strengths, potential traumatic stress and specific needs of each relevant family member to the identified permanency goal or goals.***	• Assessment. • Prior to developing case plan. • Caseworker visits & FTMs • When family's situation changes.	• Educate, model and coach caseworkers on how to use information from the family, the safety and risk assessments, FANS and CANS, case record information, and reports from providers to identify the family's strengths and needs to inform the case plan. • Educate, model and coach caseworkers to match services to address strengths and needs, and the permanency goal and to support creation of the conditions for return/permanency that must exist in the home in order for the child to achieve safe permanency. • Monitor whether identification and referral is done in collaboration with the child and family that will best meet identified needs and engage families in service participation and provide feedback to caseworkers. • Monitor case planning to ensure that services have a reasonable chance of supporting the conditions for return/permanency and provide feedback to caseworkers. • Educate, model and coach caseworkers to collaborate with families to determine which services are most appropriate for their needs before considering the availability of services. See DPG_help_family_ID_services.
KCA 12 **CASE PLANNING** ***Develop plans that have behaviorally specific and achievable goals and action steps.***	• Within first 30 days of placement. • Every 90 days after initial case opening.	• Educate, model and coach caseworkers on how to develop plan objectives that specify the exact steps and milestones that indicate progress toward resolving the problems, which led to the maltreatment. Departmental involvement and the steps that will create the conditions necessary for safe permanency/return should be included in the plan. Objectives should consist of a series of small steps and be written at a level that the family members can understand and achieve. • Educate, model and coach caseworkers on how to develop a parenting time plan that identifies measurable, observable goals and progress milestones and outlines type, frequency, location and duration of parenting time and if parenting time must be supervised. • Monitor the quality and substance of caseworker practice by reviewing case plans to ensure goals, objectives and action steps are

		SMART - specific, measurable, attainable, results-oriented and timely and provide feedback to caseworkers.
KCA 13 **CASE PLANNING** ***Use visits with the child and parent to make progress on goals and action steps.***	• Caseworker visits.	• Educate, model and coach caseworkers on how to discuss with families and children progress toward goals, emerging issues, changing needs in service delivery, or changes in goals/activities/steps in case plans. • Ensure caseworker is actively engaging and visiting with both parents throughout the life of the case. • Monitor the quality and substance of caseworker practice by reviewing case documentation to determine if the worker is having individual visits with parents and children and if the content of these discussions is being used to drive and support case planning. Provide feedback to caseworkers on compliance and quality of visits.
KCA 14 **CASE PLANNING** ***Track progress on case plan implementation and adjust as needed.***	• Reassessment • Case Plan Reviews • Caseworker visits • Case plan monitoring • FTMs	• Observe caseworker practice to assess the caseworker's ability to monitor case plans, determine that change is needed and negotiate needed changes with families, children/youth and service providers in FTMs and provide feedback to caseworkers. • Educate, model and coach caseworkers on how to determine a change in permanency goal is necessary and how to meet with parents/children/youth to discuss changes in permanency goals, case plans or service providers. • Educate, model and coach caseworkers on how to evaluate effectiveness of services to produce desired results/changes and discuss these assessments with service providers to refocus treatment. • Monitor quality and substance of caseworker practice by scheduling regular case conferences with each worker to review case plans to ensure their relevancy to progress and events and that case plans can reasonably be expected to achieve permanency goals timely. • Educate, model and coach caseworkers on how to team with parents, caregivers and service providers to evaluate responsiveness and relevancy of current services in achieving designated permanency goals/ addressing needs. • Monitor the quality and substance of caseworker's activities by reviewing if and how caseworkers use re-assessments to re-evaluate strengths and needs of parents and children, based on changing circumstances, progress in achieving goals, emerging issues. Review with and provide feedback to caseworkers.

10. Practice through a Trauma Lens: Focus on Case Plan Implementation

Utilization of a trauma-informed approach to case plan implementation with children, families, and other individuals will assist in the application of the KCAs and improve overall practice. The essential elements below were identified as critical to effective case plan implementation. The explanations of each Essential Element were taken directly from "Guidelines for Applying a Trauma Lens to a Child Welfare Practice Model" (Chadwick Trauma-Informed Systems Project [CTISP], 2013):

Essential Element: Partner with Youth and Family

Youth and family members who have experienced traumatic events often feel like powerless pawns in the system, reinforcing feelings of powerlessness felt at the time of the trauma. Treating youth and families as partners by providing them with choices and a voice in their care plays a pivotal role in helping them to reclaim the power that was taken away from them during the trauma and tap into their own resilience. Youth and family members who have been involved in the child welfare system have a unique perspective and can also serve as partners by providing valuable feedback on how the system can better address trauma among children and families. These partnerships should occur at all levels of the organization, as youth and families can help shape trauma-informed practices and policies (CTISP, 2013).

Essential Element: Partner with Agencies and Systems that Interact with Children and Families

No one agency can function alone, and in a trauma-informed system, child welfare must reach out and coordinate with other systems so they too can view and work with the child and family through a trauma lens. This partnering includes:

- Teaming with law enforcement to minimize the number of front-end interviews a child must experience
- Working with mental health agencies to ensure therapists are trained in specialized trauma assessment and evidence-based or evidence-informed trauma treatments
- Coordination with schools, the courts, and attorneys.
  Such coordination is necessary to prevent one part of the system undoing the good trauma-informed work of another part of the system (CTISP, 2013).

The following Trauma-informed Practice Strategies (TIPS) were identified as critical effectively operationalize case plan implementation skills through a trauma-informed lens:

Identify Trauma

- Continually assess/screen for potentially traumatic/secondary traumatic events and potential trauma as a result of agency involvement.
- Refer for further trauma assessment when necessary as indicated by preliminary assessment/screen.

Utilize Trauma Knowledge

- Continually consider the impact of trauma on children, youth, parents, team members, workers, supervisors and relationships during agency intervention.
- Consider the impact of potentially traumatic events when making decisions and plans.

- Connect behaviors, emotions, school problems, and relational/attachment difficulties to the impact of traumatic events.
- Reframe trauma history as what has happened versus what is wrong with the person.

Address Trauma:

- Build Resiliency in children, families, family team members, and self through building Trauma - Informed case plans that:
    - Promote mastery/competency,
    - **Promote ability to develop and build relationships,**
    - Promote ability to regulate emotion and behavior,
    - Foster development of self-esteem

- Refer for evidence based/evidence supported intervention when appropriate

Educate about Trauma

- Proactively Transfer trauma knowledge through ongoing conversations that build understanding from the first interaction to the last. May include discussion around:
    - What is trauma?
    - What can be traumatic to a child or adult?
    - How does trauma change the brain?
    - How does trauma impact people differently?
    - What is the impact and symptoms of trauma?
    - What is resiliency?
    - How does resiliency work to treat trauma?
    - How can resiliency be built?
    - How can resiliency impact long-term view?

11. Practice Guide for Caseworkers: Case Plan Implementation

Practice Guide for Caseworkers	
Case Plan Implementation	
MITEAM COMPETENCY	Case plan implementation details the who, what, where, when and how with regards to specific tasks and/or objectives for each participating case planning partner (birth parents, foster parents, relatives, caseworker and service providers). Case plan implementation is the utilization of services designed to address a family's underlying needs as identified through the assessment and case planning process. Case plan implementation begins at initial plan development and continues throughout case closure.

FIDELITY MEASURES	**Observation:**
	• Helps the individual(s) identify people who are supportive.
	• Addresses reasons for reluctance to including specific team members.
	• Facilitates teaming.
	• Asks the individual(s) what the team member(s) (informal or formal) have done to provide support.
	• Requests individual(s) input regarding the effectiveness of services.
	• Asks the individual(s) how s/he can be of assistance to the family.
	• When developing or adjusting the plan, asks for team member's input.
	Documentation:
	• The team member's suggestions and comments are documented in the case file.
	• The family's team met within the required timeframes (FOM 722-6B).
	• There is evidence in the documentation that the team implements specific safety activities to address safety concerns of the child(ren)/youth.
	• There is evidence in the documentation that the team addresses specific permanency plans.
	• There is evidence in the documentation that the team addresses specific issues of well-being for the child(ren)/youth.
	• The team regularly reviewed the plan.
	• There is evidence in the documentation that service providers were provided with clear and specific service needs for the family.
	• There is evidence in the documentation that services were provided in a timely manner.
	• There is evidence in the documentation that the child's living arrangement has been fully assessed and determined safe.
	Interview:
	• The individual(s) was able to identify helpful activities of the worker.
	• The individual(s) reports being satisfied with services offered and/or referred.
	• The individual(s) described specific examples of the worker acknowledging his/her success (however large or small).
	• The individual(s) described specific examples where his/her input was utilized in decision making.
	In Supervision:
	• The worker was able to identify:
	  ○ How trauma is addressed in the case plan.
	  ○ How the parent participates in the process of change.
	  ○ How successes are acknowledged (however large or small).
	  ○ How the case has progressed and what to expect in next 90 days.

	• Parental participation in the development of the case plan is required.

POLICY REQUIREMENTS	• Caseworker must provide service referrals within 30 days of initial out-of-home placement.
	• Caseworker must identify follow-up steps to obtain compliance when parents decline to participate in services.
	• The Parent Agency Treatment Plan (PATP) must be:
	  ○ Specific to the individual needs of the parents and children.
	  ○ Inclusive of the parent's viewpoint.
	  ○ Written in a manner that is easily understood by all parties.
	• "Active efforts" for American Indian children require the caseworker to take a proactive approach with children and families as well as actively support them in complying with the case plan rather than the case plan being implemented by family alone.

HOW TO USE YOUR SUPERVISOR	• Schedule, prepare and actively participate in regular case conferences with your supervisor to discuss:
	  ○ What has been completed, the outcome of that effort, pending activities and possible next steps to support the case planning process.
	  ○ How to address specific barriers to involving the family in the case implementation process and to verify that the plan is individualized to the family's specific strengths, needs and trauma needs.
	  ○ Ongoing assessment of safety concerns and dynamics of coercive control that might be interfering with or hindering successful completion of the case plan.
	  ○ Availability of services within the family's community or ways to access/develop the appropriate services to meet the family's individualized needs as identified in the case plan.
	  ○ Utilize time with supervisor to discuss and evaluate what has been completed, the outcome of that effort, pending activities, possible next steps to support implementation of service plan.

KEY CASEWORKER ACTIVITIES	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE TECHNIQUES
KCA 15 CASE PLAN IMPLEMENTATION ***Engage with service providers.***	Throughout the life of the case.	• Identify service providers to meet family's needs, preferences, locations, cultural needs. • Ensure providers tailor services to meet family's needs, including the frequency, and intensity of service, where and when services are provided, by negotiating clear expectations at referral for behavior changes, monitoring service attendance and improved behavioral changes, and linking payment to service delivery. Contact service providers frequently for written reports on child/family's participation in services and progress toward goals/, specific to referral needs. • Advise service providers of significant changes affecting service delivery or client needs. • Plan with service providers how to address potential barriers to successful completion of treatment. • If services are not available to address the family's unique needs, work with the service provider to develop needed services or identify another provider.

KCA 16 **CASE PLAN IMPLEMENTATION** ***Clarify specific service needs when making referrals.***	• At case plan development and reviews. • At service referrals. • Caseworker visits and FTMs. • When situation changes.	• Develop treatment goals with families and service providers. • Ensure providers tailor services to include frequency, intensity, level and location of services. • Select providers whose approach is evidence-based and whose services match the needs of families. • Provide written referrals for services that identify the needs of family members, behavioral and specific goals, time frames to complete services/achieve goals, and potential barriers to receiving/benefitting from services. • Clarify jointly with family members (including parents and children) and service providers the expectations for participation in services, including frequency, level, location, goals, and duration of services. • Document service referrals, reviews provided in individual case plans. • As circumstances and behavior changes, review progress jointly with family members and providers, adjust services as needed, confirm in writing, document in case plan. • Familiarize yourself with mission and confidentiality policies of providers.
KCA 17 **CASE PLAN IMPLEMENTATION** ***Provide services promptly and on an ongoing basis to increase safety, reduce risk, address well-being and promote timely permanency.***	From initial contact to case closure or permanency.	• Use assessment information to identify immediate needs to protect children and caregivers. • Make verbal and written referrals to appropriate service providers as soon as needs for services are identified. • Follow up with providers to ensure timely response to referrals and to mobilize service provision. • Document service referrals and provision in case file; review and revise as needed in case plan. • Review and update case plan at required intervals and evaluate progress toward achieving permanency goals. • Monitor service provision to ensure conformity with case plan and progress toward achievement of goals. • Evaluate with child/family/service provider the effectiveness of current services and adjust service levels, intensity, type, location, duration as needed. Change providers if indicated. • In family team meetings and caseworker visits, ensure that services are directly linked to overcoming barriers to achieving safety, permanency and child well-being goals within prescribed timeframes. • Make prompt written service referral when need is indicated. Referrals should specify level, intensity, duration, type of service requested. • Revise case plan with child and family when new services are implemented. • Link new services to goals. • Notify service providers of significant events or changes for the child or family, including change of permanency goal. • Implement a concurrent plan. See DPG_implement_permanency_plan.
KCA 18 **CASE PLAN IMPLEMENTATION** ***Use caseworker visits to mobilize services.***	• Caseworker visits.	• Visit with individual family members at required intervals or more frequently if necessary to support goals. • Discuss effectiveness/satisfaction with services with family members as well as their views on progress toward goals, emerging issues and changes. • Identify need for changes in service delivery with family members.

		• Discuss with family members if they feel there are any unresolved issues that the department and/or service providers are not meeting or addressing. • Conduct pre-meeting discussions with family to determine involvement of service providers at family team meetings.
KCA 19 **CASE PLAN IMPLEMENTATION** ***Evaluate the appropriateness and effectiveness of services.***	• Case plan reviews. • Caseworker visits and FTMs. • When situation changes.	• Evaluate the appropriateness and effectiveness of services. See DPG_evaluate_services. • Review PATP/SA at least monthly with the family for continuing appropriateness of services provided. • Update PATP/SA when significant changes occur or as needed through discussion with family and service providers. • Contact service providers frequently to discuss client progress, effectiveness of services, necessary changes to ensure client success.
KCA 20 **CASE PLAN IMPLEMENTATION** ***Provide services at the time of discharge and case closure.***	• At final FTM. • Reassessment. • Case closure.	• Identify and provide services to maintain behavior change at discharge and case closure. Begin to develop an after-care plan with youth, family and significant others at least six months prior to planned case closing/discharge. Plan should outline, but not be limited to, how services will address ongoing needs to provide for child safety, permanency and well-being. • Make written service referrals for discharge services and follow-up with providers. • Provide and connect youth/family with documentation, information and support needed to secure and participate in aftercare services. • Provide contact information for youth/family to contact agency, as needed. • Prepare families for identifying community services to support future needs.

12. Detailed Practice Guidance

a. Evaluate the appropriateness and effectiveness of services.

Background:

The case planning process should:

- Evaluate the strategies that have been identified that will help address the traumatic effects of the maltreatment while lessening the risk of further abuse or neglect.
- Define how resiliency (relatedness, mastery, regulation and self-esteem) will be addressed to achieve child well-being.
- Provide a clear and specific guide for the caseworker and the parent for changing the behaviors and conditions that impact the risk to the child and his or her overall safety.
- Provide a benchmark for measuring parent and child progress toward achieving identified outcomes and goals.
- Provide a framework for decision-making with the parent, child and family.

Providing a benchmark for measuring family progress toward achieving identified outcomes and goals or evaluating the appropriateness and effectiveness of services is a critical step in the implementation of the case plan. There are a series of questions which must be addressed in order to analyze the effectiveness of services and the impact or lack thereof on child and family progress.

- General questions for the team to consider regarding the appropriateness and effectiveness of all services being provided to the family and child:
  - Is the child physically safe? Is the child psychologically safe?
  - Are the caregivers physical safe and psychologically safe?
  - What traumas to the parent and/or child have been identified?
  - What is the current level of risk including the traumatic impact to the child?
  - Are the right services as determined through trauma screening and subsequent mental health assessment and resiliency case planning processes available and being provided?
  - Is the level of service still appropriate and the least restrictive while still assuring the child's safety?
  - Are the caregiver goals behavioral in nature?
  - Are the specific services being offered addressing the identified issues for both the parent and child?
  - Are the services understood by the family?
  - Have the services been provided in a timely manner?
  - Have the child and family members actively participated in the services?
  - Has the service provider engaged the parent and the child?
  - Is the provider responsive to the issues? What does the provider report?

- Are there any barriers to accessing or benefitting from the service? Does the case involve any concerns about coercive control, particularly as it relates to one caregiver potentially sabotaging or interfering with the other family members receiving treatment/assistance?
- Have there been any significant changes in family composition, dynamics or life events that are going to influence safety, risk, protective capacities, underlying conditions, contributing factors and effectiveness of services?
- How effective have the services been toward achieving the desired outcomes and the permanency goal?
- Are the outcomes, goals, objectives and action steps still appropriate?
- Are there adequate supports outside the formal child welfare system to support the family?
- Are the parents demonstrating that they have gained any benefit from services resulting in changes in the behaviors or the conditions which led to the departmental involvement?

- General questions for the team to consider regarding the child's safety, permanency and well-being and the impact of services on these outcomes:
  - Are the services being provided addressing the underlying conditions and contributing factors which resulted in the allegations of abuse or neglect?
  - Has the intersectionality of issues such as domestic violence, substance abuse, mental health, housing and employment been considered?
  - Are the services addressing the potential underlying unresolved trauma of the parents?
  - Are the services being provided able to enhance the protective capacities of the primary parents?
  - Are the services able to reduce safety threats and mitigate the need for interventions in the future?
  - Are services being provided that will address the child's potential trauma, need for permanency and well-being in a timely manner?
  - Are the services being provided working toward achieving child well-being, including permanency for the child?
  - Is the permanency goal the appropriate goal for the child and can it be achieved with the current array of services?
  - Is reunification likely in the required timeframe or is an alternative permanency goal needed?
  - Are the appropriate services being provided to assure the child's needs for well-being, including relatedness, mastery, affect regulation and self-esteem being met?
  - Are the services being provided enhancing or stabilizing the child's well-being (i.e. health needs, educational needs, mental health needs)?
  - Has there been a clear focus on the male caregivers as well as the female caregivers in the case planning process?

- General questions for the team to consider related to case closure and determination of appropriate services and supports being available to the family:
  - Have the identified safety and risk factors been eliminated or reduced to a point that the child can safely be returned to or remain in his or her own home without formal child welfare interventions?
  - Is the child's current placement permanent and safe?
  - Is the plan for the child strengthening child well-being?
  - Is there a need for an aftercare plan?

Without case plans with clear goals, objectives and action steps to guide the casework activities, decisions to close cases would be made using inappropriate or inconsistent criteria which in turn could lead to cases being closed prematurely or remaining open longer than necessary. From the beginning of departmental intervention, parents and caregivers need to know what changes they must make that will result in safe case closure or the return of their children. Additionally, children need to receive interventions that are resiliency based that will help them to manage and overcome their traumatic stress to achieve well-being. One valid reason for case closure is the completion of a well-formulated case plan that ensures child safety and well-being. Throughout case planning process, the effectiveness of the services are reviewed and used to determine the appropriateness of case closure or movement to other permanency options.

Policy Requirements:

FOM 722-8A: Foster care workers must engage the parents and the children, if age appropriate, in discussion of the family's needs and strengths. By completing the family assessment/reassessment, foster care workers are able to systematically identify critical family needs that are barriers to reunification and design effective service interventions.

FOM 722-6B: Case planning is a cooperative effort in which the child and family's strengths and needs are assessed in partnership with the family, caseworker and other team members. FTMs are held to facilitate this process, which involves developing a road map for moving children to permanence promptly while also addressing safety and well-being. FTMs serve as the primary forum for safety planning, collaborative service planning, service identification, and assessing progress.

PSM 714-1: Ongoing protective service responsibilities must be evaluated based on the need for continued services. Conduct an ongoing evaluation of the service agreement and services objectives and determine whether the child is safe and persons responsible for his or her health and welfare are benefiting from the service agreement. Include the use of extended family members for respite and ongoing family support.

Detailed Practice Guidance:

- Engage members of the family team in a process of considering the general questions (see background section above) regarding the appropriateness of services, child's progress toward improved outcomes and case closure.
- Review the case plan as part of your ongoing contact with the family.
- Review the case plan with the child taking into consideration what is age appropriate.
- Clearly communicate expectations to the caregiver and any service providers.
- Gather and analyze information from the parent and team members, including service providers, to determine the parent's and child's progress or lack of progress.
- Engage the child and parent in reviewing progress.
- Measure and document parent and child progress.

b. Implement a concurrent permanency plan.

Background:

Children need and deserve security, love, connectedness, moral/spiritual framework, mastery/efficacy/regulation skills and lifetime families to promote a healthy life. Foster care should be viewed as temporary–not a place for a child to grow up in. Concurrent, rather than sequential, permanency planning is a family-centered, child-focused and community-based approach to moving children from the uncertainty of foster care to the security of a permanent family–whether in their family of origin or a permanent home with relatives or a non-related family.

Michigan defines concurrent permanency planning (CPP) as the practice of working toward reunification while also establishing an alternative, back-up plan for permanency. CPP emphasizes reunification efforts by providing support, structure and clear expectations to families regarding timelines for permanency decision-making while keeping the focus on the child's need for safety, resiliency and permanence. Caseworkers must diligently pursue and support reunification. CPP should never be used as an excuse for circumventing or limiting reunification efforts. If the Juvenile Court determines that reunification is not possible, the alternative plan can be implemented. If implemented well, simultaneously developing two permanency plans for a child can reduce the number of foster care placements and can allow for expedited permanency. There are clear benefits to concurrent permanency planning for both children and families. If children can be placed with families who can both support reunification and are willing and able to commit to the child or youth through guardianship or adoption if needed, unnecessary placement moves can be avoided and the impact of trauma to the child can be reduced. This process oftentimes leads to earlier permanency and can result in all of the caring adults in the child's life (birth and resource) working closely together to support the child. A foundation will have been built which supports the ongoing contact between the birth family and the child's new family.

Concurrent permanency planning engages parents with a supportive relationship to help them understand exactly what is happening and what could happen (see Detailed Practice Guide on Full Disclosure) and uses the comprehensive family assessment to identify the family's strengths and needs with a case plan which clearly defines what must be done, by whom and when and/or if the children are to be returned to their parents' care.

Concurrent permanency planning is a federal requirement and most child welfare systems are very good at identifying the concurrent plan; implementation is most often much more difficult. If children are to achieve timely permanency then the courts and caseworkers must not only identify the concurrent plan, but they must work the plan while they remain committed to supporting the family with reunification efforts.

Policy Requirements:

FOM 722-6l: Policy regarding maintaining family connections through visitation and contact to be published in January 2014.

FOM 722-7A: Policy regarding concurrent permanency planning to be published in January 2014.

Detailed Practice Guidance:

These steps support effective concurrent permanency planning.[40]

- Conduct a comprehensive family assessment (see Detailed Practice Guidance).
- Front load services by making appropriate service referrals for the parents and children as soon as possible but no later than 30 days after initial placement.
- Make full disclosure (see Detailed Practice Guidance on full disclosure) of the concurrent permanency planning process (Plan A and Plan B) to all case participants (attorneys, court, Plan B caregiver, if not family team member) and family team members.[41]

[40] NRCPFC Concurrent Planning Toolkit

[41] This discussion should address parents' rights and responsibilities, the identified issues which brought their children into foster care, any changes needed as identified in the case plan, expectations of the Department and the courts and possible consequences. Parent(s)/Legal caregiver(s) must be given the opportunity to participate in the process to choose and plan for the concurrent goal. Exceptions should only include refusal on the part of the parent(s)/legal caregiver(s).

- Utilize quarterly family team meetings to identify, review and revise the concurrent plan.

- Ensure that an identified concurrent goal placement provider is involved throughout the planning process.

- Identify and locate absent parent(s) and extended family members during the investigation of abuse/neglect and continue throughout the life of the case until legal permanency for the child is achieved (see Detailed Practice Guidance on diligent search).

- Maintain connections between the child and his or her birth family with parent/child visitation as the key strategy to accomplish and support the connections. Hess and Proch (1992) referred to family visiting as "the heart of reunification" and that remains true today.[42] [43]

- Use natural opportunities for children to be in close, ongoing contact with their parents (i.e. medical/dental visits, school functions, extra-curricular activities, religious activities).

- Work with the juvenile court to set clear timelines for permanency decisions.

- Assure the family is provided access to identified services to address the areas of strength and need identified as part of the assessment and planning process.
- Ensure that case plans (PATP/SA) are clearly written and provided to the juvenile court in a timely fashion prior to court hearings (at least one week).
- Update case plan progress to provide the most updated information.
- Incorporate all court orders/requirements into case plans.
- Enlist court assistance to help address barriers to service provision.
- Make sure foster parents understand from the beginning of the licensure process that their role is to support and mentor birth parents (see Detailed Practice Guidance on facilitating birth parent involvement).

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[42] Hess, P., & Proch, K. (1993). Visiting: The heart of reunification. In B. Pine, R. Warsh, and A. Maluccio, (Eds.), *Together again: Family reunification in foster care* (pp. 119-139). Washington, D.C.: Child Welfare League of America.

[43] In domestic violence cases, assess for whether visits with the perpetrator and adult survivor should be separate or joint visits based on safety and any current orders of protection. In supervised visits, be sure to document and intervene in any abusive, coercive, or controlling behavior that takes place during visitation.

13. Practice Guide for Supervisors: Case Plan Implementation

Practice Guide for Supervisors	
Case Plan Implementation	
MITEAM COMPETENCY	Case plan implementation details the who, what, where, when and how with regards to specific tasks and/or objectives for each participating case planning partner (birth parents, foster parents, relatives, caseworker and service providers). Case plan implementation is the utilization of services designed to address a family's underlying needs as identified through the assessment and case planning process. Case plan implementation begins at initial plan development and continues throughout case closure.

FIDELITY MEASURES	**Observation:**
	• Helps the individual(s) identify people who are supportive.
	• Addresses reasons for reluctance to including specific team members.
	• Facilitates teaming.
	• Asks the individual(s) what the team member(s) (informal or formal) have done to provide support.
	• Requests individual(s) input regarding the effectiveness of services.
	• Asks the individual(s) how s/he can be of assistance to the family.
	• When developing or adjusting the plan, asks for team member's input.
	Documentation:
	• The team member's suggestions and comments are documented in the case file.
	• The family's team met within the required timeframes (FOM 722-6B).
	• There is evidence in the documentation that the team implements specific safety activities to address safety concerns of the child(ren)/youth.
	• There is evidence in the documentation that the team addresses specific permanency plans.
	• There is evidence in the documentation that the team addresses specific issues of well-being for the child(ren)/youth.
	• The team regularly reviewed the plan.
	• There is evidence in the documentation that service providers were provided with clear and specific service needs for the family.
	• There is evidence in the documentation that services were provided in a timely manner.
	• There is evidence in the documentation that the child's living arrangement has been fully assessed and determined safe.
	Interview:
	• The individual(s) was able to identify helpful activities of the worker.
	• The individual(s) reports being satisfied with services offered and/or referred.
	• The individual(s) described specific examples of the worker acknowledging his/her success (however large or small).
	• The individual(s) described specific examples where his/her input was utilized in decision making.
	In Supervision:
	• The worker was able to identify:
	  ○ How trauma is addressed in the case plan.
	  ○ How the parent participates in the process of change.
	  ○ How successes are acknowledged (however large or small).
	  ○ How the case has progressed and what to expect in next 90 days.

POLICY REQUIREMENTS	• Parental participation in the development of the case plan is required.
	• Caseworker must provide service referrals within 30 days of initial out-of-home placement.
	• Caseworker must identify follow-up steps to obtain compliance when parents decline to participate in services.
	• The Parent Agency Treatment Plan (PATP) must be:
	  ○ Specific to the individual needs of the family and children.
	  ○ Inclusive of the child and family's viewpoints.
	  ○ Written in a manner that is easily understood by all parties.
	• "Active efforts" for American Indian children require the caseworker to take a proactive approach with clients and actively support them in complying with the case plan rather than the case plan be completed by the client alone.

KEY CASEWORKER ACTIVITIES	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE TECHNIQUES
KCA 15 **CASE PLAN IMPLEMENTATION** ***Engage with service providers.***	• Prior to developing case plan. • During FTMs and case reviews. • During case monitoring.	• Observe and provide feedback on caseworker's ability to communicate the family's strengths and safety and resiliency needs to service providers, their treatment needs and expectations regarding frequency and intensity of services. • Educate, model and coach caseworkers on how to identify service providers that meet the family's needs/preferences/locations/cultural norms and team with them to support safety, permanency and well-being for children and families. • Educate, model and coach caseworkers on how to advocate for the creation of services. If services are not available to address the unique needs of the child and family, work with service provider to develop needed services or identify another provider. • Monitor the quality and substance of practice and provide feedback to caseworkers by reviewing case documentation to determine if service providers have been invited to/participated in FTMs and if the focus and outcomes of these contacts support positive achievement of goals/ outcomes for families.
KCA 16 **CASE PLAN IMPLEMENTATION** ***Clarify specific service needs when making referrals.***	Throughout the life of the case.	• Educate, model and coach caseworkers on how to use information from the family, the safety and risk assessments, FANS and CANS, case record information, and reports from providers to identify family's strengths and resiliency needs to inform case plan. • Coach the worker around assessing for safety concerns and dynamics of coercive control that might be interfering with or hindering successful completion of the case plan. • Educate, model and coach caseworkers to match services to build on strengths and address needs, support the permanency goal and creation of conditions for return/ permanency that must exist in home in order for child to achieve safe permanency. • Monitor whether identification of/ referral to services is done in collaboration with child and family in a way that will best meet identified needs and engage families in active service participation; discuss strategies to improve collaboration with caseworkers. • Monitor case planning to ensure that services have a reasonable chance of supporting conditions for return/permanency, create child well-being and provide feedback to caseworkers. • Educate, model and coach caseworkers to collaborate with families to determine which services are most appropriate for them before considering service availability.

		• Review case notes and provide feedback to caseworkers on the specificity and relevance of referrals to meeting needs of child and family to support safe permanency and well-being. • Review case notes and provide feedback to caseworkers on setting clear expectations for service providers regarding parental/caregiver behavioral changes expected as result of intervention.
KCA 17 **CASE PLAN IMPLEMENTATION** ***Provide services promptly and on an ongoing basis to increase safety, reduce risk, address well-being and promote timely permanency.***	• At case plan development and reviews. • At service referrals. • Caseworker visits and FTMs. • When situation changes.	• Monitor the completion of safety and risk assessments early and often throughout the life of a case according to required timeframes. • Educate, model and coach caseworkers on expectations for using assessment information to identify safety issues and develop plans to immediately and reliably control safety threats to keep children safe. • Review/provide feedback to caseworkers on strengths/needs of safety plans. Provide feedback, support for developing plans that ensure immediate, reliable protection. • Observe and assess caseworker's ability to monitor case plans and progress toward achievement of permanency goals, determine that a change in plan, goal or services is needed, and negotiate needed changes with parents, children/youth, and service providers in FTMs. Provide feedback. • Educate, model and coach caseworkers on how to determine a change in case plan, services/service provider or permanency goal is necessary, how to meet with parents/children/youth and service providers to discuss needed changes. • Educate, model and coach caseworkers on how to evaluate the effectiveness of services to produce desired results/changes and discuss these assessments with service providers to focus/refocus treatment. • Monitor the quality and substance of caseworker practice by scheduling regular case conferences to review case plans to ensure their relevancy to progress and recent events/emerging needs and that case plans can reasonably be expected to achieve permanency and well-being goals timely. Provide feedback.
KCA 18 **CASE PLAN IMPLEMENTATION** ***Use caseworker visits to mobilize services.***	• Caseworker visits.	• Educate, model and coach caseworkers on how to discuss with families and children their perception of the effectiveness of services, how services are helping them make progress toward their goals, their satisfaction with the services/service provider, emerging issues, changing needs in service delivery, or changes in goals/activities/ steps in case plans. • Monitor the quality and substance of caseworker practice by reviewing case documentation to determine if the worker is having individual visits with parents and children and if the content of these discussions is being used to drive and support case plan implementation. Provide feedback on improving compliance and quality of visits to support plan implementation.
KCA 19 **CASE PLAN IMPLEMENTATION** ***Evaluate the appropriateness and effectiveness of services.***	• Case plan reviews. • Caseworker visits and FTMs. • When situation changes.	• Observe and provide feedback on caseworker's ability to monitor case plans and progress toward achievement of permanency goals, determine that change in plan, goal or services is needed, and identify and negotiate needed changes with parents, children/youth, and service providers in FTMs. • Set expectations regarding frequency/ focus of communication with service providers to include goals, progress toward goals, changing needs and effectiveness of services. • Observe and provide feedback to caseworkers on the timing and quality of their interaction with service providers.

		• Educate, model and coach caseworkers on how to determine a change in case plan, services/service provider or permanency goal is necessary and on how to meet with family/children/youth and service providers to discuss needed changes. • Educate, model and coach caseworkers on how to evaluate the effectiveness of services to produce desired results/changes and discuss these assessments with service providers to focus/refocus treatment. • Monitor the quality and substance of caseworker practice by scheduling regular case conferences with each worker to evaluate effectiveness of services being provided to ensure their relevancy and responsiveness to changing needs. Make sure that continued services can reasonably be expected to support the capacity of families to achieve permanency goals timely. Share findings and provide feedback to caseworkers.
KCA 20 **CASE PLAN IMPLEMENTATION** ***Provide services at the time of discharge and case closure.***	• At final FTM. • Reassessment. • Case closure.	• Monitor that discharge FTMs are conducted prior to discharge and that post-discharge needs and services are identified and in place prior to the child leaving foster care and provide feedback to caseworkers. • Review case documentation and provide feedback to caseworkers on the clarity, execution and description of post-discharge services, what they are, why they are needed, when they will start and end, how they will be monitored, and how they know they have been effective. • Educate, model and coach caseworkers on how to talk openly with children and families about what they will need to ensure safe permanency after discharge and what services or supports will best meet those needs.

14. Practice through a Trauma Lens: Focus on Placement Planning

Utilizing a trauma-informed approach to placement planning with children, families, and other individuals will assist in the application of the KCAs and improve overall practice. The essential elements below were identified as critical to effective placement planning. The explanations of each essential element were taken directly from "Guidelines for Applying a Trauma Lens to a Child Welfare Practice Model" (Chadwick Trauma-Informed Systems Project [CTISP], 2013).

Essential Element: Maximize Physical and Psychological Safety for Children and Families

While child welfare has always had a focus on the physical safety of the child, a trauma-informed child welfare system must go further and recognize that psychological safety of both the child and his/her family is extraordinarily important to the child's and family's long-term recovery and social and emotional well-being. Psychological safety is a sense of safety, or the ability to feel safe, within one's self and safe from external harm. This type of safety has direct implications for physical safety and permanence, and is critical for functioning as well as physical and emotional growth.

A lack of psychological safety can impact a child's and family's interactions with all other individuals, including those trying to help them, and can lead to a variety of maladaptive strategies for coping with the anxiety associated with feeling unsafe. These survival strategies may include high-risk behaviors, such as substance abuse and self-mutilation. The child (and his/her siblings) may continue to feel psychologically unsafe long after the physical threat has been removed or he/she has been relocated to a physically safe environment, such as a relative's or foster parents' home. The child's parent(s) may feel psychologically unsafe for a number of reasons including his/her own possible history of trauma, or the uncertainty regarding his/her child's well-being that emerges following removal.

Even after the child and/or parent gains some degree of security, a *trigger* such as a person, place, or event may unexpectedly remind him/her of the trauma and draw his/her attention back to intense and disturbing memories that overwhelm his/her ability to cope again. Other times, a seemingly innocent event or maybe a smell, sound, touch, taste, or particular scene may act as a trigger and be a subconscious reminder of the trauma that produces a physical response due to the body's biochemical system reacting as if the trauma was happening again.

A trauma-informed child welfare system understands that these pressures may help to explain a child's or parent's behavior and can use this knowledge to help him/her better manage triggers and to feel safe (CTISP, 2013).

Essential Element: Enhance Child Well-Being and Resilience

A child's recovery from trauma often requires the right evidence-based or evidence informed mental health treatment, delivered by a skilled therapist, that helps the child reduce overwhelming emotion related to the trauma, cope with trauma triggers, and make new meaning of his/her trauma history. But to truly address the child's trauma and subsequent changes in his/her behavior, development, and relationships, the child needs the support of caring adults in his/her life. It is common for a trauma-exposed child to have significant symptoms that interfere with his/her ability to master developmental tasks, build and maintain relationships with caregivers and peers, succeed in school, and lead a productive and fulfilling life.

Case planning must focus on giving the child the tools to manage the lingering effects of trauma exposure and to help him/her build supportive relationships so that the child can take advantage of opportunities as he/she grows and matures. By helping him/her develop these skills in setting and build supportive relationships, mental health and child welfare professionals enhance the child's natural resilience (i.e., strength and ability to overcome adversity) (CTISP, 2013).

The following Trauma-informed Practice Strategies (TIPS) were identified as critical effectively operationalize placement planning skills through a trauma-informed lens:

Utilize Trauma Knowledge

- Continually consider the impact of trauma on children, youth, parents, team members, workers, supervisors and relationships during agency intervention.
- Consider the impact of potentially traumatic events when making decisions and plans
- Connect behaviors, emotions, school problems, and relational/attachment difficulties to the impact of traumatic events.
- Reframe trauma history as what has happened versus what is wrong with the person.

Educate about Trauma

- Proactively Transfer trauma knowledge through ongoing conversations that build understanding from the first interaction to the last. May include discussion around:
  - What is trauma?
  - What can be traumatic to a child or adult?
  - How does trauma change the brain?
  - How does trauma impact people differently?
  - What are the impact and symptoms of trauma?
  - What is resiliency?
  - How does resiliency works to treat trauma?
  - How can resiliency be built?
  - How does resiliency impact long-term view?

15. Practice Guide for Caseworkers: Placement Planning

Practice Guide for Caseworkers	
Placement Planning	
MITEAM COMPETENCY	The placement planning process is a methodology to ensure that children are placed in the most appropriate, least restrictive living arrangement consistent with their needs. This placement would ideally enable the child to maintain connections to family and friends and receive assistance with any special needs and stay in the same school. This process is critical to ensuring that family connections are maintained through appropriate visits when the child, his or her siblings and/or parents are temporarily living away from one another, unless compelling reasons exist for keeping them apart.
FIDELITY MEASURES	**Observation:** • Prepares family team members (informal or formal) for participation on the team. • Facilitates Teaming. • Asks the individual(s) how s/he can be of assistance to the family. • Inquires about individual(s)'s perspective on the child(ren)/youth's safety (both physical and psychological). • Inquires about individual(s)'s perspective on the child(ren)/youth's well-being (both physical and psychological). • Asks individual(s) about their perspective on the parent's ability to keep the child(ren)/youth safe. • If child(ren)/youth is not residing with custodial parent: Asks individual(s) their perspective on the caregiver's ability to keep the child(ren)/youth safe. • If child(ren)/youth is not residing with custodial parent: Inquires about the caregiver's perspective on the impact of traumatic events on the child. • Requests individual(s) input regarding living arrangement options for the child(ren)/youth. • Inquires about individual(s)'s perspective regarding how the living arrangement options impact child(ren)/youth connections. • Inquires about the individual(s)'s perspective on the safety of all family/household members (both physical and psychological). **Documentation:** • A team that provides support to the child(ren)/youth and family has been formed. • The worker prepares the family team members (informal or formal) for participation on the team. • Documentation indicates the worker maintained contact with the family and support person(s) between in-person meetings. • The parent's ability to keep the child(ren)/youth safe was documented. • The impact of trauma and resiliency on parent's ability to keep child(ren)/youth safe was documented. • There is evidence in the documentation that the child's living arrangement has been fully assessed and determined safe. • There is evidence in the documentation that the child(ren)/youth current living arrangement supports the permanency plan. • There is evidence in the documentation that the worker noted 2 or more of the following: the condition of the home, attitude of the family members, behaviors of family members, or relationship patterns between family members. **Interview:** • The individual(s) was able to identify helpful activities of the worker. • The individual(s) described specific examples where his/her input was utilized in decision making.

	• The individual(s) reports the worker addressed the potential impact of trauma to the child. **In Supervision:** • The worker was able to identify: ○ What is most important to the individual/family. ○ How trauma is addressed in the case plan. ○ How the parent participates in the process of change. ○ If the current living arrangement meets the well-being needs of the child(ren)/youth. ○ How the current living arrangement is helping build resiliency. ○ How the child's current living arrangement ensures the child's physical and psychological safety. ○ How he/she educates the family about the importance of teaming. ○ How committed the family's team is to support the family's plan.
POLICY REQUIREMENTS	• Maintain children in their own homes whenever safely possible. • Give preference to placement with a relative - if all requirements are fulfilled - when children must be removed from their home. • Place children in the most family-like setting and keep siblings together whenever possible. • Preserve and encourage permanent connections with siblings and caring and supportive adults. • Choose a placement that helps facilitate and support return home if the plan is reunification. • Consider a placement with a view toward preparing the child for permanency.
HOW TO USE YOUR SUPERVISOR	• Explore, with supervisor, community resources and services to assist in placement stability. • Discuss with supervisor ways to facilitate engagement with family members. • Seek review by supervisor of assessment and decisions around placement. • Explore, with supervisor, ways to ensure that parents spend natural, quality time with their child.

KEY CASEWORKER ACTIVITIES	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE TECHNIQUES
KCA 21 PLACEMENT PLANNING ***Assess whether potential relative or kin caregivers are willing and able to safely care for children and youth.***	Throughout the life of the case.	• Observe family relationships and how the family and child relate to each other. Gather information from a potential relative caregiver to determine if a placement with that relative would be in a child's best interest, if this would be temporary or permanent.[44] • Remove barriers to relative placement and licensing, specifically related to unemployment, poverty, criminal histories of other adults in the home and needed home repairs, if it is determined that the child's physical, psychological and well-being needs would best be met in the relative placement. • Ensure relatives are fully informed about the option to become licensed foster parents. Explain the merits of full licensing to potential relative caregivers. • Ensure relative caregivers have the necessary information and support to care for their children. See DPG_ensure_relative_caregivers_info.

[44] In domestic violence cases, assess relative caregivers' ability to support positive relationships with the non-offending parent/adult survivor, as well as promote healing from trauma.

KCA 22 PLACEMENT PLANNING ***Work closely with members of the family team to make initial placement decisions, support those placements and plan for transitions.***	Throughout the life of the case.	• Identify, locate and assess family members (i.e. fictive kin, fathers and their families, incarcerated parents, mothers and their families) who should be involved in the placement planning process. • Prepare parents and potential caregivers to participate in the process of finding the most suitable placement for a child by explaining what it is about, how the information will be gathered, how the information will be used and how they can contribute to the decision. • Discuss with foster parents and other substitute caregivers the ways they can be active in the placement process (i.e. mentoring parents, speaking up for their own needs). • Ensure persons with the most knowledge about the children are involved in the search and identification of the most appropriate placements. • Plan for transitions for children from one placement to another with members of the team.
KCA 23 PLACEMENT PLANNING ***Use assessment information to match children and youth to the most suitable placements.***	Throughout the life of the case.	• Reduce trauma for children by matching them to the most appropriate placements and planning for transitions. See DPG_reduce_trauma_matching_placements. • Ask the child or youth where he or she would like to be placed. • Listen to the child or youth. • Ask parents and other family members for input on where child should be placed. • Consider the child's needs, vulnerabilities, placement wishes, caregiver capacities, and potential for life-long permanency when assessing placement options. • Gather input from current and former caregivers as to the type and characteristics of the most suitable placement for the child. • Ask the persons responsible for placement in your county to help identify the full array of unrelated placement options that could meet the child's need. Assess the needs, strengths and parental capacities of potential relative caregivers, foster parents or other caregivers. • Identify supports for children and caregivers that support placement stability, child safety and well-being.
KCA 24 PLACEMENT PLANNING ***Use visits to preserve connections, strengthen relationships and make progress on identified goals.***	Throughout the life of the case.	• Arrange immediate, frequent visits between children and their parents throughout their time in care. • Prepare and support parents, families and children to make critical case decisions and participate as full members of family team. • Use assessment tools to determine how often and under what types of circumstances (i.e. supervised, unsupervised) children should be spending time with their own parents and siblings. • Plan for and use visits as a tool for maintaining relationships between children, their parents and siblings. • Visit children/ youth where they are placed to assess their adjustment to the placement, including the impact of separation from family, capacity of the substitute caregivers to meet the child's needs and any emerging concerns related to the child's physical, developmental, emotional and behavioral status. • Meet with children privately to discuss satisfaction with relationships, contacts with family members and siblings, and support needed to strengthen their important relationships. • Interview foster parents and relative caregivers privately about child's needs for and response to maintaining important connections. • Prepare parents/caregivers and children prior to visits on what to expect before, during and after visits and what support is needed for each of them to ensure physical and psychological safety. • Discuss and prepare foster parents and relative caregivers to support important connections for and with the child.

		• Provide supervision as may be needed to ensure child or youth safety and at the same time help them preserve important relationships being mindful of the impact of trauma. • Schedule visits when it is convenient and reasonable for the parent, child, and/or caregiver. • Check on progress toward agreed-upon goals, problem-solve and provide reassurance at every visit. • Provide feedback on what they have accomplished and discuss what may need to happen to achieve their goals during every visit. • Ask children, caregivers and parents for feedback on what you could do differently to assist them in achieving their goals.
KCA 25 PLACEMENT PLANNING ***Facilitate parent involvement with their children.***	Throughout the life of the case.	• Facilitate parent involvement with their own children when they are in foster care. See DPG_facilitate_birth_parent_involvement. • Conduct icebreaker meetings with children, their current caregivers (i.e. foster parents or substitute caregivers) and their own parents to plan for ways to support each other and promote timely reunification. • Support parents in maintaining an active role in their child's life during out-of-home placement. Shared parenting between foster and birth parents should be the expectation unless there are identified/agreed upon safety concerns. • Help children be in regular contact with their parents and siblings. This may be by email, telephone, in person visits, or participation in regular school or community activities. • Consult with parents in making daily decisions about the care, treatment and activities of their child or youth. • Make sure parents are invited and encouraged to participate in community events, school activities, church services and other activities their children are involved in doing. • Facilitate a productive working relationship between parents and foster parents. Encourage, where appropriate, for the parent and foster parent to develop a relationship without the worker's direct, ongoing participation. • With approval and consultation from caregivers and parents, help them to develop plans for visits and other specific activities in which parents will participate (i.e. reading a book to a child at night, cooking dinner, accompanying to school meetings, etc.). • Attempt to place children in close proximity to parents to facilitate their involvement. • When necessary, help secure the support of family resources and other programs and persons who would be willing to help facilitate and/or supervise visits between parents and their children.
KCA 26 PLACEMENT PLANNING ***Help children stay connected to their siblings.***	Throughout the life of the case.	• Help children stay connected to their siblings. See DPG_help_connect_to_siblings. • Facilitate visitation between siblings when they are not placed together. • When not placed together and appropriate, create a plan for helping siblings stay connected, including visits, phone calls, email or through other methods that work well for them. • Encourage and support foster parents and other caregivers to ensure sibling connections are maintained and take place in their homes or as part of other community events or activities to feel normal and regular.

16. Detailed Practice Guidance

a. Reduce trauma for children and youth and build resiliency by matching them to the most appropriate placements and planning for transitions.

Background:

A stable, nurturing family environment can protect foster children against the traumatic effects of maltreatment prior to foster care and multiple moves while in foster care. Children and youth who are in foster care or at risk of foster care have often experienced some type of trauma from their own life experiences within their own families or communities. Multiple moves while in foster care can often exacerbate the impact of trauma children and youth have already experienced. Children and youth will struggle with the lack of predictability and uncertainty of life in their new environments and relationships. The children will continue to miss and grieve for loved ones and their own communities. This grief is compounded by placement disruptions and case management transfers. Providing children and youth with relational safety and stability while in foster care helps to facilitate resiliency and build well-being. Family stability can have a positive effect on a child's behaviors and outcomes, academic performance and achievement, social skills development and emotional functioning.[45]

Research during the last decade has shown that between one-third and two-thirds of traditional foster care placements are disrupted within the first one or two years.[46] The most frequently cited reason for a failed foster placement is the inability of foster parents to manage children's behavior problems.[47]

One step that can be taken by caseworkers and their supervisors to increase the likelihood that children and youth will be safe, stable and on a path to permanency while in foster care is to carefully place them in homes that understand their trauma and are able to recognize and help meet their psychological needs. The best match for a child is often a person with whom the child already has a positive relationship. This means that parents and other support persons must be involved in the process, relative and kin caregivers should be prioritized along with siblings for placement and the availability of services and supports must be identified at the outset. Children and youth should be placed according to their own individual needs and

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[45] Harden, B. (2004) Safety and Stability for Foster Children: A Developmental Perspective. *Children, Families and Foster Care.* 14(1), 30 – 47.

[46] Wulczyn, F., Kogan, J., & Harden, B.J. (2003) Placement Stability and Movement Trajectories. *Social Services Review,* 77(2), 212-236.

[47] James, S. (2004) Why do foster care placements disrupt? An investigation of reasons for placement change in foster care. *Social Service Review,* 78, 601-626.

strengths. Residential placements should be utilized when the child is no longer safe in the community and/or there is no placement that is able to manage the child's behaviors.

Parents should be involved in the placement process. Parental involvement in their child's foster care experience (i.e., buying clothes, visits to the dentist, meeting with teachers, deciding with foster parents how to manage a child's behavior, deciding on plans for visitation, etc.), including the placement process, is both important and positive. Despite this knowledge, many parents are not involved in the placement process for their own children. Research results reveal a large discrepancy between the new philosophy advocating recognition of the importance of the involvement of parents and the reality of what actually happens.[48] While some parents do have difficulties that may impact their ability to be involved, many feel ill-equipped to engage social workers and work with them to help make placement decisions.

These same researchers found evidence that:

- There is greater participation of parents in the placement process when caregivers clearly understand the importance of the natural parents in the lives of their own children.
- The presence of a spouse or partner increases parental participation in care-related tasks and school activities.
- Parents who can count on the support of a spouse or partner take part in a greater number of decisions and activities involving the child's placement.
- Parents who report fewer difficulties (i.e. long distance between placement setting and their home, problems in relationship with caseworker, personal or family problems) take part in more activities.
- Parents who perceive the caseworker as having a positive opinion of them participate more often in their child's foster care experience.
- Parents who perceive that foster parents are in favor of their participation do so more often.[49]

Simply put, time must be spent promoting and encouraging the ongoing involvement of a child's parents in the placement process.

Kin placements are often more stable. Data suggests that children placed with relative and kin caregivers experience fewer placements moves. Findings suggest that the average number of placements children experience could be effectively reduced by placing them with relatives at

[48] Poirier, M. and Simard, M., (2006) Parental Involvement during the Placement of a Child in Family Foster Care: Factors Associated with the Continuation of Parental Roles. *Children and Youth Care Forum.* 35, 277-288.

[49] Ibid.

entry to care, which would afford children the stability of relative homes without requiring them to endure a subsequent change in placement.[50]

As part of the assessment of kin placement is a determination of the kin caregiver's ability to provide a safe stable environment for the children. For example, in domestic violence cases, placement with the family of the alleged domestic violence perpetrator must examined closely for safety, issues of access to the child by the perpetrator and denial of the adult survivor's access to the child by the perpetrator's kin.

Siblings should be placed together. Children have the inherent right to maintain their sibling relationships and live with their siblings. All available placement resources to keep children and youth with their siblings must be explored and when they cannot be placed together, some level of contact must be maintained. While the reasons are very limited, the family team should consider the merit of placing siblings together if one sibling is physically, emotionally or sexually abusive toward another sibling and therapeutic interventions have been unsuccessful in ameliorating the behavior.

Placements are more stable when needed support and services are provided. This must be taken into consideration when making placement decisions. Research has found that interventions to help foster parents support the emotional needs of their foster children have met with success.[51] Homes for which family-based, wraparound services are more readily available have been found to be one-third less likely to experience placement moves than children in traditional, non-relative placements.[52]

Care must be taken in coordination with the parents and members of the family team to reduce the trauma associated with the initial removal and subsequent placement moves that may be warranted. Recent studies indicate that the removal and placement can be profoundly frightening, disorienting and frustrating to the child or youth. Children and youth fear being abandoned and overwhelmingly helpless. It is very difficult to process information during this time.[53]

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[50] Courtney, M., Zinn, A., Goerge, R., DeCoursey, J., (2006) A Study of Placement Stability in Illinois, *Chapin Hall Center for Children at the University of Chicago Working Paper.*

[51] Harden, B. (2004) Safety and Stability for Foster Children: A Developmental Perspective. *Children, Families and Foster Care.* 14(1), 30 – 47.

[52] Courtney, M., Zinn, A., Goerge, R., DeCoursey, J., (2006) A Study of Placement Stability in Illinois, *Chapin Hall Center for Children at the University of Chicago Working Paper.*

[53] ACS-NYU Children's Trauma Institute. (2012) *Easing Foster Care Placement: A Practice Brief.* New York: NYU Langone Medical Center.

Policy Requirements:

PSM 715-2: During removal and replacement, CPS must review with parents and children any potential placements even during an emergency removal, including an evaluation of placement with the non-custodial parent first and with a relative second. Preference must be given to a relative before an unrelated licensed caregiver.

FOM 722-3: When making a temporary out-of-home placement, MDHHS must evaluate factors to ensure the selected placement is safe and is in the child's best interest. Workers may not routinely consider race, national origin and ethnicity in making placement decisions except for American Indian children, for whom placement priorities are to be followed. If the plan is reunification, placement selection must be in the least restrictive placement that preserves and maintains relationships with the relative network, friends, teachers, etc.; facilitates and supports return home, considers the parental wishes and the child's preference as age appropriate; be in close proximity to the child's family to facilitate parenting time, minimize the number of placements, and be the ongoing placement for the child with the potential for permanency if needed. MDHHS must consider placement history when seeking placement and any relationship with a previous caregiver. If the family agrees and a relative home is not in the county or state, MDHHS must pursue this placement option immediately.

FOM 722-6: MDHHS must make reasonable efforts to identify and locate an incarcerated parent to ensure the absent parent issue is addressed as early as possible in child protection proceedings.

NAA-215: MDHHS must follow federal guidelines regarding the temporary placement and adoptive placement of Native American children and ensure that the placement be within "social and cultural standards of the Indian community." The placement must be made in descending order from extended family, child's tribe and other Indian families.

ADM 400: MDHHS must make efforts to find an adoptive family that will provide a stable home for the child which may include locating relatives or friends who have an established positive relationship with the child, a photo listing on state and national websites and recruitment through distribution of information about a specific child.

ADM 610: Consideration for the adoption of a specific child means that the child's adoption worker will explore the child's relationship with relatives and other families who have a history with the child and/or a relationship that is significant to the child.

Detailed Practice Guidance*:*

A. Here is guidance on the process of matching children to the most appropriate placement:
    - Identify and locate all family members and support persons.

- Assess the appropriateness of family members and support persons in the placement process.
- Make sure potential relative caregivers understand all of the support available to them if they become fully licensed.
- Submit licensing waivers as may be needed.
- Advocate for needed support for potential relative caregivers to be eligible for licensing.
- Supervisors must assess the extent to which all relative options have been fully explored and the support caseworkers may need to screen these relatives.
- If no relatives or other support persons are options for placement, engage identified placement staff to bring information on the available unrelated homes and other placements that may be available to the family team.
- Prepare parents to participate in the process of finding the most suitable placement for a child or youth by explaining what it is about, how the information will be gathered, how the information will be used and how they can contribute to the decision.
- Make sure everyone involved in the review of available unrelated homes and available placements understands the trauma, strengths and subsequent needs of the child and where the child is from before making any placement decisions.
- Deliberate on and document the team's vision for the best possible placement for the child that will ensure safety, permanency and well-being.
- Ensure persons with the most knowledge about children are involved in the search and identification of the most appropriate placements.
- Ask the child where he or she would like to be placed.
- Ask parents and other family members for input on where the child should be placed.
- Consider the safety and appropriateness of these suggestions as well as the longer-term prospect that this placement could be for a lifetime.
- Contact the potential family/placement to discuss the child that has been recommended for placement. Prepare them for the child.
- Make sure the potential family/placement fully understand the trauma, strengths and needs of the child.
- Listen to family/placement about whether or not they feel the child would be a good fit for their home/agency.
- Listen to family/placement about the type of support they would need to provide care for the child.
- Call your supervisor if you or the child has reservations about the potential placement.
- Agree on the best placement for the child.

B. Here is guidance on transitioning children from one placement to another:

- Explain why they have been removed and placed. Provide information as to what is going to happen next.

- Take the child or youth to the new placement. Stay with the child for a while. Be sure to talk with the child alone before you leave about how he or she is feeling.
- Remember that the child is likely scared, confused and overwhelmed.
- Discuss the supports and services that are needed for the child. Assess whether or not these can be made available.
- Determine if the child is in school. If so, gather information about grade level, performance, behavior, favorite teacher, etc.
- Gather as much information related to the child's routine, behaviors and personal preferences to ensure his or her well-being while in foster care.
- Gather clothing, favorite toys and other personal items that the child will want to have while they are in foster care.
- Discuss any medical or behavioral health issues for the child and get parental consent for medical treatment, if needed.
- Arrange for immediate visitation between the child and his or her parents, siblings and other family members.
- Clarify roles and responsibilities of team members regarding the placement decision and provision of support and services.
- Keep asking the child what he or she needs to feel safe and comfortable.
- Listen to the child.
- Keep calm.
- Advocate for the needs of the family, if needed and appropriate.

b. Help children and youth stay connected to their siblings.

Background:

You can pick your friends, but not your siblings. Brothers and sisters play a significant role throughout a child's life, and when children enter foster care and are not placed together, that fact becomes clear. Siblings often are each other's support, especially in families where parental capacities are compromised or diminished. Research has found that when siblings cannot be placed together, regular contact is critical to maintaining the relationships and can affect permanency outcomes.

> *"When siblings cannot be placed together, facilitating regular contact is critical to maintaining these relationships. Regular contact may even affect permanency outcomes. Findings from the Child and Family Services Reviews conducted in all states found a significant association between visiting with parents and siblings and both permanency and well-being outcomes (USMDHHS, 2011)."*
>
> ~ Child Welfare Information Gateway, Sibling Issues in Foster Care & Adoption Bulletin for Professionals, January, 2013

When children do come into foster care, it is important to conduct an initial assessment of sibling relationships. If appropriate and safe, siblings should be placed together. If they cannot be placed together, then a proactive plan for preserving sibling ties needs to be developed and implemented.

Policy Requirements:

PSM 715-2: Reasonable efforts to place siblings together are required unless the placement would be contrary to the safety or well-being of any of the siblings. If the sibling group is not placed into the same out-of-home placement, the efforts made must be documented.

FOM 722-2: Siblings are entitled to be placed together when in foster care. If this proves impossible, the reasons are to be documented. Certain reasons for siblings being separated may be rectified by applying for a licensing variance. When separated, the relationship between siblings must be maintained by a detailed plan of visits, phone calls and letters. Visits must occur monthly.

FOM 722-3: If reasonable efforts to place siblings together are documented, but a sibling group is separated at any time, the caseworker must make immediate efforts to locate or recruit a family in whose home the siblings can be reunited. These efforts must be documented and maintained in the case file. A reassessment of the sibling split placement is required in the case plan each quarter.

FOM 722-6: It is required that whenever siblings are not placed together, reasonable efforts must be made to provide frequent visitation or other ongoing interaction between the siblings. The visitation plan is to be documented in the applicable service plan.

ADM 650: Unless it has been determined that sibling visits are not in the child's best interest, a child's visits with siblings must continue at the interval established prior to the termination of parental rights until the court has signed an order placing the child. If a child has been placed for adoption and his/her siblings remain in care, the adoptive parents should be encouraged to continue contact with the child's siblings.

Detailed Practice Guidance:

Here are recommended steps to help children and youth stay connected to their siblings.[54]

[54] Child Welfare Information Gateway, Sibling Issues in Foster Care & Adoption Bulletin For Professionals, January 2013

- Place siblings with relative caregivers who have an established personal relationship with the child. Even when siblings cannot be placed in the same home, they are more apt to keep in close contact if they are each placed with a relative.
- Place nearby. Placing siblings in the same neighborhood or school district ensures that they will be able to see each other regularly. Also, keeping children in their same schools contributes to better educational outcomes.
- Arrange for regular visits. Frequent visits help to preserve sibling bonds. Visits with parents should try to be arranged to occur at a time when all the siblings can be together.
- Structure visits to create physical and psychological safety for the child, parents and caregivers. Verbalize that having visits in an office is artificial and difficult for families. Verbalize that children may have worries and fears about the parental responses during visits. Verbalize what is already clear to everyone that the children were removed and the children, parents and family members may be angry, sad or confused about why this happened and what may happen next.
- Arrange other forms of contact. If the distance between siblings is great, caseworkers need to assist foster and adoptive families in maintaining frequent contacts through letters, email, social media, cards, and phone calls. Make sure that children have full contact information for all their siblings. For instance, providing older siblings with calling cards may facilitate sibling communication.
- Involve parents and caregivers in planning. The adults in the siblings' families should be involved with the caseworker in developing a plan for ongoing contact. This meeting should include working through any barriers to visits, and the plan needs to be reviewed and revised as needed. Sometimes, there are value differences between families or differences in rules that cause parental discomfort with visits. Such differences need to be discussed and resolved.
- Plan joint outings or experiences. Siblings may be able to spend time together in a joint activity or at summer or weekend camps, including camps specifically for siblings or through short-term outings. Such camp experiences help siblings build and maintain their relationships.
- Arrange for joint respite care. Families caring for siblings may be able to provide babysitting or respite care for each other, thus giving the siblings another opportunity to spend time together.
- Help children with emotions. Sometimes sibling visits stir up emotional issues in children, such as the intense feelings they may experience when visiting their parents. Children need to be helped to express and work through these feelings; this does not mean visits should not occur. Visits should provide some opportunities for joint Lifebook work with siblings. If siblings are in therapy, they should be seeing the same therapist, and it may be possible to schedule appointments either jointly or back-to-back. Children may also need help with feelings of guilt if they have been removed from an abusive home while other siblings were left behind or born later.

- Encourage sustained contact. Sustaining sibling contact often requires a unique understanding and commitment from parents. Many adoptive and foster parents recognize the importance of children having contact with siblings living with their families, in other foster homes or adoptive families. Some families, for example, travel across the country or to other countries to give their children the opportunity to get to know their siblings.

c. Facilitate parent involvement with their children.

Background:

The majority of children who come into care eventually exit the system to be reunited with their families. Placing focus on practices that involve the parents in their children's daily lives while in foster care makes reunification more likely and more expedient. Maintaining and growing the parent-child relationship is a key ingredient that supports positive permanency. Including parents in a way that is natural and replicates daily situations provides an opportunity for stronger, more lasting connections and creates a smoother transition for both parents and children when they are ready to return home. However, depending on the child's traumatic stress, contact with parents and siblings may trigger prior traumatic events that increase intrusive thoughts, re-enactment, avoidance and/or hyper-vigilance. Recognition and responsiveness to the triggering and subsequent child reactions are critical for the child's well-being. The role of the parent or sibling in the re-triggering must be determined in order to understand where support may be needed for the child as well as his or her parents.

Policy Requirements:

FOM 722-6: In order to help maintain and strengthen the relationship between the parent and child, MDHHS must establish a parenting time plan that continually involves the parents in activities and planning for their children, such as attendance at school conferences and involvement in medical and dental appointments, unless documented as harmful to the child. The schedule must be done with primary consideration for the parent's time commitments, which may include employment and mandated service requirements. Barriers to parenting time are to be identified and, if possible, resolved. There must be a written plan for progression of parenting time for children with the goal of reunification, including successfully addressing barriers, increasing the frequency and/or duration, along with changing the location to support a more family friendly environment and encourage typical parent/child interaction.

FOM 722-8C: MDHHS must identify in the Parent-Agency Treatment Plan and Service Agreement the parenting time plan for all parents/caretakers and non-parent adults, if applicable, which includes the type, frequency, location, and duration of parenting time; who will supervise visits (if required); what conditions must exist for unsupervised visits; what behaviorally specific activity is expected of the parent during this time; and the requirements necessary for expansion of parenting time.

Detailed Practice Guidance:

- Make sure children are frequently spending time with their parents.
- Implement parenting time for parents and children. Parenting time for parent(s) and children must occur frequently prior to initial disposition and at least weekly thereafter. If the child is an infant, ages 0-2, parenting time should be more frequent.[55]
- Place children as close to their parents as possible. If there aren't sufficient caregivers in the areas where families with children in care live, help to support recruitment efforts in those neighborhoods.
- Involve parents continually in activities and planning for their children, such as attendance at school or conferences and involvement in medical and dental appointments, unless documented as harmful to the child.
- Use case aides, foster parents, relative caregivers and other team members to supervise visits.
- Develop a written plan for progression of parenting time for children with the goal of reunification.
- Set the expectation for parents to spend natural, quality time with their children.
- Be creative about the visit to support the family's traditions, culture and milestones.

[55] The frequency, location and duration of parenting time for parents and children and the visitation requirements described above must be identified in the Parent-Agency Treatment Plan/Service Agreement (PATP/SA). Supervising agencies must use parenting time to maintain and strengthen the relationship between parent and child. Parenting time must be provided for every parent with a legal right to the child, regardless of prior custody. If the non-removal parent had established visitation, these visits should continue accordingly unless there are new factors that would negatively impact the child or there is a court order changing the visitation plan. The Juvenile Code requires parenting time between parent and child no less than every seven calendar days after the dispositional hearing, unless clearly documented as harmful to the child. Unless there is documented evidence that parenting time or contact would be harmful to the child or there is a no-contact order in place, the foster care worker must arrange for regular visits or contact between an incarcerated parent and the child. Alternatives to regular visitation at a jail or prison facility may be contact via letters sent through the worker or phone contact. Issues pertaining to a schedule of parenting time must be discussed with the parent(s) and an agreement reached as to a parenting time schedule. Scheduling of parenting time must be done with primary consideration for the parent's time commitments, which may include employment and mandated service requirements. The supervising agency must institute a flexible schedule to provide a number of hours outside of the traditional workday to accommodate the schedules of the individuals involved. Barriers to parenting time are to be identified and, when possible, resolved. Parenting time must occur in a child and family friendly setting conducive to normal interaction between the child and parent. Parenting time supervisors must be aware of the expectations of the parent(s) during parenting time and are to facilitate and encourage appropriate behaviors during parenting time.

- Plan visits carefully and understand the purpose of each visit. The caseworker should talk with the parent about ways to interact with their children during the visit and, when possible, link to service plan expectations (i.e. providing appropriate, nutritious meals during visits, play educational games with them).
- Demonstrate and encourage flexibility in parental visitation schedules to accommodate the changing needs of parents, caregivers and children.
- Identify opportunities throughout the child's daily routine to engage parents in connecting with their child (i.e. walk or take to or from school, meet the child for lunch at school, volunteer at school, attend doctor appointments, do a project together or have a play date, go to the store or run other errands or watch a movie together).
- Arrange for parent-child visits in the home of the parent.
- Support caregivers to develop visitation ground rules that are flexible and provide for natural time between parents and their children. When necessary, help to mediate conflicts that may jeopardize natural time between both current and future families.
- Advocate for as much visitation as parents can do and that ensures child safety. The psychological impact to the child must be considered. It is important to consider the type and quantity of visits, if these visits are re-triggering traumatic stress and leading to regression in the child's behaviors and his or her ability to manage his or her emotions.
- Accommodate parental work and case plan schedules when arranging visitation.
- Link parents to the resources they need that will enable them to spend frequent, natural time with their children, including transportation or care for other children that may be in their custody.
- Facilitate visits, letter writing and phone calls between children and their incarcerated parents. Prepare them for these visits by making sure they understand the security protocols, dress codes, long waits, the presence of guards and the change in appearance of their parent. Know the visiting rules and teach them to the child.[56]
- Be mindful of the typical prejudice in our society regarding incarcerated parents also exists with professionals who have not been trained in the research on understanding children of incarcerated parents. Make referrals to therapists and other service providers who have experience and compassion for children of incarcerated parents.[57]

Here is guidance on working with foster parents to share parenting responsibilities with parents:

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[56] Adapted from *Ten Tips of Kinship Caregivers of Children of Incarcerated Parents,* Arkansas Voices for the Children Left Behind, Dee Ann Newell (2011).

[57] Adapted from *Ten Tips of Kinship Caregivers of Children of Incarcerated Parents,* Arkansas Voices for the Children Left Behind, Dee Ann Newell (2011).

- Help caregivers find ways to be active in the placement process (i.e. mentoring parents, speaking up for their own needs). [58]
- Help caregivers work in a partnership with parents.
- Make sure caregivers are members of the family team.
- Provide support to caregivers so they understand the value of, help to maintain, and nourish the child's relationship with his or her parents.
- Make sure caregivers understand when and how it is appropriate for them to take the lead to make arrangements made for the family and the child to have contact, including visits and correspondence.
- Ensure caregivers support reunification efforts.
- Solicit caregivers' help in providing transportation for family visits.
- Help caregivers have discussions with the parents about the visits.
- Help caregivers promote and support a positive non-judgmental relationship between the child and his or her parents.

d. Ensure relative caregivers have the necessary information and support to care for their children and youth.

Background:

The main goal for children and youth in foster care is a permanent, safe, and stable home with a nurturing caregiver who is able to support their well-being. Relatives play an important role in ensuring the safety and well-being of children in foster care as they provide safety and stability while maintaining connections with their siblings and communities. In many cases, relative caregivers assist in the reunification process by facilitating contact that allows parents to maintain a significant role in the child's life. Relative caregivers can also provide children with stability through guardianship or adoption if they cannot return home.

Relative caregivers are often asked to make decisions quickly about opening their hearts and homes to children in need of care. Unlike other forms of out-of-home care in which foster parents choose to offer their home to children and then undergo training and preparation, relative caregivers are often contacted as a child is about to enter out-of-home care or shortly thereafter, requiring immediate decisions and expedited training. This can put added stress on relative caregivers. In addition, relative caregivers often juggle mixed emotions related to taking on the new role of primary caregiver. Some experience feelings of loss and embarrassment. Others may feel a sense of guilt because of the child's maltreatment by members of their

[58] Include foster parents in domestic violence safety planning, (as needed) and ensure that their own safety is included in any planning. Additionally provide support/education for foster parents specific to domestic violence and how best to support talking with the children about the abuse/violence and any concerns/anxiety regarding the non-offending parent/adult survivor.

family.[59] Their loyalties may be divided between wanting to help the parents with their problems and wanting to ensure the children are safe and protected. Relative caregivers may even feel anger and resentment toward the child's parent and may experience stress and confusion as roles and boundaries are redefined.[60] All of these feelings are normal, and caseworkers can help caregivers work through their reactions by providing support and services and by linking them to support in their community.

Planning and delivering services and supports for relative caregivers should be guided by family-centered practice, cultural competence and sensitivity to the complex issues of the relative caregiver. Services and supports should strengthen the relative caregiver's capacity to provide a safe, nurturing home for the child and to help achieve permanency for the child. Additionally, supports and services should assist the relative caregiver in addressing the effects that maltreatment and trauma may have had on the child in their care. Relatives should be educated on trauma, its potential emotional, relational and behavioral impact on children, and ways to help children heal. Support begins with fully informing the caregivers, assessing their strengths and needs and then working with them to identify resources, supports and training that can help them meet those needs.[61]

Policy Requirements:

PSM 711-1: Appropriate relative caregivers should be the first choice of placement whenever the child can be safely placed with them. When children must be removed from their home and placed in court-ordered out-of-home care, preference must be given to placement with a relative that meets all established requirements.

PSM 715-2: CPS must begin the relative search prior to transferring the case to foster care. The CPS worker must, at a minimum, ask the parents and age-appropriate children to identify the paternal and maternal relatives. Within 30 days of removal, diligent efforts must be made to identify and provide notice that a child is in foster care to all adult relatives.

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[59]Child Welfare Information Gateway (2012) *Working with Kinship Caregivers,* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

[60] Child Welfare League of America (2000) *CWLA Standards of Excellence for Kinship Care Services*, Washington, D.C.

Crumbley, J., & Little, R. L. (Eds.) (1997) Relatives Raising Children: An Overview of Kinship Care, Washington, D.C.: Child Welfare League of America.

[61] Child Welfare Information Gateway (2012) *Working with Kinship Caregivers,* Washington, D.C.: U.S. Department of Health and Human Services, Children's Bureau.

FOM 722-3: The relative search must begin as soon as the child is removed from the home. The CPS worker must, at minimum, ask the parents and age-appropriate children to identify paternal and maternal relatives. The foster care worker must continue to pursue the identification and notification of relatives if a child needs a replacement; the previously identified relatives must be considered as placement resources provided they meet the guidelines within the basic assessment process.

FOM 722-6: Throughout the case, the foster care worker must continue to seek, identify and notify relatives until legal permanency for the child is achieved.

Detailed Practice Guidance:

- Be prepared to work with the parents as well as with the relative caregivers to help mediate the relationship between them.
- Assist the relative caregiver in the licensing process.
- Assess and regularly reassess additional needs of the relative caregiver and provide or refer to services when needed.
- Ensure the relative caregiver understands the policy requirements of being a licensed foster home, particularly as it relates to discipline.
- Educate the relative caregiver on trauma and its' impact on children.
- Ensure that concurrent permanency planning for the child or children is also part of the case plan.
- Involve many family members in the case planning process; this may result in extra support for the caregiver and the children and ultimately a permanent commitment from the family.
- Provide the relative caregiver with information about the children's specific medical, educational, emotional, sexual orientation, and relational needs.
- Encourage the relative caregiver to attend trainings that address the needs of children that have experienced trauma.
- Address cultural, ethnic and religious orientations, as appropriate.
- Ensure that the parents and relative caregiver know and understand their expectations as identified in the case plan.
- Recognize that the relative caregiver may have different issues and concerns than the non-related caregiver.
- In domestic violence cases, include the relative caregiver in safety planning, including planning around their own safety.

17. Practice Guide for Supervisors: Placement Planning

Practice Guide for Supervisors	
Placement Planning	
MITEAM COMPETENCY	The placement planning process is a methodology to ensure that children are placed in the most appropriate, least restrictive living arrangement consistent with their needs. This placement would ideally enable the child to maintain connections to family and friends and receive assistance with any special needs and stay in the same school. This process is critical to ensuring that family connections are maintained through appropriate visits when the child, his or her siblings and/or parents are temporarily living away from one another, unless compelling reasons exist for keeping them apart.
FIDELTY MEASURES	**Observation:** • Prepares family team members (informal or formal) for participation on the team. • Facilitates Teaming. • Asks the individual(s) how s/he can be of assistance to the family. • Inquires about individual(s)'s perspective on the child(ren)/youth's safety (both physical and psychological). • Inquires about individual(s)'s perspective on the child(ren)/youth's well-being (both physical and psychological). • Asks individual(s) about their perspective on the parent's ability to keep the child(ren)/youth safe. • If child(ren)/youth is not residing with custodial parent: Asks individual(s) their perspective on the caregiver's ability to keep the child(ren)/youth safe. • If child(ren)/youth is not residing with custodial parent: Inquires about the caregiver's perspective on the impact of traumatic events on the child. • Requests individual(s) input regarding living arrangement options for the child(ren)/youth. • Inquires about individual(s)'s perspective regarding how the living arrangement options impact child(ren)/youth connections. • Inquires about the individual(s)'s perspective on the safety of all family/household members (both physical and psychological). **Documentation:** • A team that provides support to the child(ren)/youth and family has been formed. • The worker prepares the family team members (informal or formal) for participation on the team. • Documentation indicates the worker maintained contact with the family and support person(s) between in-person meetings. • The parent's ability to keep the child(ren)/youth safe was documented. • The impact of trauma and resiliency on parent's ability to keep child(ren)/youth safe was documented. • There is evidence in the documentation that the child's living arrangement has been fully assessed and determined safe. • There is evidence in the documentation that the child(ren)/youth current living arrangement supports the permanency plan. • There is evidence in the documentation that the worker noted 2 or more of the following: the condition of the home, attitude of the family members, behaviors of family members, or relationship patterns between family members. **Interview:** • The individual(s) was able to identify helpful activities of the worker. • The individual(s) described specific examples where his/her input was utilized in decision making. • The individual(s) reports the worker addressed the potential impact of trauma to the child. **In Supervision:**

	• The worker was able to identify: ○ What is most important to the individual/family. ○ How trauma is addressed in the case plan. ○ How the parent participates in the process of change. ○ If the current living arrangement meets the well-being needs of the child(ren)/youth. ○ How the current living arrangement is helping build resiliency. ○ How the child's current living arrangement ensures the child's physical and psychological safety. ○ How he/she educates the family about the importance of teaming. ○ How committed the family's team is to support the family's plan.
POLICY REQUIREMENTS	• Maintain children in their own homes whenever safely possible. • Give preference to placement with a relative, if all requirements are fulfilled, when children must be removed from their home. • Place children in the most family-like setting and keep siblings together whenever possible. • Preserve and encourage permanent connections with siblings and caring and supportive adults. • Choose a placement that helps facilitate and support a return home if the plan is reunification. • Consider a placement with a view toward preparing the child for permanency.

KEY CASEWORKER ACTIVITIES	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE TECHNIQUES
KCA 21 PLACEMENT PLANNING ***Assess whether potential relative or kin caregivers are willing and able to safely care for children and youth.***	Throughout the life of the case.	• Develop and implement tools to support caseworker assessment of potential relative/kin caregivers to safely meet the needs of children/youth and to support identified permanency goals. • Review placement decisions and their supporting logic and facts with caseworkers and provide feedback on improving placement choices moving forward. • Observe and provide feedback to caseworkers on how they engage and communicate with relatives and kin regarding their ability and willingness to care for their relative's children. • Engage MDHHS leadership on the barriers relatives/kin are confronted with (i.e. unemployment, criminal histories of adults in the home, needed home repairs or furnishings) when willing to care for and support their family members involved with child welfare and participate in developing solutions.
KCA 22 PLACEMENT PLANNING ***Work closely with members of the family team to make initial placement decisions, support those placements and plan for transitions.***	Throughout the life of the case.	• Review case documentation and provide feedback on steps taken by caseworkers to support placements once made to ensure stability and achievement of permanency goals. • Educate, model and coach caseworkers to have frequent, targeted communication with team members regarding decisions to be made, their implications and status and ways they can be active and positive in the placement process. • Monitor placement transitions for all children on assigned caseloads. During supervisory meetings discuss caseworker status with the plan and if the plan is working, and discuss strategies to further promote positive placement transition.

KCA 23 PLACEMENT PLANNING ***Use assessment information to match children and youth to the most suitable placements.***	Throughout the life of the case.	• Educate, model and coach caseworkers on key variables to consider for matching children to placements that will best meet their needs and support permanency. Encourage them to use assessment information to support their decision. • Encourage caseworkers to actively listen to parents and children and their wishes and concerns regarding placement options and transitions.
KCA 24 PLACEMENT PLANNING ***Use visits to preserve connections, strengthen relationships and make progress on identified goals.***	Throughout the life of the case.	• Educate, model and coach caseworkers to prioritize and conduct quality visits (child-parents; sibling; caseworker-caretaker; caseworker-parents; caseworker-child) as a critical strategy for maintaining placement stability and productive relationships and as a means to support achievement of case and permanency goals. • Observe and provide feedback to caseworkers on technique and content of their visits to support the maintenance of relationships and achievement of goals.
KCA 25 PLACEMENT ***Facilitate parent involvement with their children.***	Throughout the life of the case.	• Periodically discuss with a sample of parents the extent and type of involvement they have with their children on a daily basis and what additional involvement they would like to have and how it would support their success. During supervision, discuss these findings with caseworkers and their potential for implementation. • Educate, model and coach caseworkers to identify, structure and facilitate opportunities for parents to interact with and be actively involved daily in decisions affecting their children, when safe. • Monitor the distance from placement to their parents and discuss with caseworkers how they plan on supporting parent involvement.
KCA 26 PLACEMENT PLANNING ***Help children stay connected to their siblings.***	Throughout the life of the case.	• Review sibling visitation plans with caseworkers, ensuring appropriateness and feasibility. • Monitor sibling visitation to ensure that it is consistently occurring as planned and discuss with caseworkers strategies to improve visitation plan compliance and quality.

18. Additional Resources to Support Effective Assessment (includes Case Planning, Case Plan Implementation and Placement Planning)

A comprehensive family assessment is an ongoing and continuous process of information gathering, analysis and collaborative decision-making that includes families, children, caregivers and professionals as partners. The assessment process is both dynamic and multi-faceted and includes a compilation of additional screenings and evaluations used to design plans and provide children and families with services that focus on safety, permanency and well-being. Throughout the life of the case, assessment is the critical element that drives case planning and service provision with the children and families involved with the child welfare system. The resources listed below provide further information regarding the various types of assessments in child welfare, the relationship between assessment and case planning/service delivery, and emerging best practices and lessons learned in working with families.

a. Assessing Safety and Risk

http://www.ocwtp.net/PDFs/CAPMIS/D.%20Protective%20Capacities%20Reading.pdf. ***Critical Thinking in Assessing Protective Capacities in Child Welfare.*** This website of the Ohio Child Welfare Training Program provides access to numerous training materials in the areas of safety and risk assessment throughout the life of the case and at critical junctures in case planning and case implementation. The excerpt referenced above is from one training curriculum. This website offers practical tools and sample questions to guide the caseworker in gathering and synthesizing critical information necessary to determining appropriate interventions to assure child safety.

http://www.nccdglobal.org/assessment/structured-decision-making-sdm-model. The website for the National Council on Crime and Delinquency provides extensive information regarding its blueprint model for structured decision-making in child welfare. There are numerous publications and studies referenced and one recent article, SDM-News, Issue 27, July 2012, that highlights recent insights and emerging trends in practice regarding a move to incorporate structured decision-making (SDM) into ongoing family assessment and case planning.

http://www.mfia.state.mi.us/OLMWEB/EX/PS/Public/PSM/713-11.pdf. ***Children's Protective Service Manual, PSM-713-11. Michigan MDHHS Policy Manual, Risk Assessment, PSM 713-11.pdf.*** The Michigan Department of Health and Human Services' Policy Manual outlines the requirements and procedures along with forms and instructions regarding the completion of a risk assessment and the factors to be considered along with the criteria for rating and scoring.

www.michigan.gov/mMDHHS/0,4562,7-124-7119-15399-,00.html. Michigan MDHHS Children's Protective Policy Manual. This link provides the general instructions and outline for the Structured Decision-Making Assessment Process (SDM) that is required for all child abuse and neglect investigations.

http://action4cp.org/resources/archives/. *February, 2011. Q&A about Safety Intervention.* This publication highlights the specific issues, factors, and criteria to be considered when assessing risks of child maltreatment and appropriate safety interventions in child protection.

www.childwelfare.gov/topics/systemwide/domviolence/assessment/family/. This link to the Child Welfare Information Gateway highlights the information that serves to inform the caseworker in the assessment of domestic violence and provides a series of questions for interviewing children to obtain information regarding safety and risk.

www.childwelfare.gov/systemwide/assessment/overview/terms.cfm. This site provides a common set of terms and definitions that are frequently connected to the assessment process pertaining to child welfare intervention.

https://www.childwelfare.gov/pubPDFs/cps.pdf. This chapter describes the purposes of the initial assessment or investigation - to gather and analyze information in response to CPS reports, to interpret the agency's role to the children and families, and to determine which families will benefit from further agency intervention.

http://action4cp.org/documents/2011/pdf/February_Q_and_A_about_Safety_Intervention_edited.pdf. This site provides numerous articles regarding critical issues and priorities for child protection. This links to an article that discusses the differences between present danger and foreseeable danger in child welfare practice, and the difficulties in assessing foreseeable danger.

Hawkins, R. P. (1979). "The functions of assessment: Implications for selection and development of devices for assessing repertoires in clinical, educational, and other settings." ***Journal of Applied Behavior Analysis****, 12*, 501-516.

Drake, B. (2000). "How do I decide whether to substantiate a report?" In H. Dubowitz & D. DePanfilis (Eds.), ***Handbook for child protection practice*** (pp. 113-117). Thousand Oaks, CA: Sage.

DePanfilis, D. (1997). "Is the child safe? How do we respond to safety concerns?" In T. Morton & W. Holder (Eds.), ***Decision-making in Children's Protective Services: Advancing the state of the art*** (pp. 121-142). Atlanta, Georgia: Child Welfare Institute and Denver, Colorado: ACTION for Child Protection.

www.ocwtp.net/PDFs/CAPMIS/D.%20Protective%20Capacities%20Reading.pdf (Critical Thinking in Assessing Protective Capacities, Developed by IHS for the Ohio Child Welfare Training Program, June 2011, Section II: Applying the Seven Steps of Critical Thinking)

b. Comprehensive Family Assessment

Cohen, Elena. Hornsby, Donna T. Priester, Steven. "Assessment of Children, Youth, and Families in the Child Welfare System." Section I in Child Welfare for the Twenty-First Century- A Handbook for Practices, Policies, and Programs by Gerald P. Mallon and Peg McCartt Hess, September, 2005. This chapter discusses the critical importance of the comprehensive family-centered assessment process in child welfare practice as a result of the Adoption and Safe Families Act and the Child and Family Services Reviews. The authors illustrate how the assessment is developed, revised and updated throughout the life of a case at significant junctures in case planning.

http://www.acf.hhs.gov/programs/cb/resource/cfa-guidelines-for-cw. ***National Resource Center for Family-Centered Practice and Permanency Planning (2005) (PDF - 301 KB)*** This link provides information regarding a publication regarding the components of comprehensive family assessment, its relationship to service planning and service provision, and how child welfare agencies can support their use. There is also a link to a set of guidelines for comprehensive family assessments and this can be downloaded to be reviewed in its entirety.

www.childwelfare.gov/systemwide/assessment/family_assess. Comprehensive Family Assessment. Child Welfare Information Gateway, provided by the Children's Bureau, U.S. Department of Health and Human Services. This summary of key components of a comprehensive family assessment highlights important considerations regarding culture but also emphasizes an approach to assessment based on family-centered principles and in the context of strengths and needs.

www.michigan.gov/documents/FIA0145_17156_7.dot. FAMILY ASSESSMENT OF STRENGTHS AND NEEDS. This link provides the actual assessment form with the specific areas/domains to be assessed and the fields to be completed.

http://cascw.umn.edu/wp-content/uploads/2013/12/CW360-Ambit_Winter2013.pdf. ***Trauma-Informed Child Welfare CW 360, Winter 21013. The University of Minnesota, Center for Advanced Studies in Child Welfare.*** This link provides access to this publication which provides a comprehensive framework for best practices in establishing a trauma-informed child welfare system. The framework underscores the importance of assessing and identifying trauma and its impact on children and their families and developing thoughtful and informed plans to deliver appropriate services to address these complex issues.

https://view.officeapps.live.com/op/view.aspx?src=http%3A%2F%2Fwww.wmich.edu%2Fsites%2Fdefault%2Ffiles%2Fattachments%2Fu438%2F2014%2FTrauma%2520screening%2520checklist%25200-5%2520final.docx. Southwest Michigan Children's Trauma Assessment Center. This link provides a checklist for a trauma assessment form with questions/items for identifying signs and symptoms of trauma in children across the spectrum of age and developmental stages.

***Comprehensive Family Assessment Guidelines for Child Welfare*,** Foundation Document Prepared by Patricia Schene, Ph.D. National Child Welfare Resource Center for Family-Centered Practice, a service of the Children's Bureau. Current Version available through National Resource Center for Family-Centered Practice and Permanency Planning, a service of the Children's Bureau, May 24, 2005.

http://www.vitalsmarts.nl/wp-content/uploads/Crucial-Accountability-Conversation-Planner.pdf. The Accountability Conversation Planner lists the six sources of influence on pages 3 and 4 of the planner and provides a series of questions to consider when exploring what may be impacting the parent's behavior.

www.childwelfare.gov/pubs/usermanuals/cps/index.cfm. The Child Information Gateway's website shares the article "Child Protective Services: A Guide for Caseworkers". In Chapter Three: The Helping Relationship the article discusses techniques for building rapport, engaging the resistant client, techniques for handling hostile and angry situations, and reviews the stages of change.

***www.michiganchildwelfaretraining.com/LinkClick.aspx?fileticket=gm0XLPOGS1Y%3d&tabid=125.** One way to help families envision their preferred futures is to utilize the 21 Not Knowing Skills. Families are the experts of their own lives. The purpose of using the Skills for Not Knowing is to allow families to recognize, identify and address their problems, strengths and solutions. The best way to help a family is to allow them to help themselves.
De Jong, Peter and Kim Berg, Insoo, ***Interviewing for Solutions.*** California: Thompson Brooks, 2008.

www.ocwtp.net/PDFs/CAPMIS/D.%20Protective%20Capacities%20Reading.pdf. (Critical Thinking in Assessing Protective Capacities, Developed by IHS for the Ohio Child Welfare Training Program, June 2011, Section II: Applying the Seven Steps of Critical Thinking).

http://action4cp.org/documents/2010/pdf/Sep_The_Protective_Capacity_Progress_Assessment_Indicators_of_Change.pdf. **(**pages 3-7) Provides behavioral indicators associated with an individual's readiness to change, which enables one to measure progress in goal achievement.

https://michigandhs.training.essentiallearning.com. A link to the State of Michigan Essential Learning Courses on Motivational Interviewing and Advanced Motivational Interviewing. The initial course teaches about the motivational interviewing approach to helping people change and see the crucial importance of matching interventions to individuals' stages of change in order to improve the likelihood of success. In addition to examining the principles of Michigan, you will learn specific skills and techniques that will support the primary goals of Michigan, which include establishing rapport, eliciting change talk, and establishing commitment language.

c. Case Planning

www.childwelfare.gov/systemwide/laws_policies/statutes/caseplanning.cfm*.** ***Child Welfare Information Gateway. (2011). Case planning for families involved with child welfare agencies. Washington, D.C.: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. This link provides the legal requirements set out by the Adoption Assistance and Child Welfare Act (PL 96-272) along with other federal mandates.

***www.childwelfare.gov/permanency/overview/concurrent.cfm*. Concurrent Planning, 2000 to present. Child Welfare Information Gateway, Washington, D. C. U.S. Department of Health and Human Services, Administration for Children and Families**. This link provides an overview of concurrent planning as an approach to achieving permanency for children and includes additional information regarding issue briefs and articles pertaining to competencies and comparative studies that evaluate practices and outcomes based on this approach to case planning.

****https://michigandhs.training.essentiallearning.com/lib/Authenticate.aspx?ReturnUrl=%2f*** . This is a link to the State of Michigan Essential Learning Courses on Motivational Interviewing and Advanced Motivational Interviewing. The initial course teaches about the motivational interviewing approach to helping people change and see the crucial importance of matching interventions to individuals' stages of change in order to improve the likelihood of success. In addition to examining the principles of Michigan, there are also specific skills and techniques that support the primary goals of Michigan, which include establishing rapport, eliciting change talk, and establishing commitment language.

Additional resources for Parenting Time Planning:
Hyde, J. & Kammerer, N. (2009). Adolescents' perspectives on placement moves and congregate settings: Complex and cumulative instabilities in out-of-home care. Children and Youth Services Review, 31: 265-273.

CW 360: a comprehensive look at a prevalent child welfare issue:
http://cascw.umn.edu/wp-content/uploads/2013/12/CW360_Sp2009_FINAL.pdf.
Resource for developing age-specific activities for children and parents during visitation

https://books.google.com/books?id=63wSBQAAQBAJ&pg=PA6&lpg=PA6&dq=Adapted+from+material+by+Vera+Fahlberg:+A+Child%E2%80%99s+Journey+Through+Placement&source=bl&ots=D57zoTndzc&sig=LBuL7fScvEivzSlFYR_zbbkC3IQ&hl=en&sa=X&ved=0ahUKEwi5qpCa-p_LAhUHkoMKHUQwBbkQ6AEIMjAD#v=onepage&q=Adapted%20from%20material%20by%20Vera%20Fahlberg%3A%20A%20Child%E2%80%99s%20Journey%20Through%20Placement&f=false.

Parent-Child visitation planning:
http://partnersforourchildren.org/sites/default/files/2011._family_visitation..... helping_children_cope_brief.pdf'.

Understanding and planning for a child's reaction to Parent-Child visits:
http://www.fosteringperspectives.org/fpv15n1/understanding.htm'

Supporting foster parents for Parent-Child visits:
http://www.fosteringperspectives.org/fpv15n1/10ways.htm10 Ways to support foster parents in visitation planning.

http://www.fosteringperspectives.org/fpv15n1/reflect.htm Foster Parent Perspectives.

Visitation coaching:
Visit Coaching Manual: Building on Family Strengths to Meet Children's Needs:
http://www.martybeyer.com/content/visit-coaching-manual.

Child and Family visitation: A Practice Guide to Support Lasting Reunification and Preserving Family Connections for Children in Foster Care:
http://www.ourkids.us/SiteCollectionDocuments/Handbooks/Visitation%20Minnesota's%20Guide.pdf.

Preparing parents, children and caregivers for visits. Conducting Parent-Child Visits:
http://cfrc.illinois.edu/pubs/rp_20010301_ConductingParentChildVisitsAPracticeGuide.pdf.

d. Case Plan Implementation

www.childwelfare.gov/pubs/usermanuals/cps/cpsh.cfm. Case Planning (2003). Child Welfare Information Gateway, Washington, D.C., U.S. Department of Health and Human Services, Administration for Children and Families. This link provides access to a guide including four chapters that pertain to the essential tasks and activities in the development and implementation of a case plan including its formulation, service provision, monitoring and evaluation, revision, closure, and documentation.

http://action4cp.org/documents/2010/pdf/Sep_The_Protective_Capacity_Progress_Assessment_Indicators_of_Change.pdf. The Protective Capacity Progress Assessment: Indicators of Change and Intention to Change © ACTION for Child Protection pages 3-7 walks caseworkers through indicators for readiness to change and how this relates to progress.

www2.grandfamilies/org/FOSTERINGCONNECTIONS/FosteringConnectionsResources.aspx*.** ***Judicial Guide to Fostering Connections, 2011. Helen Redlich Epstein. This publication was produced by the Grandfamilies State Law and Policy Resource Center, a collaboration between Casey Family Programs, the American Bar Association Center on Children and the Law, and

Generations United and co-sponsored by the National Council of Juvenile and Family Court Judges and the National Center for State Courts. From the perspective of the courts, the guide provides a very detailed outline of the legal requirements of the act along with its relevance for all aspects of the case flow processes in the court system as well as the key decision points. There is information about the critical benchmarks along with the legal thresholds to be met to comply with these and other federal and state statutes and regulations.

www.socialworkers.org. NASW Standards for Social Work Case Management, 2013. The website of the National Association of Social Workers provides a search feature to access the most recent standards issued regarding social work case management. Standards 5 and 6 relate to assessment and service planning, implementation, and monitoring and set forth values, principles and guidelines for competent and ethical social work practices.

www.dshs.wa.gov/pdf/ca/PermPlanGuide.pdf. This link to Washington State's Department of Social and Health Services provides a detailed guide to case plan implementation with a focus on permanency planning for children in out-of-home care. Included in this very thorough guide are legal requirements, practice principles and specific steps and activities to be carried out as part of case plan implementation.

e. Placement Planning

www.hunter.cuny.edu/socwork/nrcfcpp/info_services/placement-stability.html. This site offers links to several articles regarding statistical data and also emerging best practices for addressing specific issues, timeframes, child populations and service provision.

www.fostercares.org. This site provides guidelines with a step-by-step outline for an approach to thoughtful preparation to placements and the anticipated issues that may arise during placement and strategies for addressing these to preserve placement stability.

http://advokids.org/childhood-mental-health/transitions/. This site provides comprehensive and detailed information regarding the emotional, behavioral and psychological issues to be addressed in the placement changes and transitions of children from one setting to another throughout the life of the case. The link provides numerous articles and resources regarding specific topics, such as loss and grief and preserving family connections.

https://www.youtube.com/watch?v=E1fjH4V7xX0. This video entitled, "Multiple Transitions", written and produced by Michael Trout, director of the Infant-Parents Institute in Champaign, Illinois, was published on September 11, 2013. Through the perspective of a child and spoken in his or her voice, the video shares the emotional impact of having experienced multiple moves within the foster care system along with the negative and often traumatic consequences.

****http://courts.michigan.gov/scao/resources/standards/APP.pdf.*** This document is the Michigan State Court Administrative Office protocol on the importance of identifying fathers,

paternity testing, diligent search, and court procedures involving the absent parent. The Absent Parent Protocol publication is available on the MDHHS website under Foster Care Forms and Publications Refer to this document for additional information on identifying, locating, and notifying absent parents in child protective proceedings

https://www.childwelfare.gov/topics/outofhome/. This site offers a list of factors to consider when trying to find an out-of-home placement for a child. The focus is primarily on adoptive matches, but would work for temporary foster home placement.

www.adoptuskids.org/_assets/files/NRCRRFAP/resources/finding-a-fit-that-will-last-a-lifetime.pdf. This guide gives best practices to matching children to adoptive placements. It delineates the many steps involved in the matching process to achieve permanency.

http://faculty.buffalostate.edu/hennesda/matching/temperament%20matching%20-%20doelling.pdf. This study looks at the temperament and characteristics of both the child and the foster parent to determine if there is a good match in a placement.

www.state.il.us/DCFS/docs/CFS2017.pdf. This is the state of Illinois' checklist for finding the right match for a child with a foster family. It identifies the behaviors, needs, and characteristics of the child and the proposed caregiver's capacities to meet the child's needs

http://www.aecf.org/resources/icebreaker-meetings/ This web site describes the importance of an icebreaker session between the parent and foster parent, the role of each person in the process, and things to keep in mind to have a productive meeting.

****http://info.MDHHS.state.nc.us/olm/manuals/dss/csm-10/man/.*** The online policy manuals from the North Carolina Department of Health and Human Services provides detailed information regarding the procedures, practices and plans to be carried out in the placement of children to achieve desired goals and outcomes. The procedural requirements and practice guidelines give careful focus and attention to the importance of family engagement, participation in case planning and decision-making by the child and family along with key stakeholders, and promotes a collaborative approach to support placement stability and the achievement of case plan goals and outcomes.

www.childwelfare.gov/pubs/siblingissues/siblingissues.pdf. ***Sibling Issues in Foster Care and Adoption*** This article focuses on the importance of sibling connections to child well-being and provides additional resources to guide placement decisions based on research in this area. Child Welfare Information Gateway. (2013). Washington, D.C.: U.S. Department of Health and Human Services, Children's Bureau.

www.hunter.cuny.edu/socwork/nrcfcpp/info_services/siblings.html. This link provides numerous articles with a focus on addressing the needs of siblings in placement throughout case planning and service intervention.

www.youtube.com/watch?v=E9uoqOWHosq. This video produced by Epic Ohana, Inc., provides a compelling view of placing siblings together from the perspective of the youth being served by the child welfare system.

D. Competency Four: Mentoring

1. Overview of Mentoring

Mentoring is a developmental partnership in which one person shares knowledge, skills, information and perspective to foster and empower the personal and professional growth of another person. This may mean, for example, a caseworker mentoring a parent or a supervisor mentoring a caseworker. Teaming and mentoring must work together to create the kind of opportunity for collaboration, goal achievement and problem solving on multiple levels within the system. Mentoring is the ability to empower others. It is vital to demonstrate and reinforce desired skills to promote positive outcomes and growth for children, families and professionals.

This mentoring section provides general practice guidance regarding the KCAs, detailed practice guidance for caseworkers and supervisors, a summary of key requirements, summary of relevant policy and additional resources that support the implementation of effective practice with children and families.

2. Practice through a Trauma Lens: Focus on Mentoring

Utilization of a trauma-informed approach to mentoring with children, families, and other individuals will assist in the application of the KCAs and improve overall practice. The essential elements below were identified as critical to effective mentoring. The explanations of each Essential Element were taken directly from "Guidelines for Applying a Trauma Lens to a Child Welfare Practice Model" (Chadwick Trauma-Informed Systems Project [CTISP], 2013):

Essential Element: Enhance the Well-Being and Resilience of Those Working in the System.

Working within the child welfare system can be a dangerous business and professionals in the workforce may be confronted with threats or violence in their daily work. Adding to these stressors, many workers experience *secondary traumatic stress reactions*, which are physical and emotional stress responses to working with a highly traumatized population. When working with children who have experienced maltreatment, parents who have acted in abusive or neglectful ways, and systems that do not always meet the needs of families, feelings of helplessness, anger, and fear are common. A trauma-informed system must acknowledge the impact of primary and secondary trauma on the workforce and develop organizational strategies to enhance resilience in the individual members of it (CTISP, 2013).

Essential Element: Partner with Youth and Family

Youth and family members who have experienced traumatic events often feel like powerless pawns in the system, reinforcing feelings of powerlessness felt at the time of the trauma. Treating youth and families as partners by providing them with choices and a voice in their care plays a pivotal role in helping them to reclaim the power that was taken away from them during the trauma and tap into their own resilience. Youth and family members who have been involved in the child welfare system have a unique perspective and can also serve as partners by providing valuable feedback on how the system can better address trauma among children and families. These partnerships should occur at all levels of the organization, as youth and families can help shape trauma-informed practices and policies (CTISP, 2013).

Essential Element: Partner with Agencies and Systems that Interact with Children and Families.

No one agency can function alone, and in a trauma-informed system, child welfare must reach out and coordinate with other systems so they too can view and work with the child and family through a trauma lens. This partnering includes:

- Teaming with law enforcement to minimize the number of front-end interviews a child must experience.
- Working with mental health agencies to ensure therapists are trained in specialized trauma assessment and evidence-based or evidence-informed trauma treatments
- Coordination with schools, the courts, and attorneys.

Such coordination is necessary to prevent one part of the system undoing the good trauma-informed work of another part of the system (CTISP, 2013).

The following Trauma-informed Practice Strategies (TIPS) were identified as critical effectively operationalize mentoring skills through a trauma-informed lens:

Educate about Trauma.

- Proactively Transfer trauma knowledge through ongoing conversations that build understanding from the first interaction to the last. May include discussion around:
  - What is trauma?
  - What can be traumatic to a child or adult?
  - How does trauma change the brain?
  - How does trauma impact people differently?
  - What is the impact and symptoms of trauma?
  - What is resiliency?
  - How does resiliency work to treat trauma?
  - How can resiliency be built?
  - How can resiliency impact long-term view?

3. Practice Guide for Caseworkers: Mentoring

Practice Guide for Caseworkers	
Mentoring	
MITEAM COMPETENCY	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 another person. This may mean, for example, a caseworker mentoring a parent, a supervisor mentoring a caseworker or a peer coach mentoring a supervisor. Teaming and mentoring must work hand in hand to create the kind of opportunity for collaboration, goal achievement and problem solving on multiple levels within the system. Mentoring is the ability to empower others. It is vital to demonstrate and reinforce desired skills to promote positive outcomes and growth for children, families and professionals.

FIDELITY MEASURES	**Observation:**
	• Treats individual(s) with respect.
	• Treats individual(s) with empathy.
	• Uses verbal responses that are consistent with body language.
	• Acknowledges his/her authority and the disproportionate amount of power in the relationship.
	• Addresses reasons for reluctance to including specific team members.
	• Evaluates strengths.
	• Evaluates needs.
	• Asks the individual(s) about events experienced by primary/key family members that are potentially traumatic.
	• Request(s) individual(s) input regarding the effectiveness of services.
	• Asks the individual(s) how s/he can be of assistance to the family.
	• Assists the family with navigating agency systems and processes.
	• Discusses with the family the success of the child(ren)/youth beyond case closure.
	• Provides trauma education to the individual(s).
	• Provides feedback to the individual(s).
	• Asks for feedback from the individual(s).
	Interview:
	• The individual(s) feels understood by the worker.
	• The individual(s) feels respected by the worker.
	• The individual(s) reports the worker acknowledged the unique culture of the family/household.
	• The individual(s) reports the worker provided education on how early traumatic experiences may impact parenting.
	• The individual(s) reports the worker addressed potential impact of trauma to the child.
	• The individual(s) reports the worker provided education on child safety.
	In Supervision:
	• The worker participated in monthly supervision meeting(s) with the supervisor.
	• The worker was able to identify:
	  ○ How they managed their frame of reference.
	  ○ How he/she educated parents on the potential impact of trauma.
	  ○ How he/she educated team members on the potential impact of trauma.
	  ○ How the parent participates in the process of change.
	  ○ What progress has been made so the family's team is taking ownership of the case planning process and fully participating in the shared decision-making.
	  ○ How s/he educates the family about the importance of teaming.
	  ○ How committed the family's team is to the family's plan.
	• The worker identifies own team members that support their professional development.
	• The worker exchanges feedback with the supervisor.

POLICY REQUIREMENTS	• Be knowledgeable and seek information so that you can share information with families. • Develop and enhance communication skills to deliver messages that are tailored to meet individual family's needs. • Provide effective feedback and hold others accountable. • Utilize strength-based and solution-focused communication. • Demonstrate honesty, genuineness and integrity.
HOW TO USE YOUR SUPERVISOR	Schedule, prepare and actively participate in regular case conferences with your supervisor to discuss: • Ways to mentor families to enhance their strengths and meet needs. • Specific barriers and/or resistance on the part of families to engage in a mentoring relationship and strategies to overcome obstacles to the mentoring process.

KEY CASEWORKER ACTIVITIES	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE TECHNIQUES

KCA 27 MENTORING
 	
Promote growth through coaching.
	From the initial contact to permanency or case closure.	• Engage parents in purposeful conversation regarding the dynamics of maltreatment within the family and what strategies and resources are needed to permanently change dynamics to address past trauma and ensure child safety and well-being. Coach to ensure families have needed information and are prepared to care for their own children. See DPG_coaching_ensure_families_info.
		• Coach the child's parents and caregivers on child behavior management methods utilizing a trauma-informed, brain-based approach to understand child development and behaviors. Questions may include:
		  ○ What do you do when a child brings home a poor grade?
		  ○ How do you manage homework time?
		  ○ What do you do when children are fighting with each other?
		  ○ What possible interventions can you use to eliminate disrespectful behavior with positive behavior reinforcement?
		• Discuss with parents how aggression is often a self-protective mechanism based on a fight response that was potentially triggered by past trauma.
		• Ask the parents to tell you what areas of child behavior management they would like you to coach them on.
		• Observe parents and current caregivers in their efforts to correct the behavior of their children and provide feedback on how to improve results.
		• Provide the parent and child's current caregivers with information needed to navigate the child welfare system.
		• Model to help improve skills of parents and current caregivers. See DPG_modeling_to_improve_skills.
		• Model appropriate, respectful ways to communicate with children, parents and current caregivers.
		• Demonstrate effective ways to discipline and re-direct children when their behavior warrants.
		• Validate specific strengths related to day-to-day caretaking, keeping routines, and providing nurturance and support.
		• Reinforce positive changes in behavior and attitude.
		• Demonstrate ways to read to and play with children. Encourage parents and caregivers to join/assist you.
		• Model infant feeding and soothing methods.
		• Discuss with the parents and caregivers how trauma can compromise normal child development leading to possible learning, emotional and behavioral problems. Help them understand this is a possible result of complex trauma and not willful on the part of the child.
		• Discuss with the parent and caregivers how they talk to their teenager about choices and consequences. What are some of their behavior management

		strategies that can be utilized for breaking curfews, skipping school, talking back or not following rules?
KCA 28 MENTORING ***Create a learning environment through observation and feedback.***	Initial contact to case closure.	• Provide and receive feedback. See DPG_providing_receiving_feedback. • Observe parental behavior that the family has identified as needing improvement and provide specific, concrete, useful, and timely feedback on performance and advice on how to improve. • Provide written and verbal feedback to parents in real time to support immediate learning and change. • Discuss with the parent their plans for incorporating feedback/advice into their daily lives/behaviors and how they see it supporting their family's goals.
KCA 29 MENTORING ***Support change through building honest and genuine relationships.***	From the initial contact to permanency or case closure.	• Build genuine and honest relationships with parents and children to empower and guide (see DPG_build_honest_genuine_relationships). • Communicate empathy. Acknowledge the feelings and experiences of children, parents and caregivers as natural and human. • Interact in a non-judgmental manner. • Be self-aware and regulate own emotions. • Be genuine. • Engage the child, parent and caregivers with enthusiasm. • Be aware of and respond to the verbal and non-verbal communication of children, parents and caregivers. • Follow through. Do what you say you are going to do. If you schedule a visit, honor that visitation time. If you promised transportation, be there to transport. If you advised the family you would check on possible resources, make sure you follow up with the child, parents and caregivers. • Recognize the expertise of the family. Demonstrate a belief that parents have the deepest insights into what works and what doesn't and the department strives to learn from their experiences. • Show confidence and trust that the children and parents have the capacity to change.

4. Detailed Practice Guidance

a. Coach to ensure families have needed information and are prepared to care for their own children.

Background:

Caseworkers must educate and share information with children, parents, and caregivers to prepare them to be the leaders in their change. In order to be an effective coach, the caseworker must attempt to understand the dynamics and culture of each family. The caseworkers must also be able to provide the child, parent and caregivers with effective feedback and follow up to guide the family to reach its identified goals.

Caseworkers must enter the world of the children and parents they serve by being observant, listening and asking questions to gain further insight. Caseworkers must tailor their message to each family member. The current behaviors of the child and his or her parents are an attempt to meet an underlying need. Understanding this need and that guiding the family to find alternative ways to meet that need will be critical when coaching families to make change. The questions that the caseworker asks the child and parents are vital as they may reinforce the worst of external conditions and internal experiences, or they may guide children and parents to recognize their potential.[62] Caseworkers must work to enhance their interview skills as the questions themselves can guide children and families and set the stage for significant change.

The overall child welfare system and court processes can be extremely confusing and overwhelming. Families are the experts on their own family and deserve to be given the opportunity to lead their own change and growth. It is the caseworker's responsibility to coach families and caregivers in navigating these systems by sharing relevant information and perspectives (see MDHHS publications). Once children, parents and caregivers are provided with information, they have the potential to make informed decisions about their future.

The caseworker can also use education as a way to coach children, parents and caregivers on specific knowledge and skills that will help them reach their goals. Parenting skills, the impact of trauma, effective communication techniques, organization, time management and other behavioral-specific tasks can be discussed and considered in planning. Caseworkers can educate children, parents and caregivers about different techniques they can use to meet their identified goals.

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[62]Strengths-Based Social Work Assessment: Transforming the Dominant Paradigm in Families in Society: The Journal of Contemporary Human Services, Copyright 2001 Families International, Inc.

Follow-up is also an essential component to coaching. Sometimes the family's plan of action is negatively impacting its desired outcome. Open and honest communication is essential in the coaching. The coach must be willing to share all of the information with the family and provide feedback even when the content of the message is difficult for the family to hear. The caseworker must be supportive and work to establish a safe environment[63] for the family in order to be an effective coach. It is imperative that the caseworker remains flexible and advocates for a change in action if the specific techniques are not meeting the family's needs.

Detailed Practice Guidance:

- Provide the child (when age-appropriate), parents and caregivers with publications to inform them on the child welfare system and processes. Explain this information. Take the time to answer any questions and respectfully offer reminders when helpful.
- Encourage the family team to take a lead role in assessment, teaming, placement planning, case planning and service implementation by sharing with them the benefits of leading their change, showing confidence in their abilities and exploring sources of influence[64] that may be preventing them from changing.
- Educate yourself about the resources in your community and share this information with the child, family and caregivers to support them in achieving their goals.
- When you don't know the answer to a question, be honest, find the answer and follow up with the child, parent or caregiver.
- Be creative and look for ways to guide the child, parent or caregiver based on their individual strengths and needs, including their own potential trauma history.
- Be positive.
- Be specific.
- Meet the child, parents and caregivers where they are. Utilize the Stages of Change to evaluate where individuals are and then tailor your message to meet their needs.
- Use the guiding principles as a guide and explain to the family team the reason and value behind decisions and recommendations.
- Expand your knowledge of policy. Instead of telling others that policy says to do something, understand why a policy exists and explain the rationale to all involved.
- Respectfully hold others accountable by utilizing the skills from Crucial Accountability.[65]
- Manage your own emotions and responses. Don't take the child's, parent's or caregiver's progress or lack of progress personally.

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[63]Patterson, K., Grenny J., McMillan, R., Switzer, A., Maxfield, D. *Crucial Accountability: Tools for Resolving Violated Expectations, Broken Commitments and Bad Behavior.* McGraw-Hill, 2013.

[64]Ibid.

[65] Ibid.

b. Model to help improve skills of family members.

Background:

> *"When a young person, even a gifted one, grows up without proximate living examples of what she may aspire to become–whether lawyer, scientist, artist, or leader in any realm–her goal remains abstract. Such models as they appear in books or on the news, however inspiring or revered, are ultimately too remote to be real, let alone influential. But a role model in the flesh provides more than inspiration; his or her very existence is confirmation of possibilities one may have every reason to doubt, saying, 'Yes, someone like me can do this."*
>
> *- Sonia Sotomayor*

Caseworkers are asking children and their parents to partner with them in driving change and growth to ensure child safety, permanence and well-being. Caseworkers cannot expect families to commit to this partnership without the caseworker demonstrating integrity, consistency and professionalism. Every interaction with a family is an opportunity to demonstrate these qualities.

Caseworkers who manifest integrity want to do a good job every day, give their best to the children and parents they serve, be proud of their work, find meaning in their work, continue to personally and professionally grow, recognize that they themselves can be triggered and emotionally react which can have a negative impact and make a difference. The worker shall exhibit professionalism that reflects the guiding principles of the department. Consistency is all about following through with commitments. If the follow through is not present, confidence in the relationship will be hindered. Parents who experience this are better able to focus on their children, be proud of them and protect and nurture them.

The lack of integrity, consistency and professionalism on the part of a caseworker can mean the difference between reunification and another less optimal outcome for a child.

Detailed Practice Guidance:

- Teach parents and children about the policies of MDHHS, the court process, roles of the CPS and foster care caseworkers, their rights as parents and ethical standards and other procedures and protocols that are important for them to understand.
- Mentor parents on how to build working relationships with formal and informal supporters and the skills needed to overcome barriers that have been identified.
- Model and help the parents build a team that provides the kind of support that may be needed during times of family instability.

- Be a cheerleader for the family by helping to build a supportive and positive atmosphere that is not only about making the physical location safe.

c. Provide and receive feedback.

Background:

> *When you have a tough message to share, or when you are so convinced of your own rightness that you may push too hard, remember to STATE your path.*
> ***S**hare your facts. Start with the least controversial, most persuasive elements.*
> ***T**ell your story. Explain what you're beginning to conclude. **A**sk for others' paths.*
> *Encourage others to share both their facts and their stories. **T**alk tentatively.*
> *State your story as a story; don't disguise it as a fact. **E**ncourage testing. Make it safe for others to express differing or even opposing views.*
>
> - *Crucial Conversations* (2012)

The purpose of feedback is to provide specific information about behaviors displayed. Feedback that is specific to what, how and why in regards to outcomes supports the foundation of creating a safe and genuine relationship. Providing timely feedback that speaks to the positive and developmental performance of the family allows for behavior support and/or adjustments. Finally, balanced feedback is important to acknowledge the strengths and areas for growth of the individuals.

Feedback is instrumental in helping families identify steps that they can take which are beneficial to them. Providing feedback produces an opportunity to introduce new knowledge and skills or understand how current skills may not have been productive in a particular situation. An effective feedback process will allow for the families to experience being asked questions that promote an opportunity for feedback and transition to the family eliciting feedback for self-reflection. *What could I have done differently? What did I miss? What barriers are there that you may not have seen?*

To communicate in this manner, you will specifically speak to the situation or task, action and result. This style of verbal communication allows for a natural and easy way to discuss accomplishments and areas of improvement. It becomes a learned behavior. The ultimate goal is to develop a relationship that helps families become stronger, where members make mistakes, are positively and productively instructed about what would have worked better, are given the opportunity to observe and are safely provided the chance to try it again with new knowledge and confidence.

Detailed Practice Guidance:

- Provide feedback to support and empower, not degrade or belittle.
- Provide feedback to enhance a person's self-esteem to inspire confidence and reinforce behaviors.
  - Focus on facts.
  - Respect and support others.
  - Clarify motives.
  - Acknowledge good thinking and ideas.
  - Recognize accomplishments.
  - Express and show confidence.
  - Be specific and sincere.

- Providing positive feedback strongly reinforces positive actions and results and helps to maintain the behavior. Providing opportunities for growth with the intent to facilitate discussion allows people to adjust and enhance their performance. Therefore, it is importance that feedback is **BALANCED**. Feedback that only focuses on what a person needs to do better or more of, but fails to acknowledge what's done well, may damage self-esteem. Remember that comments only about strong performance can be equally ineffective. They are missing opportunities to help people become more successful.[66]

  - **Specific**–clearly describes the behaviors observed.
  - **Concrete**–the feedback is tied to the purpose of the learning experience and to the relevant criteria for success.

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[66] Here are some ways to provide positive and opportunities for growth feedback using the Effective Feedback Process.

Types of Feedback
- Positive–recognize the performance to be maintained.
- Opportunities for Growth–recognize the performance to change/improve upon.

Criteria for Effective Feedback
- Be specific
- Be concrete
- Make message useful
- Be timely

Four Steps of the Effective Feedback Process
Step 1: Self-assessment–ask the person for his/her assessment of what they did well during their interaction.
Step 2: Other's assessment–ask what their perception of what the other person might say about their interaction.
Step 3: Mentor's assessment–provide feedback, as a mentor, about what you saw during their interaction.
Step 4: Repeat Steps 1 – 3 regarding opportunities for growth.

- **Useful**–the person receiving the feedback is able to use the message, that is, it describes behavior that the person can do something about. The person is not overwhelmed or confused by the messages.
- **Timely**–immediate feedback is most often preferred. An assessment of the emotional readiness to hear the feedback influences this criterion.

d. Build relationships with children and parents based on honesty and full-disclosure to empower and guide them through the change process.

Background:

Building an honest and genuine relationship with the child and parent is essential in creating a climate for change and growth. The caseworker's role is to empower and guide the child, parents and caregivers to utilize its available resources to change and grow.

Establishing relationships with children and parents who have a history of family or system-related trauma or who feel intense shame will prove to be challenging. Individuals who have experienced trauma have built significant defense mechanisms to protect themselves and survive very difficult circumstances. Caseworkers must recognize this and not react in ways that will trigger past traumas and/or take things personally. Self-awareness and emotional regulation will be essential for caseworkers to successfully connect with family members and maintain an atmosphere of honesty where individual members feel emotionally safe to connect with the caseworker in a way that is meaningful.

Change is a gradual process and caseworkers will need to consistently demonstrate that they are committed to working with the team through this process. Caseworkers must focus on consistently utilizing the core conditions for helping to communicate to the family that their intention is to help them ensure child safety, permanency and well-being. Questions we ask children, parents and caregivers are vital as they may reinforce the worst of external conditions and internal experiences, or they may guide" families to recognizing their potential.[67] Caseworkers must work to enhance their interview skills as the questions themselves can set the stage for significant change.

Detailed Practice Guidance:

Every interaction that the caseworker has with members of the family team should be purposeful. A caseworker's role is to create an emotionally safe environment and interact with families in ways that demonstrates a dedication to the child's well-being.

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[67] Strengths-Based Social Work Assessment: Transforming the Dominant Paradigm in Families in Society: The Journal of Contemporary Human Services, copyright 2001 Families International, Inc.

- Be physically and emotionally available. Respond to family's emotional distress. Answer phone calls.
- Build mutual purpose.[68]
- Show confidence and believe that the children and parents have the capacity to change.
  - Demonstrate a belief that parents have the most insight on what may or may not be happening within their own families.
  - Expand parenting time and add responsibilities and leeway to reflect progress.
  - Use behaviorally specific language when referring to children, parents and family members. Avoid labeling children, parents and family members. It is better, for example, to say that a parent has an issue with substance abuse than label that parent as a crack addict.
- Use empathy to help create an emotionally safe environment. Help children, parents and family members feel safe.
- *I understand that it's extremely important to you that Johnny continues to attend Attwood Elementary. Our goal is to help make this transition is as smooth as possible and to try and figure out a way to keep his daily routine as normal as possible. I have called the school to speak with the liaison about transportation. I also contacted your sister to see if she could help with driving him to school. Is there anything else that you can think of that we could do to try and help with transportation to Attwood?*
- Demonstrate respect and care about the goals of both the child and his or her parents.
- Disclose feelings and insights appropriately. Make sure your words, voice quality and body language are congruent with the message that you are delivering.
- Listen to and acknowledge what the child, parent, caregiver or family member says before responding.
- Check your voice tone, as we often increase our voice level when emotions are high.
- Pay attention. Body language says a lot about what you are feeling and what the child, parent, caregiver or family member is feeling.
- Offer the reason behind certain decisions or changes in approach. Act with integrity and explain that our guiding principles drive our recommendations and decisions.
  I hear you saying the previous worker lied to you about our recommendations to court. Unfortunately, I can't speak to that because I wasn't there. Our goal is to assist you in making sure your home is safe and that you can provide for your children's needs. My intention is to work together with you and the children's father to determine what will be best for your family.
- Hold mothers and fathers to equally high standards as parents.
- Provide support without removing responsibility.
  - Help others think and do. Ask open-ended questions that lead to an expansive view. Express genuine curiosity.

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[68] Patterson, K., Grenny J., McMillan, R., Switzer, A., Maxfield, D. *Crucial Accountability: Tools for Resolving Violated Expectations, Broken Commitments and Bad Behavior.* McGraw-Hill, 2013.

- Build ownership and confidence. Express confidence in the child and parents' ability and willingness to change.
- Resist the temptation to take over.
- Be realistic and keep commitments.

e. Identify and address Secondary Traumatic Stress (STS).

Background:

The professional and personal challenges that working in child welfare present are rarely identified within the organization. No common language exists amongst child welfare caseworkers, supervisors, and administrators for their internal responses to being exposed to child and parent/caregiver trauma on almost a daily basis. Continual exposure to maltreatment and trauma frequently stores in the bodies of staff who seek to keep children safe and provide opportunities for their future well-being. Without a common language to recognize the impact of that exposure, staff can experience harmful effects, not only professionally, but personally as well. The belief that staff can separate their professional experiences from affecting their personal life is no longer valid due to brain research that demonstrates that work experiences are stored in the brain and are impacting functioning whether one is thinking about what happened on the job or not.[69] This is especially true in child welfare because it involves "emotional labor" that engages the emotional centers of the brain that are easily triggered outside the confines of the work environment.[70]

Caseworkers must cope daily by themselves without the benefit of processing what is actually happening to them. As a consequence, it is easy and becomes the default mode to express anger and cynicism to protect oneself rather from more vulnerable feelings of sadness and helplessness. Surviving the job becomes the fundamental operating principle for many staff. The byproduct can be a loss of energy, enthusiasm and passion to help children and families. The result is a reduction in effort to support, serve and advocate for the safety and well-being of children and families, producing poorer outcomes for children and parents/caregivers in child welfare.[71]

Identifying the impact of chronic exposure to the traumatic stress of children and families for staff as secondary traumatic stress provides a language and a way to begin to process their experiences differently than the norm. Secondary traumatic stress (STS) is defined as "the natural and consequent behaviors and emotions resulting from knowing about a painful event

[69] Siegel, 2010

[70] Calagari, 2010

[71] Williams & Glisson, 2013

from a significant other, the stress from helping or wanting to help a stressed person."[72] This definition provides two important recognitions for caseworkers. First, the phrase "knowing and wanting to help a stressed person" is applicable to most every child welfare staff person and therefore it is highly likely that staff then experience STS. Second, is that it is "natural" and consequently normal to experience behaviors and emotions from exposure to trauma.

The symptoms of STS are often categorized as cognitive, social, emotional, and physical. Cognitive effects include negativism, loss of critical thinking, all or nothing thinking, and decreased self-monitoring. Social effects include decreased collaboration, social withdrawal (personally/professionally) and factionalism (i.e. me against them). Emotional effects include helplessness, hopelessness and being overwhelmed. Physical effects include headaches, tense muscles, stomach aches, fatigue and sleeplessness, eating too much and drinking too much. The majority of caseworkers, supervisors, and administrators report physical symptoms, although they rarely communicate their symptoms to others[73]. Yet, other staff persons most often perceive those who are experiencing physical symptoms as primarily exhibiting cognitive effects, primarily negativism.

When STS continues it can be exacerbated by organizational stress (i.e. continuous unrealistic organizational demands, negative culture and climate), it can result in burnout. Burnout is the "state of physical, emotional, and mental exhaustion caused by exposure to chronic stress in the workplace. Depersonalization and reduced personal accomplishment often occur."[74] Burnout often manifests as a "numbing" and/or "disengagement" from relationships. In burnout caseworkers view the job as a series of tasks and are not interested in forming relationships or providing hope. Power becomes the hammer to force client change.

There are times when staff can experience post-traumatic stress disorder (PTSD) from a primary experience with a child or family member that takes away their personal safety, leaving them powerless to protect themselves. This can have a significant, ongoing impact on their functioning for an extended period of time after the incident. Experiences such as being exposed to violence, being physically harmed or threatened, and/or the unexpected death of child due to maltreatment can result in PTSD. Symptoms of PTSD are avoidance (person, place), re-experiencing (intrusive thoughts of the incident), and/or hyperarousal (i.e. emotional and behavioral dysregulation, hyper-vigilance). Most often PTSD symptoms significantly affect a person's functioning at home and work. When a caseworker has had a prior history of PTSD through earlier traumatic experiences in his or her life they are at higher risk of experiencing PTSD.

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[72] Figley, 1995

[73] Henry, 2013

[74] Regehr, Hemsworth, Leslie, Howe, & Chau, 2004

Unaddressed pain within the workplace creates a toxic environment.[75] This statement demands that STS, burnout, and possible PTSD, when they occur, be acknowledged and responded to within the organization. Organizational culture can significantly exacerbate STS. When staff persons feel administrators are not supportive of them personally and the challenges they face and focus instead on policy implementation and statistics, then staff persons can isolate and lose the meaning and value in their work. Their goal can become personal survival. Staff persons can become unresponsive to new ideas and resistant to implementing potentially positive changes to improve services to children and families.[76] In contrast, when administrators help create an office culture that supports the identifying and addressing of STS, then staff persons are more likely to find their work meaningful despite the stress and implement new practices that increase opportunities not only for clients, but for themselves as well.

Particular attention should be paid to caseworkers' well-being when involved with cases involving violence and regular interaction with victims and perpetrators of violence. These cases can carry a high level of ongoing stress related to active safety concerns and also the challenges working perpetrators who can be difficult and adult survivors who have been traumatized themselves.

Detailed Practice Guidance:

Local office policies need to address STS. Examples include:

- All new caseworkers should receive an orientation on STS from supervisors that includes the definition, the likelihood of experiencing it and positive ways to address it.
- A STS plan should be drafted for all staff (caseworkers, supervisors, administrators) that includes how STS will be identified and specific strategies to address STS both individually and within the larger organization.
- A critical incident protocol policy (i.e. death of a child, severe injuries, coworker injury/death) that requires (mandatory) those specifically involved (i.e. investigator, current caseworker, supervisors) meet together with trained critical incident staff to provide a forum to discuss the impact to each staff and ways to support resolution.
- All child welfare staff following a critical incident be informed of the incident and be invited (not mandatory) to participate in an all staff meeting to process the incident and the personal and professional implications for staff.
- At all small unit meetings a time should be allotted to discuss STS potential experiences and personal responses to the circumstances. STS should be communicated as normal and a healthy response to children and parental trauma.

[75] Frost, 2007.

[76] Williams, Glisson, 2013.

- Supervisors model the processing of STS by identifying their own responses to a particular child welfare experience and facilitating discussions about STS.
- Supervisors actively identify the positive outcomes that occur within casework on a regular basis. Celebrating successes should have an allotted time within all staff meetings.

5. Practice Guide for Supervisors: Mentoring

Practice Guide for Supervisors	
Mentoring	
MITEAM COMPETENCY	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 another person. This may mean, for example, a caseworker mentoring a parent, a supervisor mentoring a caseworker or a peer coach mentoring a supervisor. Teaming and mentoring must work hand in hand to create the kind of opportunity for collaboration, goal achievement and problem solving on multiple levels within the system. Mentoring is the ability to empower others. It is vital to demonstrate and reinforce desired skills to promote positive outcomes and growth for children, families and professionals.

FIDELITY MEASURES	**Observation:**
	• Treats individual(s) with respect.
	• Treats individual(s) with empathy.
	• Uses verbal responses that are consistent with body language.
	• Acknowledges his/her authority and the disproportionate amount of power in the relationship.
	• Addresses reasons for reluctance to including specific team members.
	• Evaluates strengths.
	• Evaluates needs.
	• Asks the individual(s) about events experienced by primary/key family members that are potentially traumatic.
	• Request(s) individual(s) input regarding the effectiveness of services.
	• Asks the individual(s) how s/he can be of assistance to the family.
	• Assists the family with navigating agency systems and processes.
	• Discusses with the family the success of the child(ren)/youth beyond case closure.
	• Provides trauma education to the individual(s).
	• Provides feedback to the individual(s).
	• Asks for feedback from the individual(s).
	Interview:
	• The individual(s) feels understood by the worker.
	• The individual(s) feels respected by the worker.
	• The individual(s) reports the worker acknowledged the unique culture of the family/household.
	• The individual(s) reports the worker provided education on how early traumatic experiences may impact parenting.
	• The individual(s) reports the worker addressed the potential impact of trauma to the child.
	• The individual(s) reports the worker provided education on child safety.
	In Supervision:
	• The worker participated in monthly supervision meeting(s) with the supervisor.
	• The worker was able to identify:
	  ○ How they managed their frame of reference.
	  ○ How he/she educated parents on the potential impact of trauma.
	  ○ How he/she educated team members on the potential impact of trauma.
	  ○ How the parent participates in the process of change.
	  ○ What progress has been made so the family's team is taking ownership of the case planning process and fully participating in the shared decision-making.
	  ○ How s/he educates the family about the importance of teaming.
	  ○ How committed the family's team is to the family's plan.

	• The worker identifies own team members that support their professional development. • The worker exchanges feedback with the supervisor.
POLICY REQUIREMENTS	• Be knowledgeable and seek information so that you can share information with families. • Develop and enhance communication skills to deliver messages that are tailored to meet individual family needs. • Provide effective feedback and hold others accountable. • Utilize strength-based and solution-focused communication. • Demonstrate honesty, genuineness and integrity.

KEY CASEWORKER ACTIVITIES	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE TECHNIQUES
KCA 27 MENTORING ***Promote growth through coaching.***	From the first point of contact through case closure.	• Demonstrate mastery of the four key MiTEAM competencies: Teaming, Engagement, Assessment, and Mentoring through interactions with the caseworker (parallel process). • Educate caseworkers by assisting peer coaches and training staff in training of the caseworkers regarding the MiTEAM practice model. • Facilitate consistent weekly conferences with the caseworker. • Treat caseworkers with respect. • Maintain professional boundaries. • Maintain a climate of fairness. • Communicate expectations. • Be alert to signs of secondary trauma, stress and burnout; provide appropriate support. • Spark action in others to improve communication, practice and processes.
KCA 28 MENTORING ***Create a learning environment through observation and feedback.***	From the first point of contact through case closure.	• Actively observe as caseworkers engage stakeholders and family members throughout the life of a case to document caseworkers' demonstration of skills that support practice model. • Exhibit non-judgmental observation that focuses directly on targeted skills (behaviors) and the proficiency of the displayed target skills. • Provide feedback, support and assistance with the primary goal of improving skill performance and reaching the core outcomes of safety, permanency and well-being. Feedback will be both verbal and written and will include a plan for skill improvement. • Focus on observation of competencies: Teaming, Engagement, Assessment, Mentoring. • Review documentation of observations of caseworker interaction primarily focusing on engagement. These observations may take place during face-to-face interviews with children, parents and caregivers and through observations at court hearings, visits, medical appointments, educational system interactions, and mental health interaction. • Deliver effective, behaviorally specific feedback to the caseworker. • Deliver feedback (verbal/written) that is specific, concrete, useful and timely. • Identify the type of feedback that is required: positive or opportunities for growth. This will be given to the caseworker using the Effective Feedback Process. • Provide an opportunity for participation in consistent weekly conferences. • Develop, with the caseworker, next steps to support the elevation of behavioral performance expectations required to support best practice.

KCA 29 **MENTORING** ***Support change through building honest and genuine relationships.***	From the first point of contact through case closure.	• Respond to caseworker's concerns and needs. • Listen and respond to caseworker empathetically. • Demonstrate and encourage critical thinking. • Maintain consistency in regularly scheduled weekly conference times. • Demonstrate flexibility to address individual needs. • Model recognition of strength and positive performance. • Model in all settings where engagement, teaming, assessment, case planning and case plan implementation occur. • Model the delivery of written and verbal opportunities for growth.

6. Additional Resources to Support Effective Mentoring

The articles, materials and tools listed below provide additional resource information regarding innovative approaches, strategies, tools, and best practices to strengthen supervisory capacity and also create an organizational culture that is conducive to collaborative mentoring.

Rubin, Jon. Building Workforce Capacity through a Child Welfare Practice Model: Lessons from the Field: An article published by American Public Human Services Association, October, 2012. This publication highlights key processes, strategies and practices that individual states have utilized in an effort to implement successful child welfare practice models. While these practice models have distinct elements that are unique to each state, there are common themes regarding the critical need for systemic supports that give priority to the development of a qualified and competent workforce. The importance of quality supervision is underscored in pages 13-18 of this article, noting several of the approaches that state child welfare systems have taken to increase the capacity of its supervisory workforce.

Williams, N. J., & Glisson, C. Testing a theory of organizational culture, climate and youth outcomes in child welfare systems: A United States national study. Child Abuse & Neglect (2013), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3975827/. This study lays out the results of a national study focusing on the relationships between the organizational culture and climate and its impact on child and family outcomes. The study's findings concluded that child welfare agencies with more proficient and less resistant organizational cultures exhibited more engaged, more functional, and less stressful organizational climates. This research provides detailed descriptions regarding the characteristics of work environments that are most likely to support positive casework relationships, including the tenacity, availability, responsiveness, and continuity that children and families in the child welfare system need from their caseworkers in order to achieve positive outcomes.

Kadushin, Alfred and Daniel Harkness. Supervision in Social Work, Fifth Edition, (September, 2002) Columbia University Press. New York. This textbook provides valuable information regarding the varied roles, functions and processes inherent to supervision in a social work agency or organization. Its last updated edition now includes information regarding working with minorities and understanding cultural diversity. Professor Kadushin has authored a number of publications and is widely viewed as having contributed tremendously to the development of the knowledge base for social work *and* child welfare practice, supervision, policy, education and research.

Pryce, Josephine G. and David Pryce and Kimberly K. Shackelford. Secondary Traumatic Stress and the Child Welfare Worker. Lyceum Press. Chicago, IL (2007). This book is based on the authors' 10 year study of over 600 child welfare practitioners and their experiences with traumatic stress. The book focuses on the identification of secondary traumatic stress (STS) and its implications for child welfare workers, supervisors, and administrators. Additional attention

is given to the range of interventions that can best address the realities of secondary trauma stress for individuals working in the field of child welfare.

http://www.nctsn.org/sites/default/files/assets/pdfs/secondary_traumatic_tress.pdf. This link to the National Child Traumatic Stress Network provides a fact sheet on secondary traumatic stress for child-serving professionals.

Herzberg, Frederick Irving. "One More Time, How Do You Motivate Employees?" Harvard Business Review, 1968. The author, a psychologist, became influential in the field of business management and is well-known for his introduction of the Motivator-Hygiene theory. Also known as the Two Factor or Dual Factor Theory, its basic premise is that as employees, individuals are most influenced by motivating factors related to: 1) achievement, 2) recognition, 3) the work itself, 4) responsibility, 5) promotion, and 6) growth. This article gave rise to numerous studies and publications that utilize these theories to apply to human resources management across many fields, including child welfare.

McKenzie, Judith, Jackson, Rosemary, and McKenzie, John. The Practice of Retention-Focused Supervision. Michigan State University School of Social Work. 2007. This series of six workbooks is an accompaniment to an expansive training curriculum and is based on a review of research literature, focusing on the many studies that have to do with staff turnover and retention in child and family service, human services and business. The complete workbook series that is utilized throughout the training program for supervisors provides a great deal of information, including case materials, tools, and methods to develop supervisory capacity to create favorable workforce conditions that support staff retention. Additionally, these workbooks emphasize the parallel processes between how child welfare staff are treated by the agency and, in particular, by their supervisors becomes a mirror for how clients will be treated by staff.

Hess, Peg, Kanak Susan, Atkins, Julie. Building a Model and Framework for Child Welfare Supervision. A Report Published by the National Resource Center for Family Centered Practice and Permanency Planning and the National Child Welfare Resource Center for Organization Improvement with support from the Children's Bureau, U.S. Department of Health and Human Services. (2009) Available online at http://muskie.usm.maine.edu/helpkids/rcpdfs/BuildingAModelandFrameworkforCWSupervision.pdf and www.nhttp://muskie.usm.maine.edu/helpkids/rcpdfs/BuildingAModelandFrameworkforCWSupervision.pdfrcfcppp.org. This report, *Building a Model and Framework for Child Welfare Supervision,* presents the findings from an extensive review of the most recent literature combined with interviews of experts in the field of child welfare, currently practicing child welfare administrators, supervisors, frontline practitioners, and trainers. Included in the report is the description of an emerging model of supervision in child welfare that encompasses the multi-faceted roles and responsibilities of supervisors as well as their challenges. The report

also recommends strategies and tools for child welfare leadership to utilize to support supervisors in carrying out their diverse activities.

Patterson, Grenny, McMillan, Switzler, Crucial Conversations: Tools for Talking When Stakes are High (New York: McGraw Hill, 2012), 3-4, 101-102. This book provides skills on how to conduct a conversation and discussion between two or more people in crucial times where (1) stakes are high, (2) opinions vary, and (3) emotions run strong. The concepts are relevant for the supervisory relationship, as well as the relationship between the agency and individual family members being served.

"Trust in the Workplace" monograph by Development Dimensions International ***www.wip.ddiworld.com/pdf/ddi_trustmonograph_mg.pdf***. This link provides an article regarding dynamics and characteristics of an organization and the culture of the workplace.

Supervision & Mentoring in Child Welfare Services. (September 2003) **NEW Partnership for Children & Families, University of Wisconsin at Green Bay.** This document was drafted by a team of technical consultants, advisors and supervisors in the field to address the changing roles, challenges and paradigm shift for supervision in the child welfare system.

http://sourcesofinsight.com/mutual-purpose**.** Provides additional information from Grenny and Switzler's Crucial Conversations.

www.ted.com/talks/brene_brown_on_vulnerability.html. This link provides access to a video presentation by Brene Brown at a Ted Conference in Houston, Texas, where she presents her research findings and insights regarding aspects of relationships, including ideas regarding vulnerability, authenticity and conflict.

www.michiganchildwelfaretraining.com/LinkClick.aspx?fileticket=N530y3fdX8o%3d&tabid=132. This link provides a questionnaire regarding life events and stress indicators from the participant's guide from training that was initially developed by the Georgia Department of Human Resources, Division of Family and Children's Services. This is relevant in the context of supervision, but can also apply to work with children and families.

https://ncwwi.org/files/Supervision__Perf_Management/Workbook_4_Com_Skills_for_Supervisors__Staff_6-07-07.pdf. This provides a link to an excerpt from an article by McKenzie Consulting, Inc. (June 2007) and includes tips and suggestions for nonverbal techniques to be used to improve and enhance communication.

III. Licensing

A. Practice Guide for Licensing Workers: Engagement

Practice Guide for Licensing Workers	
Engagment	
MITEAM COMPETENCY	**Licensing** is the process of collecting and assessing information to determine if a home is suitable for a foster care placement. The assessment process involves the licensing staff engaging with potential caregivers to acquire the information needed to assess compliance, along with the caregiver's capacity and commitment to serve the characteristics of the children in care. Licensing staff utilize opportunities for engagement to assess the needs of caregivers in an effort to provide support and aide in recruitment and retention strategies. **Engagement** is a series of intentional interventions that work together in an integrated way to successfully establish a relationship with children, parents and other individuals. Caseworkers will engage with the child, mother, father, extended family, primary caregiver, professionals working with the family and other team members for the purpose of building an authentic and collaborative working relationship.
FIDELITY MEASURES	**Observation:** • Treats individual(s) with respect. • Treats individual(s) with empathy. • Acknowledges his/her authority and the disproportionate amount of power in the relationship. • Helps the individual(s) identify people who are supportive. • Addresses reasons for reluctance to including specific team members. • Assists the family with navigating agency systems and processes. • Discusses with the family the success of the child(ren)/youth beyond case closure. • Provides trauma education to the individual(s). • Provides feedback to the individual(s). • Observation: Asks for feedback from the individual(s). **Documentation**: • A team that provides support to the child(ren)/youth and family has been formed. **Interview:** • The individual(s) was able to identify helpful activities of the worker. • The individual(s) feels understood by the worker. • The individual(s) feels respected by the worker. • The individual(s) reports the worker acknowledged religious and/or cultural beliefs. **In Supervision:** • Identify what is most important to the individual/family. • Identify Positive supports for the individual(s).
POLICY REQUIREMENTS	• Support and educate prospective caregivers to ensure safety of children in out of home placements. • Give preference to placement with a relative - if all requirements are fulfilled - when children must be removed from their home. • Place children in the most family-like setting and keep siblings together whenever possible. • Initial and ongoing assessment of rule compliance and safety, as well as thorough recruitment and retention efforts.

	• Preserve and encourage permanent connections with siblings and caring and supportive adults. • Assess placements that helps facilitate and support return home if the permanency plan is reunification. • Consider a placement with a view toward preparing the child for permanency.
HOW TO USE YOUR SUPERVISOR	• Second set of objectives eyes when you are trying to identify concerns. • Explore, with supervisor, community resources and services to assist in placement stability. • Discuss with supervisor ways to facilitate engagement with family members. • Seek review by supervisor of assessment and decisions around placement. • Explore, with supervisor, ways to assess a prospective caregiver's willingness and ability to assist in ensuring that birth parents spend natural, quality time with their child. • Track causes of foster home closures to identify effective recruitment and retention strategies.
LICENSING ACTIVITIES	**PRACTICE GUIDANCE TECHNIQUES**
LICENSING ACTIVITY ***Create an environment of empathy, genuineness, respect and empowerment for all caregivers.***	• Be mindful and aware of the grief, loss and frustration that relative caregivers may be feeling. • Make sure caregivers are full participants in family team meetings. • Attend Family Team Meetings with caregivers for support. • Express empathy during the assessment process to encourage caregivers to be open and honest about family dynamics and traumatic events that may have occurred. • Encourage caregivers to work with the birth parents. • Listen to caregivers and reflect back what you understand from them. Do this often. • Spend time with them. Be available. Return phone calls. • Discuss with the caregiver the preferred method of communication, e.g. phone message, email, etc. • Share information with them that is both accurate and timely. • Facilitate open communication between MDHHS/Agency and caregivers. • Prepare them for the assessment process and explain that it is comprehensive and may feel intrusive at times. • Respond when a need is identified. • Identify non-training barriers to the family's performance of the essential tasks of fostering. • Develop a plan to build on the caregiver's knowledge and skills. • Make sure caregivers are provided needed training. • Make sure caregivers are a part of the placement planning process by ensuring that they have an opportunity to share with the team their knowledge and opinions about children in their care. • Assist caregivers with obtaining documentation, completing paperwork and completing tasks. • Work closely with relative caregivers as they go through the licensing process. • Keep caseworkers up to date on where caregivers are in the licensing process.
LICENSING ACTIVITY ***Support foster/adoptive/kinship parents***	• Talk to caregivers about emerging needs and identify trainings/resources to assist them in meeting those needs. • Support caregivers by attending Family Team meetings as a resource for the caregivers. • Assist caseworkers in responding to the needs of caregivers. • Check in with the caregiver during times of transition. This includes initial placements, when a child is having difficulty, or after a child is replaced from their home.

	• Make sure you understand from the foster/adoptive/kinship parent what they feel they need to be successful and identify members of the family team and other resources to help meet these needs. • Make sure parents are full participants in family team meetings. • Do your best to respond. Be available and accommodating. • Utilize active listening skills and empathy so that caregivers feel heard and understood. • Review and discuss written material and any necessary written information. • Make sure they understand any forms you are asking them to sign. • Recognize and acknowledge them through gift cards and awards. • Hold support groups. • Assist prospective parent throughout the licensing process to facilitate a timely and reasonably stress-free process. • Identify and connect new foster parents to mentoring opportunities with experienced caregivers.
LICENSING ACTIVITY ***Use child specific, targeted and general recruitment efforts to increase the number of appropriate foster homes.***	• Recognize that families take time to think about becoming a foster parent before contacting an agency. Therefore, ongoing recruitment efforts spread out over a period of at least 12 months are most effective to create a climate of awareness over time. • Recognize the connection between support of existing families and their ability to recruit additional families. Well supported families are more likely to be retained and to encourage others to foster or adopt. • Coach and train current foster parents to present at and/or organize community events to assist in recruitment efforts. • Arrange compensation for foster parents who assist in recruitment efforts. • Establish relationships with agencies and/or providers that may be a resource for recruitment. • Expand partnerships with small businesses, community organizations, and faith based organizations to recruit and support foster/adoptive families. • Insert self in arenas that may be a potential resource for recruitment (PTA meetings, church groups etc.) and support. • Engage the community with the highest placement needs to help recruit families who can best meet the needs of children from their community entering foster care. • Engage in community activities that involve community leaders, media, schools and businesses. • Engage community partners is finding ways to support caregiving families. • Engage the faith community, current foster/kinship/adoptive parents and agency staff to help recruit families. • Focus the majority of marketing and recruitment activities on the strategies that generate the most initial inquiries; Word of Mouth, Internet, media events, and recruitment activities within the community including faith based communities. • Utilize MARE and other tools to help match children to prospective families.

B. Practice Guide for Licensing Workers: Teaming

Practice Guide for Licensing Workers	
Teaming	
MITEAM COMPETENCY	**Licensing** is the process of collecting and assessing information to determine if a home is suitable for a foster care placement. The assessment process involves the licensing staff engaging with potential caregivers to acquire the information needed to assess compliance, along with the caregiver's capacity and commitment to serve the characteristics of the children in care. Licensing staff utilize opportunities for engagement to assess the needs of caregivers in an effort to provide support and aide in recruitment and retention strategies. **Teaming** is a collective effort that necessitates a team approach. Caseworkers will form a team comprised of the important people in the child and family's life that meets, talks and plans together. Caseworkers will ensure team functioning by making sure the team has the ability and cultural competence to design effective services and supports, adjust as may be needed and use collaborative problem solving.
FIDELITY MEASURES	**Observation:** • Helps the individual(s) identify people who are supportive. • Addresses reasons for reluctance to including specific team members. **Documentation**: • A team that provides support to the child(ren)/youth and family has been formed. • The worker prepares the family team members for participation on the team. • The family's suggestions and comments are documented in the case file. • The team member's suggestions and comments are documented in the case file. • Documentation indicates the worker maintained contact with the family and support persons. • The family's team meets within the required timeframes (FOM 722-6B). • There is evidence in the documentation that the team implements specific safety activities to address safety concerns of the child(ren)/youth. • There is evidence in the documentation that the team addresses specific permanency plans. • There is evidence in the documentation that the team addresses specific issues of well-being for the child(ren)/youth. **Interview:** • The individual(s) was able to identify helpful activities of the worker. • The individual(s) reports the worker acknowledged religious and/or cultural beliefs. • The individual(s) described specific examples where his/her input was utilized in decision-making. **In Supervision:** • Identify how the parent participates in the process of change. • Identify positive supports for the individual(s).

POLICY REQUIREMENTS	• Support and educate prospective caregivers to ensure safety of children in out of home placements. • Give preference to placement with a relative - if all requirements are fulfilled - when children must be removed from their home. • Place children in the most family-like setting and keep siblings together whenever possible. • Initial and ongoing assessment of rule compliance and safety, as well as thorough recruitment and retention efforts. • Preserve and encourage permanent connections with siblings and caring and supportive adults. • Assess placements that helps facilitate and support return home if the permanency plan is reunification. • Consider a placement with a view toward preparing the child for permanency.
HOW TO USE YOUR SUPERVISOR	• Second set of objectives eyes when you are trying to identify concerns. • Explore, with supervisor, community resources and services to assist in placement stability. • Discuss with supervisor ways to facilitate engagement with family members. • Seek review by supervisor of assessment and decisions around placement. • Explore, with supervisor, ways to assess a prospective caregiver's willingness and ability to assist in ensuring that birth parents spend natural, quality time with their child. • Track causes of foster home closures to identify effective recruitment and retention strategies.
LICENSING ACTIVITIES	**PRACTICE GUIDANCE TECHNIQUES**
LICENSING ACTIVITY ***Assist caregiver in identifying formal and informal supports for the child and caregiver.***	• Utilize timelines, Eco-maps, Genograms and/or other tools to assist the caregiver in identifying formal and informal supports. • Connect caregivers to faith based organization, online community or support group. • Use all available human resources–children and youth, parents, maternal and paternal relatives, youth, and community members–to identify extended family networks for the child and caregiver. • Attempt to identify supports at every step in the child welfare process, including when children are first placed in the home, in court hearings, and in all team decision-making/family meetings, etc. • Empower caregivers to develop partnerships with other community providers that can help meet the needs of children.
LICENSING ACTIVITY ***Prepare caregivers to be an active part of the family team.***	• Help the caregiver identify ways that they can support the birth parents relationship with their child. • Inform prospective caregivers of the agency's expectations regarding their role in teaming, with birth parents and other team members, to ensure a child's/youth's needs for safety, permanency and well-being. • Remind the caregiver to be mindful of their own frame of reference- personal beliefs and perceptions- when interacting with the birth parents and relatives. • Process with the caregiver ways that they can best prepare for attending the family team meeting. • Process with the caregiver about how they can best prepare children for the team meeting and parenting time visitation. • Remind caregivers that team meetings are opportunities to get to learn more about the birth families and gain beneficial information about the youth. • Encourage caregivers to reach out to the youth's family and other supportive individuals to assist in creating a support system for the youth. • Provide opportunities during orientation sessions or initial training sessions to help caregivers address the immediate needs of the children placed in their care – emotional; financial, health, legal, educational, etc.

LICENSING ACTIVITY ***Building working relationships with other programs/agencies to positively impact the continuum of care.***	• Educate other programs on the licensing process so they are better informed when working with families. • Attend family team meetings (FTM) as often as you can to assist in the placement process. • Share information that is both accurate and timely • Facilitate open communication between MDHHS/Agency and caregivers • Empower kinship units, staff and private providers to develop partnerships with other community providers that can help meet the needs of children living with relatives • Develop kinship-specific provisions in contracts to ensure that private providers understand kinship policy and preferences and employ staff skilled at working with kinship families. • Partner with community-based organizations that serve caregivers, to ensure that foster families can access needed community supports. • Identify or develop community support groups for kinship caregivers.

C. Practice Guide for Licensing Workers: Assessment

Practice Guide for Licensing Workers	
Assessment	
MITEAM COMPETENCY	**Licensing** is the process of collecting and assessing information to determine if a home is suitable for a foster care placement. The assessment process involves the licensing staff engaging with potential caregivers to acquire the information needed to assess compliance, along with the caregiver's capacity and commitment to serve the characteristics of the children in care. Licensing staff utilize opportunities for engagement to assess the needs of caregivers in an effort to provide support and aide in recruitment and retention strategies. **Assessment** is an ongoing process of information gathering, analysis and collaborative decision-making that includes parents, children, caregivers, extended family members and professionals as partners. A comprehensive family assessment is a compilation of evaluations used to design plans and provide children and parents services that focus on safety, permanency and well-being.
FIDELITY MEASURES	**Observation:** • Asks the individual(s) to identify strengths. • Asks the individual(s) to identify primary needs. • Asks the individual(s) about events that have been experienced that are potentially traumatic. • When developing or adjusting the plan, asks for team member's input. • Asks individual(s) their perspective on the parent's ability to keep the child(ren)/youth safe. • If child(ren)/youth is not residing with custodial parent: • Asks individual(s) their perspective on the caregiver's ability to keep the child(ren)/youth safe. • If child(ren)/youth is not residing with custodial parent: Inquires about the caregiver's perspective on the impact of traumatic events on the child. **Documentation:** • A team that provides support to the child(ren)/youth and family has been formed. • The worker prepares the family team members for participation on the team. • The family's suggestions and comments are documented in the case file. • The team member's suggestions and comments are documented in the case file. • Documentation indicates the worker maintained contact with the family and support persons between in-person meetings. • The family's team meets within the required timeframes (FOM 722-6B). • There is evidence in the documentation that the team implements specific safety activities to address safety concerns of the child(ren)/youth. • There is evidence in the documentation that the team addresses specific permanency plans. • There is evidence in the documentation that the team addresses specific issues of well-being for the child(ren)/youth. • The history of the family's involvement with MDHHS is thoroughly reviewed and outlined in the case file. • The case file contained documentation of a trauma screening for the child(ren)/youth. • The case file contained documentation of completion of a mental health screening as noted on the child's well child exam form.

	• The worker documented a thorough assessment of the family's circumstances. **Interview:** • The individual(s) reports being satisfied with services offered and/or referred. • The individual(s) reports the worker acknowledged religious and/or cultural beliefs. • The individual(s) described specific examples where his/her input was utilized in decision-making. **In Supervision**: • Identify what is most important to the individual/family. • Identify how trauma has potentially impacted each individual. • Identify how the parent participates in the process of change.
POLICY REQUIREMENTS	• Support and educate prospective caregivers to ensure safety of children in out of home placements. • Give preference to placement with a relative - if all requirements are fulfilled - when children must be removed from their home. • Place children in the most family-like setting and keep siblings together whenever possible. • Initial and ongoing assessment of rule compliance and safety, as well as thorough recruitment and retention efforts. • Preserve and encourage permanent connections with siblings and caring and supportive adults. • Assess placements that helps facilitate and support return home if the permanency plan is reunification. • Consider a placement with a view toward preparing the child for permanency.
HOW TO USE YOUR SUPERVISOR	• Second set of objectives eyes when you are trying to identify concerns. • Explore, with supervisor, community resources and services to assist in placement stability. • Discuss with supervisor ways to facilitate engagement with family members. • Seek review by supervisor of assessment and decisions around placement. • Explore, with supervisor, ways to assess prospective caregiver's willingness and ability to assist in ensuring birth parents spend natural, quality time with the child. • Track causes of foster home closures to identify effective recruitment and retention strategies.
LICENSING ACTIVITIES	**PRACTICE GUIDANCE TECHNIQUES**
LICENSING ACTIVITY ***Assess the foster/kinship parent's ability, strengths and needs.***	• Assist prospective parents in assessing his/her own strengths, needs, motivations and parental capacities. • Conduct an assessment of the safety of the home and barriers within the home, including conditions of the home (i.e. fire alarms, gun locks). • Assess willingness and ability of prospective parents to work effectively with birth parents and educate on the positive impact that shared parenting will have on the child. • Assess prospective foster/adoptive/kinship parent's ability and willingness to make a permanent commitment to the child or youth. • Create a plan to address needs and barriers that are identified for that prospective foster parent to becoming licensed. This plan should include the resources and supports that may be needed to meet the needs of the prospective parent • Update the plan as needed to ensure that supports are in place to meet any needs or barriers identified for the caregiver.

	• Observe family relationships (how the family members relate to each other) to understand responses to questions asked as a part of the assessment. Assess the extent to which parent responses align with your observations. • Spend time with the prospective parent in person. Use questionnaires as tools and not as replacement for interviews and in person interaction. • Thoroughly complete all forms in a timely manner to provide a comprehensive assessment. • Listen to what children in the parent's care are saying about their experiences in the home. This may include biological, adoptive or other foster children. • Ask prospective parents about how he or she would handle certain behaviors or events (i.e. child steals a toy from a friend at school, biological parent is interested in joining you for a meeting with the child's teacher). • Ask prospective parent if he or she has experienced trauma. If he or she has, help him or her understand how this might affect his or her parenting style. • Think of creative ways to remove barriers to placement. This assessment includes knowing when a variance is appropriate. • Ask the tough questions. Be direct, but also culturally sensitive. • Gather input from the prospective parent about certain child characteristics, conditions and/or life experiences that may be a good fit for his or her strengths and capacities (i.e. medically fragile child, children with significant trauma histories, children who have experienced multiple moves, children with ADHD or depression).
LICENSING ACTIVITY ***Use assessment information to match children and youth to the most suitable placements and inform recruitment efforts.***	• Reduce trauma for children by matching them to the most appropriate placements and planning for transitions. • Assist caseworkers in making thorough and timely placement and replacement decisions. • Utilize opportunities to team with the child's caseworker and birth parents to understand more about the child (i.e. what he or she loves to do, family members, natural supports, needs, what he or she wants and needs). • Read the child's file. Look for family members and other persons who may be able to care for the child (i.e. grandmother of the child's best friend in kindergarten). • Find out as much as you can about the child before reaching out to any prospective foster/kinship/adoptive parents or group home/hospital staff. • Meet with the prospective foster/kinship/adoptive parent to discuss the child and the needs he or she may have in order to care for the child. • Use information gathered from assessment tools to help inform whether or not to place a child in a particular home. (i.e. screening assessments, mental health status assessments and trainings) • Request placements for children that align with the types of services caregivers are willing and able to provide (i.e. matches service types). • Recruit a variety of homes to facilitate thoughtful placement decisions. • Reinforce early and often the goal to return home.

D. Practice Guide for Licensing Workers: Mentoring

Practice Guide for Licensing Workers	
Mentoring	
MITEAM COMPETENCY	**Licensing** is the process of collecting and assessing information to determine if a home is suitable for a foster care placement. The assessment process involves the licensing staff engaging with potential caregivers to acquire the information needed to assess compliance, along with the caregiver's capacity and commitment to serve the characteristics of the children in care. Licensing staff utilize opportunities for engagement to assess the needs of caregivers in an effort to provide support and aide in recruitment and retention strategies. **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 another person. This may mean, for example, a caseworker mentoring a parent, a supervisor mentoring a caseworker or a peer coach mentoring a supervisor. Teaming and mentoring must work hand in hand to create the kind of opportunity for collaboration, goal achievement and problem solving on multiple levels within the system. Mentoring is the ability to empower others. It is vital to demonstrate and reinforce desired skills to promote positive outcomes and growth for children, families and professionals.
FIDELITY MEASURES	**Observation:** • Treats individual(s) with respect • Treats individual(s) with empathy • Uses verbal responses that are consistent with body language. • Acknowledges his/her authority and the disproportionate amount of power in the relationship • Assists the family with navigating agency systems and processes • Discusses with the family the success of the child(ren)/youth beyond case closure. • Provides trauma education to the individual(s). • Provides feedback to the individual(s). • Asks for feedback from the individual(s). **Interview:** • The individual(s) feels understood by the worker. • The individual(s) feels respected by the worker. • The individual(s) reports the worker acknowledged religious and/or cultural beliefs. • The individual(s) reports the worker provided education on how early traumatic experiences may impact parenting. • The individual(s) reports the worker addressed the potential impact of trauma to the child. • The individual(s) reports the worker provided education on child safety. **In Supervision:** • The worker participated in monthly supervision meeting(s) with the supervisor. • Identify How they managed their frame of reference • Identify How he/she educated team members on the potential impact of trauma • Identify How the parent participates in the process of change

POLICY REQUIREMENTS	• Support and educate prospective caregivers to ensure safety of children in out of home placements. • Give preference to placement with a relative - if all requirements are fulfilled - when children must be removed from their home. • Place children in the most family-like setting and keep siblings together whenever possible. • Initial and ongoing assessment of rule compliance and safety, as well as thorough recruitment and retention efforts. • Preserve and encourage permanent connections with siblings and caring and supportive adults. • Assess placements that helps facilitate and support return home if the permanency plan is reunification. • Consider a placement with a view toward preparing the child for permanency.
HOW TO USE YOUR SUPERVISOR	• Second set of objectives eyes when you are trying to identify concerns. • Explore, with supervisor, community resources and services to assist in placement stability. • Discuss with supervisor ways to facilitate engagement with family members. • Seek review by supervisor of assessment and decisions around placement. • Explore, with supervisor, ways to assess a prospective caregiver's willingness and ability to assist in ensuring that birth parents spend natural, quality time with their child. • Track causes of foster home closures to identify effective recruitment and retention strategies.
LICENSING ACTIVITY	**PRACTICE GUIDANCE TECHNIQUES**
LICENSING ACTIVITY ***Educate caregivers***	• Identify seasoned foster parents to mentor new foster parent. • Review and discuss written materials with caregivers (policy, rules, application of materials etc.). • Provide childcare at trainings to decrease barriers to caregiver participation. • Explain and review rules, policies and procedures during orientation sessions and ongoing as often as may be needed. • Deliver training using a variety of methods (i.e. web-based training, support groups, videos, and books) to increase caregiver participation and understanding. • Ask caregivers and caseworkers to provide input on training topics. • Provide opportunities for ongoing training and learning based on input from caregivers and caseworkers. • Train on topics that are specific to the unique needs of families. • Educate caregivers on: 1) child development and developmental milestones; 2) the impact of trauma on child development; 3) their role in the teaming and case planning processes; and 4) their role in working with and mentoring birth parents. • Provide a simple definition of trauma to caregivers. Help them understand that overwhelming events can happen to children and adults that take away their sense of safety and make them feel powerless. • Inform caregivers that children and adults who experience trauma may have behavior changes. Explain to them that trauma can affect learning in school, attention, and listening, because these persons may be on high alert for danger much of the time. • Tell them that children and adults can heal from trauma. • Guide planning for enhancing the development and competencies of caregivers. • Educate caseworkers on how to make initial assessments on the safety of placements.

E. Detailed Practice Guidance for Licensing Workers

1. Create an environment of respect, empathy, and support to engage resource families and birth families to develop collaborative parenting partnerships.

Background:

A licensing specialist has a unique role in the child welfare process as they are not responsible for the removal of the child, or on-going daily case management, but may assist in making many critical decisions for the child, including recruiting appropriate families, assessing families, and placement of children. As one of the first professionals to introduce the resource family to the birth family, it is critical that the licensing specialist have the ability to work collaboratively with both the resource family and the birth family for improved child well-being, including timely permanence. Safety should always be assessed first before determining the level of engagement resource families should have with birth families, but families should not be deterred from working together for the best interest of the child.

The parenting between birth families, resource families and the child placing agency when a child enters foster care helps determine the success of the permanency plan for the child. This parenting partnership results in “shared parenting”. Shared parenting occurs when two or more adults have joint responsibility for care, nurturing and decision-making for the same child. What makes shared parenting work is communication, cooperation, support of each other, good planning, joint-decision-making and role clarity (Falberg, 1991).

Just as resource families are team members, it is important to remember that birth families are also team members with their own strengths and skills. Facilitating positive connections between foster parents and birth parents, regardless of whether the children remain in foster care or are reunified with their birth parents, can increase family connectedness, reduce childhood trauma, expedite permanency, and increase the likelihood of reunification (Burton & Showell, 1997). Licensing specialists can bridge the gap between resource families and birth families by being an unbiased support for the parenting relationship to develop between the two families. Examples of additional supports may include resource family peer mentors, resource family support groups, birth parent peer mentors, and birth parent support groups. Including resource families and birth families in trainings together is another way to provide support as well. While birth families have the right to determine who attends Family Team Meeting with them, relationship building at the beginning of the foster care case allows for positive engagement with resource families from the onset of the case.

The establishment of clear boundaries between birth and resource families and the use of support services are crucial for developing these relationships. Birth and resource families can determine the boundaries they are comfortable with during their initial meeting, with

the help of the licensing specialist. A foster care case manager can be helpful in facilitating this conversation with the licensing specialist and families in the form of an "icebreaker" meeting (McNall, 2008). These discussions should occur when all team members are present during the initial Family Team Meeting. These topics can be discussed at future Family Team Meetings as well. During Family Team Meeting, resource parents can learn what foods, toys, and comfort items a child prefers. They can learn about a child's bedtime routine, hygiene routine, medical, mental health and school history, culture and religious practice from the birth family's perspective. Families can share information about each other as well, at their level of comfort. Many birth parents would like to know about the home, community, and family that the child is now with, and some information can be shared without disclosing placement information, addresses, or the resource family's confidential information. The birth family can feel support from the resource family and become more comfortable with the boundaries and limitations of the visits. Suggestions for building connections include: writing letters to the children (from the parent or resource parent), planning positive visits, invitations to special events, or planned phone calls (Rise, 2009). This meeting is a good time to discuss opportunities for engagement with the child. However, child contact should always be in accordance with the Parent Agency Treatment Plan and approved by the case manager in advance.

Policy Requirements:

FOM 722-03: Parent Involvement:

- At the time of placement or placement change (during the applicable family team meeting [FTM]), the caseworker and parent should meet with the caregiver to orient them to the specific needs and characteristics of the child. Information about medications, allergies, cultural practices, food preferences, temperament, sleep schedules, special and/or personal toys, books or clothing that will aid in a smooth transition, and other specifics about the child should be requested from the parent. In the best interest of the child, the caseworker should encourage the caregiver to meet with the birth parent to facilitate an ongoing exchange of child information.
- To the extent possible and appropriate, the caregiver should have phone access to the parent and should consult with the parent whenever major decisions or problems arise. Parental access to the caregiver home may be limited within reason, based on the best interests of the child.

FOM 922: MDHHS is committed to:

- Developing a network of family foster care that is neighborhood-based, culturally sensitive, and located primarily in communities in which children currently live.
- Ensuring that siblings are routinely placed together with families.
- Increasing the number and quality of foster homes to meet projected needs.
- Providing services to birth families and children in a timely fashion to promote reunification as soon as possible.

- Involving birth parents, foster parents, relatives and family support persons as team members.
- Becoming a neighborhood resource for children and families by investing in the communities where large numbers of families involved in the child welfare system live.

Detailed Practice Guidance:

Some of the decisions birth families and resource families can discuss and share include:

- Food and meals: what the child likes to eat, allergies, mealtime customs, table manners.
- Clothes: favorite colors, styles, clothing items.
- Hair: how the child usually wears his/her hair, hair hygiene routine.
- Toys and hobbies: favorite toy items, toys the parent doesn't want the child to have (i.e. toy guns, specific video games).
- Photographs: photos of the child and the birth family, photos of the child's community, photos of the child with the birth and resource family.
- Schedule: Child's typical routine, what chores the child is used to, what is the birth family's daily schedule, what is the resource family's daily schedule, (i.e. bedtimes, homework, picking up child's bedroom, personal hygiene routine).
- Health: current, history, conditions.
- Religion: birth family and child's religious custom and practice, birth family's wishes for child's religious practice.
- Family Traditions: customs such as family gatherings, celebrations, games, etc. (NYS Citizens' Coalition for Children, Inc.).

Advantages of birth families and resource families sharing decisions and working together as a team:

- Maintains the parent-child relationship.
- Improves the parent's self-esteem.
- Gives the birth parent and the foster parent more information about the child.
- Allows the foster parent to model appropriate behavior.
- Helps the birth parent to grow in understanding of a child's needs and appropriate expectations and management of the child.
- Helps the foster parent understand the child's past and what is usual or unusual for the child.
- Eases reunification process.
- Promotes ongoing support for the family after the child returns home.
- Promotes supportive relationships if the resource family adopts when reunification cannot occur. (NYS Citizens' Coalition for Children, Inc.)

2. Support and educate resource families on the importance of collaborative parent partnerships and the impact of trauma on families for improved child welfare outcomes.

Background:

Families are more likely to be satisfied with their experience with fostering and adopting when the following supports are in place:

- They are treated respectfully and as part of a team.
- They have experienced full disclosure and complete information about a child's background, personality and needs.
- They have been prepared for the experience of adopting and fostering and have access to ongoing training and personal development opportunities.
- They are connected, involved with other foster/adoptive parents.
- They are supported during hard times and family crises by their agency, their personal support network and other community resources.
  (NRCDR, Practitioners Guide: *Getting More Parents for Children from Your Recruitment Efforts,* pg. 25)

At the beginning of the licensing process, licensing specialists have an opportunity to be transparent about birth family involvement in the child welfare process and disclose how family visitation occurs at the agency (for example, giving a tour of the family visitation space). Resource families need child welfare staff to be honest about birth family involvement, including the involvement of any relatives. Licensing specialists should help resource families address their fears and support them through any hesitancies with accurate information, case scenarios, and talking with other resource families as mentors. (NRCDR, Practitioners Guide).

In order for families to experience full disclosure and receive complete information about a child's background, personality and needs, it is best practice for the resource family to develop a cooperative parenting relationship with the birth family who can provide this information. When approaching a resource family to team with a birth family, there may be resistance from either family. It is important to remember that each family comes with their own experiences and biases. Licensing specialists have a unique role in assisting the resource family in understanding the birth family's unique history and circumstances that lead to the child entering foster care. Just as many children in foster care carry with them an "invisible suitcase" of traumatic experiences, birth families also may carry their own "invisible suitcase" (Stokes, 2013). Approaching birth families with empathy, respect, and genuineness will allow the resource family to understand the family trauma history without judgment for the reasons the child entered foster care. Instead of approaching birth families with judgment that the family is bad, broken, or immoral, approaching the birth family with a trauma lens will allow resource families to understand the effects of generational trauma.

> What if instead of viewing the adults as addicts, criminals, co-dependents, mentally challenged, and bad parents, we looked at them as adult children who have survived

adverse childhood experiences and viewed their co-occurring conditions and maladaptive behaviors as symptoms of having survived these experiences? (Toohey, 2013).

Policy Requirements:

FOM 922: Twenty-four (24) hours of training must be provided to a foster parent by the end of the first year of licensure. The required training program is the Foster PRIDE/Adopt PRIDE curriculum. The training is organized around five competencies:

- Protecting and nurturing children;
- Working as a member of a professional team;
- Supporting relationships between children and their families;
- Meeting children's developmental needs and addressing developmental delays;
- Connecting children to safe, nurturing relationships intended to last a lifetime.

FOM 922: The initial foster home study and all subsequent annual and renewal studies must contain a section that assesses the training needs of individual foster parents. The required topics may be prioritized based on the identified needs of the foster parent.
Training topics that must be covered within the first two and one-half (2 1/2) years are:

- Characteristics and needs of children.
- Effective parenting.
- Behavior management.
- Importance of the foster child's family.
- Role of the agency.
- Emergency procedures, first aid, and fire safety.
- Preparation of the foster child for independence.

Detailed Practice Guidance:

- Invite birth family speakers to present at PRIDE or other resource family trainings.
- Cross-train resource families and birth families together when appropriate.
- Team with other licensing specialists to form coalitions and share recruitment and retention supports including the development of resource family support groups.
- Develop resource family peer mentor programs where seasoned and "retired" resource families may mentor current resource families as support.
- Utilize monthly or quarterly resource family engagement activities to encourage resource families to build relationships with each other. Use local community partners to facility these activities, such as community centers or faith-communities. Consider inviting birth families to these events when appropriate.
- Remember there are no sides to parenting. When a child is in foster care, the family includes the resource family, the birth family, and even the service agency.

References:

Arkansas Division of Children and Family Services Practice Guide Series: How We Do the Work is As Important as the Work We Do, *How We Do the Work of Engaging and Supporting Birth Families or "Bridging the Gap"*.

Burton, D., & Showell, P.W. (1997). Partnership parenting in foster care. *Families in Society, 78,* 520-521.

Corwin, T. (2012). Strategies to increase birth parent engagement, partnership, and leadership in the child welfare system: A review.

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McKenzie, J. K., & McKenzie, J.L. (2012). Practitioner's guide: Getting more parents for children from your recruitment efforts. National Resource Center on Diligent Recruitment, *AdoptUSKids*.

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Rise. (2009). Building a bridge: Stories about connections between parents and foster parents. New York, NY: Rise.

Stokes, C. (2013). Repacking the invisible suitcase. *CW 360 Degrees: A comprehensive look at a prevalent child welfare issue.* 28.

Toohey, P. (2013). A birth parent's perspective: What happened? *CW 360 Degrees: A comprehensive look at a prevalent child welfare issue.* 29.

3. Assess the foster/kinship parent's ability, strengths and needs.

Background:

When parents are unable or unwilling to care for a child, child welfare agency staff may determine that the child must be removed from their parents to keep the child safe. If this level of intervention is required, and a child is placed with an alternative caregiver, at the very least we must ensure that the child is safe. The majority of children are safe while in care, yet despite our best efforts, maltreatment in foster care does occur. Although maltreatment in care is rare, when it does happen it provides an opportunity to look at the systems put in place to ensure child safety.

With this in mind, it is possible to reduce the likelihood of foster child maltreatment by ensuring that caregivers are ***well-screened***, ***trained***, and ***supported***. There are several decision points that a comprehensive evaluation can be conducted. These decision points occur during the Family Study process which includes recruitment, screening, and licensing and ongoing. Specifically, the process of screening is critical as it is one of our earliest opportunities to realistically and candidly explore the ability of a prospective foster parents to keep a child safe. Effective screening practices include comprehensive assessment for all providers, multiple home visits and interviews, the use of structured assessment protocols in combination with engagement and assessment skill. (NCCD, 2014).

Despite the great need for more adoptive and foster parents, there are factors that could and should have an adverse impact on accepting an applicant (Farmer, 2102). There are common characteristics of children and caregivers and specific factors that are strongly related to an increased likelihood of maltreatment and/or inadequate care of a child in foster care. These characteristics and factors should be considered when conducting a comprehensive assessment for placement (NCCD, 2014).

Common characteristics for the Child:	**Common characteristics for the Caregiver:**
• Multiple prior placements • Child behavior concerns • Emotional health needs • Prior runaway attempts • Age 5 or younger at time of placement	• Multiple children placed in the home • Prior criminal convictions • History of domestic violence • History of perpetrated child maltreatment • History of having a corrective action plan • Mental health diagnosis and/or treatment

Factors contributing to potential instances of maltreatment include:

- Difficulties related to caring for a foster child because of the child's needs (e.g. behavioral issues, mental health issues, special needs).
- Decisions about how to supervise or time needed to supervise children in care (sometimes related to employment or multiple children in the home).
- The presence of other adults in the home (renters, significant others, and relatives)
- Incidents or conflicts between children in the home.
- Alcohol use and substance abuse (by caregiver or other adults).
- Domestic Violence.
- Concerns about the living conditions of the home.

Policy Requirements:

FOM 922: There must be an assessment of the training needs of individual foster parents at the time of the original home study and at each annual assessment of the family.

FOM 922-1: The certifying agency is to make an initial thorough study of each foster family prior to placing a child with the family. The home study process must include visits at the residence of the foster home applicants for observations of, and interviews with, each member of the household.

Detailed Practice Guidance:

The effective screening of foster or kinship caregivers should be done with the purpose of ensuring the child's safety and well-being. A successful placement is the result of an accurate screening and evaluation; a good assessment does not just happen (Pollack, 2012). Workers and their supervisors must be trained to take into account the needs of the child, the biological parents, the adoptive or foster parents, and the agency. Each question an applicant answers should provide another perspective into the potential success or failure of the placement.

> Screening prospective adoptive and foster parents requires workers to ask questions about and evaluate the answers to sensitive topics. To probe and weigh these responses means that an applicant cannot necessarily be taken at face value. Instead, screeners need to be trained to be keen observers of spoken and unspoken behavior and feel there is no time constraint. What an applicant might be willing to disclose after several interviews, each lasting more than a couple of hours, may be unattainable in a single, brief interview (Pollack, 2012).

Interviews are commonly utilized as a primary resource to attain information to assess a prospective caregivers' willingness and ability. Therefore one of the interviewer's purposes of evaluating prospective parents is to encourage them to talk. "The underlying purpose of the interviewer's questions is to explore and probe (through both open-ended and specific questions) the applicant's personality, attitudes, and behavior, to gauge if the applicant is minimally qualified to be an adoptive or foster parent" (Pollack, 2012).

There are numerous organized lists that include hundreds of questions to use in the screening process. Among the more probing questions are:

- Why do you think the time is right for foster parenting?
- Have you ever applied elsewhere to care for foster children?
- Describe the child that you think would fit best into your home.
- How do you think fostering will change your life?
- How do you and your spouse/partner settle conflicts?

- How often do you and your spouse/partner fight or argue?
- Is there any domestic violence in your relationship? In your past relationships?
- How do you/will you discipline your children?
- Do you use corporal punishment with your children?
- How were you disciplined as a child?
- How do your family and friends feel about you becoming a foster parent?
- How do your children feel about having foster siblings?
- What kinds of activities do you like to do as a family?
- Why do you want to do foster care?

Once all the information has been obtained and it is determined that a caregiver will be approved, to help address maltreatment before it occurs, caregivers and children with identified characteristics or factors, or who are facing significant change, should be targeted for extra support. Extra support may include, but is not limited to:

- Identification and engagement of additional support people and/or professionals (teachers, counselors, supportive friends/family, and other service providers).
- Referrals to appropriate services for child and/or caregiver (infant mental health support, counseling, etc.).
- Regularly scheduled calls with caregiver to address concerns.
- Regular review of the family's safety plan; updates as needed.
- Assistance locating and/or accessing resources to meet the family's needs (financial assistance, food, daycare, clothing, etc.).

Resources:

Elaine Farmer et al., Foster Care Strain and Its Impact on Parenting and Placement Outcomes for Adolescents, 35 BRITISH J. SOC. WORK 237, 241–51 (2005).

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Pollack, Daniel. "THE NEED FOR A CONSENSUS STANDARD OF CARE IN SCREENING PROSPECTIVE ADOPTIVE, FOSTER, AND KINSHIP PLACEMENTS." Capital University Law Review 40.397 (2012): n. pag. Print.

IV. APPENDICES

Appendix A: Domestic Violence Guide for Caseworkers

Michigan Practice Model Manual:

Domestic Violence Guide for Caseworkers

Department of Health and Human Services
Children's Services Administration

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Background and Introduction

Child maltreatment and domestic violence often co-exist within families, with estimates ranging from 30-60% of child welfare cases.[77] Children can be harmed by a domestic violence perpetrator's choices and behaviors in numerous ways, from being physically harmed, to being exposed to the perpetrator's abuse, to having housing disruptions, to not being medically-up-to date due to a perpetrator's control of the insurance card. The research also suggests that domestic violence perpetrators are more likely than other parents to physically or sexually abuse their children.[78] The impact of a perpetrator's abusive behaviors can affect children socially, developmentally, physically, and emotionally, even if a child is not physically harmed.

Because of the high rates of domestic violence on child welfare caseloads and its correlation with degradation of child and family functioning,[79] it is important for caseworkers to approach each case from a domestic violence-informed perspective, beginning with screening for domestic violence in all cases, even if domestic violence is not the presenting issue, and continuing to assess for coercive control as the case remains open.[80]

The *Safe and Together*™ approach, developed by David Mandel and Associates, serves as a framework for how to better interact with perpetrators and survivors of domestic violence. The approach supports the MiTEAM competencies of engagement, teaming, assessment and mentoring. The following includes strategies and guidance to support:

- Safe engagement of perpetrators, adult and child survivors.
- Safe family teaming, including separate family team meetings when safety is an issue; using kin networks of both the perpetrator and the adult survivor.
- Using a perpetrator pattern-based, child-centered and survivor strength-based assessment lens.
- Mentoring is critical to supporting engagement and intervention with perpetrators and building strong partnerships with adult survivors.

This guide is intended to supplement and to be used in coordination with the MiTEAM manual; it does not replace the manual.

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[77] See https://www.childwelfare.gov/topics/systemwide/domviolence/impact/children-youth/

[78] See http://www.lundybancroft.com/articles/the-connection-between-batterers-and-child-sexual-abuse-perpetrators

[79] Journal of Family Violence, Vol. 18, No. 1, February 2003 (°C 2003) Effects of Family Violence on Child Behavior and Health During Early Childhood. Diana J. English, David B. Marshall, and Angela J. Stewart

[80] See Domestic Violence Addendum for Domestic Violence Investigations Protocol

Definition of Domestic Violence

For the purposes of this guide, domestic violence[81] is defined as: "A pattern of coercive control perpetrated against one or more intimate partners. Behaviors can include sexual abuse, physical violence, threats, intimidation, financial control, possessiveness and isolation, among others. The abuse may continue after a couple has separated or is no longer living together and often directly involves, targets and impacts the children in the family."

Michigan policy (PSM 712-6 Special Cases) defines domestic violence as: "A pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks as well as economic coercion that adults or adolescents use against their intimate partners."

It is important to remember that this is not a relationship-based, incident-based or geographically-based definition of domestic violence. It's a perpetrator pattern-based definition similar to what is used when evaluating the risk from sex offenders. Though consistent with policy and criminal statute, this definition goes beyond and looks at patterns of coercive control and how the perpetrator's behaviors impact overall family functioning.

Gender-Neutral Language: Efforts were made to make the information in this section as gender-neutral as possible; however, research suggests that males are reportedly the primary batterers/perpetrators and females are reportedly the primary victims/survivors of domestic violence.

The following provides a combination of practice guidance from the MiTEAM manual, information and guidance from David Mandel and Associates *Safe and Together*™ approach, and guidance from "Family Team Conferences in Domestic Violence Cases: Guidelines for Practice."

Engagement and Initial Assessment

It is important to conduct initial engagement and assessment activities in cases where domestic violence (DV) is suspected or known to be present. This section includes guidance for engagement and initial assessment using David Mandel and Associates *Safe and Together*™ approach.

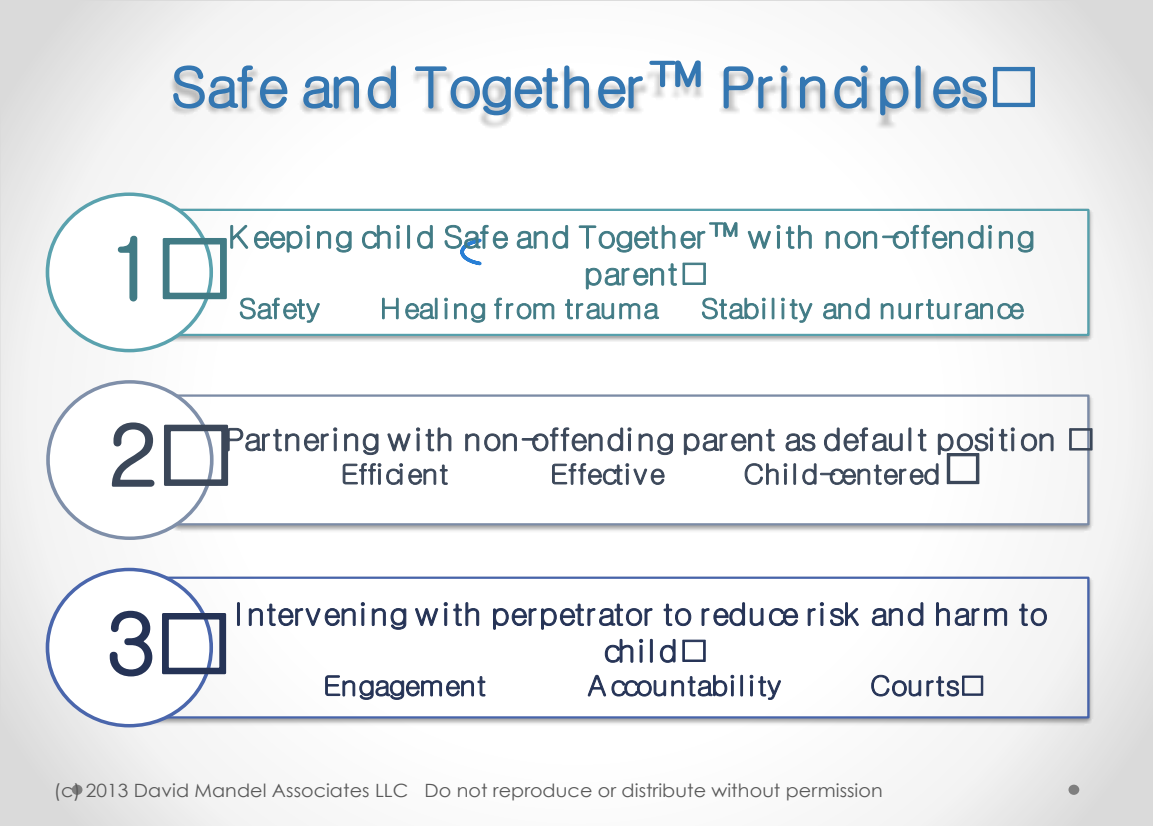
The Safe and Together™ Approach

The *Safe and Together*™ approach is a perpetrator pattern-based, child-centered approach that was developed to help child welfare systems in more effectively identifying, assessing, and

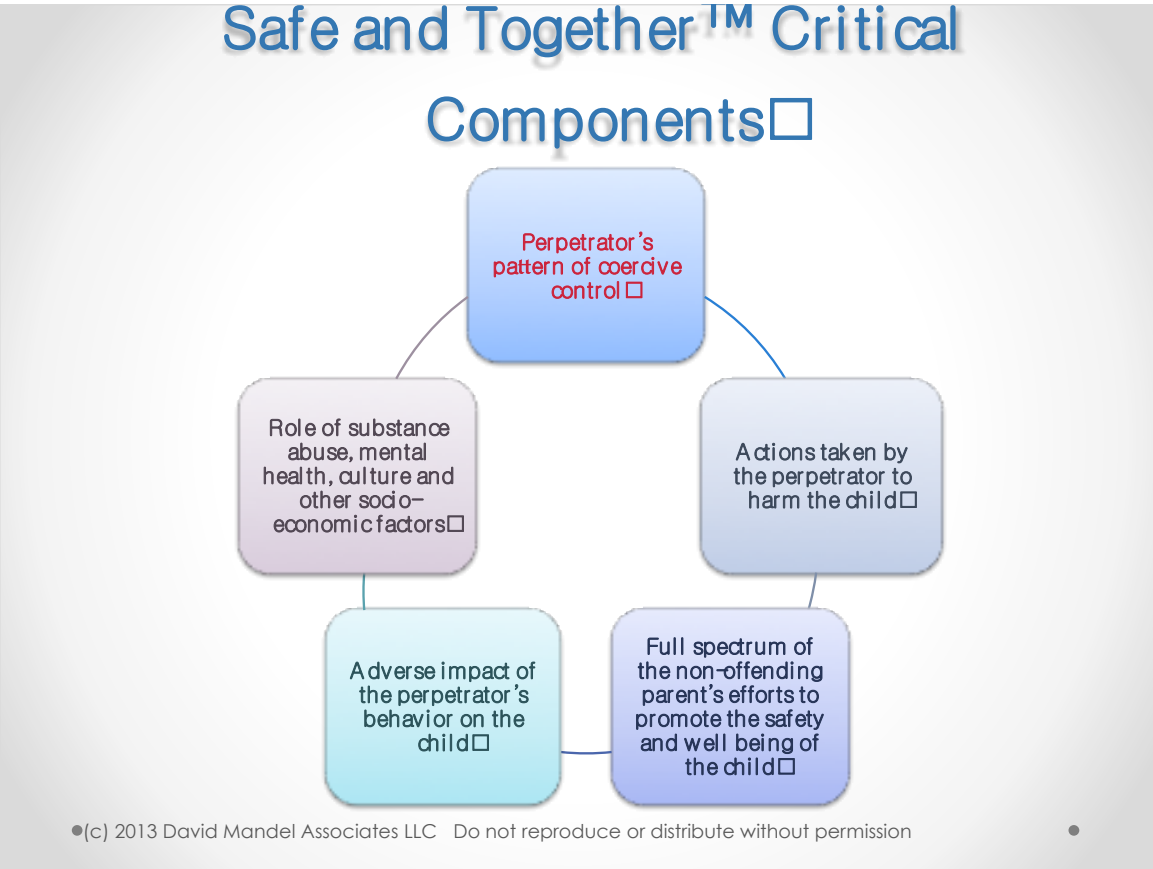
[81] Mandel

intervening with families being impacted by a domestic violence perpetrator. The approach is based on three Principles and five Critical Components.

The Principles, below, outline the overarching goals when working with families in which domestic violence is a concern:



Whereas the Critical Components serve as “road map” for case practice:



The Principles and Critical Components can serve as a basic framework and common language for working with families that have been impacted by a domestic violence perpetrator, as well as assisting with providing a template for better documentation.

Engagement

You should use the engagement guidance in the MiTEAM manual and the primary engagement guidance in a case involving domestic violence.

When using the MiTEAM engagement guidance, it is also important to keep the following in mind and tailor your engagement activities appropriately.[82]

[82] Quoted directly from the Safe Engagement of Fathers When Domestic Violence is Present: Building a model response to domestic violence within Responsible Fatherhood Programming David Mandel and Associates

1. **Domestic violence is a pattern of coercive behaviors perpetrated by one current or former partner against another that often directly involves the children.**

   It is not the result of an "anger management" problem or impulsivity. Nor is it a "conflictual" or "combative relationship" or "dysfunctional family system".

2. **Domestic violence perpetrators may or may not use physical violence against their partners and/or children as part of their coercive control.**

   Likewise, not all behaviors perpetrators engage in can be defined as criminal acts (for example, isolating the family or not allowing their partner access to the family car).

3. **There is significant variation in the coercive behavior patterns engaged in by individual perpetrators.**

   Not all perpetrators use the same tactics or behaviors, and some may never engage in physical violence. Perpetrators may also change their behaviors over time or in response to systems interventions. Co-occurring issues like substance abuse or mental health may also impact a perpetrator's behaviors. For instance, a perpetrator who gets sober may be less physically abusive, but more controlling and undermining. Ongoing assessment of the perpetrators' behaviors is crucial in order to accurately determine. Efforts to engage domestic violence perpetrators should vary according to an ongoing assessment of each perpetrator's behaviors, the impacts of these behaviors on the family, and the risk that the perpetrator poses to the children and adult survivor.

4. **Domestic violence is a parenting choice.**

   Abusive behavior is not the result of a skills deficit, or caused by substance abuse or mental health issues. This choice is often rooted in unrealistic expectations about relationships, gender and family. It persists because of the tangible benefits that derive from it. For a perpetrator who is also a parent, making the choice to be abusive should be viewed in the context of how his/her choices are impacting the safety and well-being of the children and the overall family functioning. A perpetrator who exposes his/her children to the abusive behaviors is making a choice as a caregiver and all assessment, engagement and interventions with perpetrators should be grounded in viewing how the perpetrator is impacting the children's safety, as well as how he/she is meeting (or not meeting) the children's needs for nurturance, stability and connection.

5. **Domestic violence and the values/social norms that support it are strongly influenced by culture.**

   In each culture, there are values, traditions and practices that support abusive and coercive relationships and there are also values, traditions and practices that support and promote

safe and respectful relationships. To fully understand perpetrators' choices to abuse their partners and children requires an examination of cultural meaning and influence as behaviors are frequently grounded in cultural and societal norms related to gender, gender roles, and relationships. Identifying and supporting motivations to change behavior also requires an exploration of culture and cultural resources available to individual perpetrators. Engagement should include culturally relevant strategies, highlight cultural strengths and be individually tailored to each family.

6. **The person responsible for the harm/impacts is the person who engaged in the behavior causing the harm/impact.**

   Supporting a perpetrator's acceptance of responsibility for their behavior and the impact of their behavior on the children and family is an essential component of supporting behavior change and reflects a strengths based approach recognizing a person's capacity for change. Setting clear behavioral expectations and working with other systems such as courts, probation and parole does not need to conflict with a strengths-based approach, or recognition of obstacles or issues that a perpetrator may face in their lives such as homelessness, discrimination, trauma, and mental health issues.

7. **Domestic violence perpetrators cause long term impacts for the whole family.**

   These impacts must be considered and addressed throughout our work with families even if the behaviors were committed in the past, the couple is no longer together, or the perpetrator currently does not have contact with the children. Identifying and understanding the perpetrator's pattern of abusive behaviors and the impact of the behaviors on overall family functioning assists in assessment, safety planning, and case planning as well as identifying adverse impact. Understanding the multiple pathways in which perpetrators impact child and family functioning also assists us in building more effective partnerships with adult survivors and supporting children's healing from trauma. An example of this is understanding how the perpetrator has continually undermined the adult survivor's parenting and authority resulting in the children not listening to their parent vs. assessing an adult survivor as having parenting deficits because the children do not listen to him/her.

Engaging the Perpetrator

As one of the key Principles of *Safe and Together*™ is intervening with perpetrators to reduce risk and harm to children, safe engagement of perpetrators is a necessary skill. Below are some specific strategies to engaging the perpetrator:

1. **Have Clear Goals.**

Before interviewing or meeting with perpetrators, have clear goals and clearly state your role and purpose for the meeting. Goals may include: assessing if the perpetrator is able to talk about his/her behaviors and how they may be impacting the children; the perpetrator's parenting and relationship with the children; and whether or not perpetrator is willing to work with you in changing his/her behaviors.

2. **Focus on Behaviors.**

   It is important to be very clear and straightforward about the behaviors that the perpetrator is engaging in and how it impacts the children and the family. Being able to draw clear lines between what is happening and the resulting impact is crucial to creating a clear plan for increasing safety. A perpetrator may want to focus on the behavior of his/her partner or the children, but it is important to keep bringing the focus back to the perpetrator's behavior and how it is impacting the children and family.

3. **Be Strengths-Based**.

   As the overall goal of engaging perpetrators is to keep children and families safe, it is important to see perpetrators as three-dimensional. For instance: *What is the perpetrator's role in the family? What is the perpetrator's relationship with the children? What is his involvement with the caretaking of the children on a daily basis?* Identifying and building on strengths, such as wanting to be a good parent, greatly assists with buy-in and gives you an opportunity to talk about your expectations for behavioral change in order to help the perpetrator achieve his/her goal.

4. **Address trauma.**

   Many perpetrators may have their own unaddressed trauma needs. While a history of trauma does not excuse violence, nor take precedence over addressing behavioral change, it is vital to screen for past trauma and take trauma needs into consideration when case planning or making referrals for services.

Additional Tips for Interviewing Perpetrators:

- Discuss with your supervisor beforehand how best to interview and engage the perpetrator and any concerns you may have regarding your personal safety.
- Review criminal history, child welfare history, and whether there are any current orders of protection.
- Let the adult survivor know you will be meeting with the perpetrator and ask if the survivor has concerns. Check in with the survivor post-interview if you have concerns about him/her or the children's safety.
- Refrain from arguing. If a perpetrator is unable or unwilling to talk about his/her behaviors and how they relate to the safety of the children, bring the interview to a close.

- Look beyond physical violence to controlling behaviors, including threats, intimidation, financial, emotional abuse, undermining the other person's parenting, using children as weapons against the other person, etc.
- Pay attention to attempts to get you to collude or focus on the adult survivor. Do not ask a perpetrator for "their side of the story".
- Beware of gender double standards and maintain high expectations of men as parents.

Engaging the Adult Survivor

Partnering with adult survivors is often the most efficient and effective way for child welfare to ensure child safety and well-being. As survivors are often the best source of information regarding the perpetrator's pattern of behaviors and those behaviors have impacted the children, good engagement with survivors impacts the quality of assessment, safety planning, and successful interventions.

Some tips for effective partnership with survivors:

1. **Pay attention to language.**

   Pay attention to the language, especially language that connotes that the victim is also responsible for the violence such as "you have a history of engaging in domestic violence". Instead, focus on behaviors of concern and who is responsible for the behaviors: *"I am here because we have some concerns regarding your partner's physically abusive behaviors and how it is impacting you and the children".*

2. **Validate strengths.**

   Often survivors are actively safety-planning for themselves and the children, providing day-to-day care and nurturance, as well as trying to maintain stability and routines for the children. Validating a survivors actions to provide safety and normalcy for the children is key to building an effective partnership.

3. **Build on existing safety planning efforts and know that safety plans may change over time.**

   Always ask a survivor about what he/she has done in the past to help with their safety and the safety of the children. What was effective? What made the survivor feel less safe? This is the foundation for a collaborative safety plan. Additionally, as perpetrator's may change their behaviors, continue to check in with survivors and updates plans accordingly.

Additional Tips for Engaging and Interviewing the Adult Survivor

- Discuss with your supervisor how best to interview and engage the adult survivor, including your goals for the interview.
- Consider the safety of adult survivor when organizing, structuring and conducting interviews and meetings; make accommodations for needed security and check in with adult survivors regarding interviewing the perpetrator and any concerns he/she may have.
- Ask about his/her history of efforts to keep the adult survivor and the children safe and the adult survivor's current concerns regarding the perpetrator's behaviors.
- Check in with the adult survivor after your interview with the perpetrator, especially if he/she became escalated.
- Be transparent about limits of confidentiality/plans to protect information.
- Use a trauma-informed approach when interviewing adult survivors, especially if you are interviewing immediately after a traumatic incident.
- Ask survivor how he/she is talking with the children about the perpetrator and the perpetrator's behaviors. Assist the survivor with safe, child-centered language if needed. For example, "Your father loves and misses you very much, but right now he needs some help to be a safer dad."

Engaging Children

Interviewing children helps us to learn more about how the children are functioning, how they have been impacted, what their concerns are, and how we can best support healing from trauma and keeping them safe. While there are several tools and tips for interviewing children, some things to consider in domestic violence cases:

1. **Tell them it's not their fault.**

   Some children think they may have done something to cause the perpetrator to be abusive or that they should have intervened. Some also feel guilty if they disclosed to an adult or called the police. From a trauma-informed perspective it is very important to let children know it's not their fault, they did not cause the perpetrator to be violent and that they did the right thing by not intervening or calling the police.

2. **Give permission to talk about difficult events and feelings.**

   Children look to adults for cues to talk about traumatic events. Assure them that they are not in trouble and you are not there to get their parents in trouble, but to make sure that everyone is safe. Ask them if they have an adult that they can talk to about their feelings.

3. **Use language of safety.**

Use language of safety, especially when talking about the perpetrator. Many children worry about the perpetrator, especially if he/she is out of the home. Assure the children that the perpetrator loves them and that he/she is getting help to be a safer parent.

4. **Know that children may have conflicting feelings about both parents.**

   Know that children may have conflicting feelings about both parents and let them know that their feelings are not right or wrong. As perpetrators often undermine the adult survivor's parenting and authority and interfere with the relationship between the survivor and the children, sometimes children present as angry at the survivor and not at the perpetrator. Also, most children love, care and worry about the perpetrator, even if they do not like the perpetrator's abusive behavior. Validate for them how sometimes having good and bad feelings about people is hard.

5. **As age appropriate, involve children in safety planning and answer questions.**

   A survivor may have already safety planned with the children by telling them to go to their rooms or a neighbor's home if the perpetrator escalates, or to call the police. Involving children as developmentally appropriate may lessen anxiety and may help them feel that they are being helpful. Also, sometimes children have questions about what may happen. Be honest about your role and what may happen.

Additional Tips for Engaging and Interviewing Children

- Discuss with your supervisor how best to interview and engage the children, including your goals for the interview.
- Consider the safety of the children when organizing, structuring and conducting interviews and meetings.
- As age appropriate, be transparent about limits of confidentiality/plans to protect information.
- Use a trauma-informed approach when interviewing children, especially if interviewing immediately after a traumatic incident.

Initial Assessment

Assessing a perpetrator's pattern of coercive control is the first concrete step that should be taken in a case where domestic violence is suspected or confirmed. The guidance below combines key elements of the Assessment Competency's Detailed Practice Guidance related to safety assessments (section 3a). It has been enhanced and adapted with the *Safe and Together*™ approach's Mapping Perpetrator Patterns tool and the Mapping Survivor's Protective Capacities tool.

Assessing the Perpetrator

Engaging, interviewing and assessing safety and risk with perpetrators of domestic violence can be challenging and, at times, dangerous for you and/or the adult survivor and children. The following information will help you to review the existing information and gather additional information on the alleged perpetrator behaviors and assess the safety and risk to the adult and child survivors.

- Review and determine if domestic violence allegations are part of the initial intake. If they are, screen for the perpetrator's pattern of coercive control, actions taken to harm the children, and any potential threats to the worker including:
    - Violence, threats, intimidation, financial, emotional and sexual abuse, undermining the other person's parenting, using children as weapons against the other person. Physical and emotional abuse and neglect of children are part of this pattern as well.
    - Include violent behavior and threatening behavior to others outside the family in this list including gang involvement, behaviors towards interveners (police, CPS workers, service providers, etc.), other violent criminal behavior, and sanctioned violence as part of work/career (e.g. martial arts, military service, and law enforcement).
- Gather information from a variety of sources. Include information on the type, frequency and circumstances related to the perpetrator's pattern.
- Contact the police to see if they have responded to reports of domestic violence at the family member's address.
- Review if there are any current orders of protection (civil or criminal) in effect and if they include the children.
- Conduct criminal record reviews and educate yourself on charges related to domestic violence. Information gleaned from the criminal record is extremely helpful for the investigator to have prior to making a home visit in order to plan for both worker safety and family safety.
    - Use record reviews to assess whether any of the family members have a history of domestic violence perpetration in other CPS or criminal cases. This information may help you assess worker and family safety.
- Gather and evaluate parental histories related to health, mental health, employment, alcohol and drug use, family relationships, history of violent and abusive behaviors towards current and former partners, general outlook on life and outlook on their role as a parent and education.
- Interview the perpetrator, adult survivor, and child survivor. Make every effort to interview family members separately in domestic violence cases.
- Interview other family members about coercive control and abusive behaviors. Also interview collateral contacts: family, friends, providers, adult probation/court, etc.

- Use MiSACWIS to research history/contact information and complete a criminal background check.
- Use pattern to improve assessment and determine if there is one parent who is a greater concern in "mutual battering" cases.
- Describe the full range of:
    - Behaviors before, during and after presenting incident;
    - Pattern in current relationship;
    - Behaviors in prior relationships;
    - Other relevant behavior, e.g. violence in other settings;
    - Indirect and direct actions towards children (includes both abuse and neglect);
    - Include not taking responsibility for prior violence as part of pattern.

Once you have gathered this information, be sure you have information about the survivor's protective capacities. See the next section for information about working with the adult survivor. Once information is gathered from all possible sources, you will return to the Safety and Risk Assessment section of the MiTEAM manual and use this information to make determinations about safety and risk as it relates to this family.

Questions to Determine Perpetrator Pattern and Risk

- Has the perpetrator ever choked the survivor?
- What types of injuries has perpetrator caused?
- Has perpetrator ever violated a restraining order?
- Has perpetrator made lethal threats against survivor or the children?
- Has perpetrator killed or attacked pets?
- Is perpetrator extremely jealous or possessive?
- Does perpetrator have access to weapons?
- Is perpetrator depressed, despondent, or paranoid?
- Does perpetrator stalk survivor?
- Is perpetrator escalating?
- What is perpetrator criminal record?
- Does perpetrator chronically abuse substances?
- Has perpetrator been violent towards the children, or towards nonfamily members?
- Does perpetrator use pornography? (These additional indicators of danger are based on Weisz et. al, 2000; Campbell et al., 1998; Holtzworth-Munroe & Stuart, 1994; Koss et al., 1994; Demare, Briere, & Lips, 1988.)*

*Bancroft, L. & Silverman, J. G. (2002). Assessing Risk to Children from Batterers. Vawanet.org

Assessing the Adult Survivor[83]

It is impossible to understand the adult survivor's decision making, particularly his/her protective efforts and safety planning without understanding the perpetrator's behavior. Meaningful and effective partnerships with adult domestic violence survivors are built on an understanding of the perpetrator's pattern.

Building a partnership with the adult survivor requires the ability to identify the perpetrator's behavior, not his/her behavior and choices nor the relationship as the source of the child welfare concern. Ask the adult survivor about his/her history of efforts to keep the survivor and the children safe and survivor's current concerns regarding the perpetrator's behaviors. This foundation allows you address child safety and risk without blaming the adult survivor and is more likely to lead to collaboration if the perpetrator is unwilling to change his/her behaviors and/or engage in planning and services.

Information to gather from adult survivor[84]:

- What were the behaviors the perpetrator has engaged in to degrade child and family functioning?
- What did the perpetrator do to disrupt or interfere with the primary caregiver's parenting, protective efforts, and relationship with the children?
- What has the adult survivor done to keep the children physically safe? What actions did the survivor take to safeguard them?
    - For example, removing the children from the room, having a code word with the children standing between the perpetrator and the children, developing plans with the school or family members to prevent the perpetrator from getting them, having the children stay with another person, etc.
- What has the survivor done to help the children heal from the trauma or the emotional impact of the abuse?
    - For example, talking with the children about their experiences and feelings, maintaining stability for the children, getting the children into therapy, getting the children into an activity/sport, defending the children, saying positive things to the children.
- What has the survivor done to provide stability and nurturance for the children?
    - For example, has consistent rules, routines and discipline, nurtures the children, the children and the survivor have a clear attachment, provides financially for the children, ensures the children's needs are taken care of (food, education, shelter, clothing, medical treatment), etc.

[83] The language in this section comes directly from the Mapping Perpetrator Patterns tool.

[84] Mapping Survivors' Protective Capacities, David Mandel and Associates.

- Has the system created any barriers preventing the survivor from promoting the safety and well-being of the children?
    - For example, social service systems expecting the victim to make the violence stop, the police not responding in a timely manner to her calls, the court denying an order of protection, etc.
- What are some examples of factors the might increase his/her vulnerability to the perpetrator or in general?
    - For example, survivor has: a criminal record and is afraid to call the police; has a history of substance abuse; is undocumented; is part of a tight-knit immigrant community that makes it easy for perpetrator to monitor the survivor.

Once you have gathered this information, be sure you have information about the impact of the perpetrator's pattern on the child(ren). See the next section for information about information to gather from the child. Once information is gathered from all possible sources, you will return to the Safety and Risk Assessment section of the MiTEAM manual and use this information to make determinations about safety and risk as it relates to this family.

Assessing the Child

It is important to understand the perpetrator's pattern as it relates to child safety and risk by determining if:

- The perpetrator's behavior pattern represents a threat to child physical safety.
- The perpetrator physically abused this child or other children.
- There have been violence or threats of violence towards the partner that create child safety concerns, e.g. driving dangerously.
- The perpetrator's behavior pattern has caused or exacerbated trauma related issues for the children.
- The perpetrator's behavior has interfered with the children's basic needs being met.
- Determine the impact on immediate and overall functioning and stability of household, e.g. safe, stable housing or educational disruptions.
- Determine if the perpetrator's pattern has:
    - Interfered with adequate food and/or medical care.
    - Caused neglect that creates safety issues. For example, has the perpetrator's behavior led to the children being placed in unsafe situations? (e.g. left alone for long periods of time without supervision.)
    - Led to educational and social problems related to violence leading to relocation.
    - Caused disruption in relationship with extended family.
- Does the child have emotional, behavioral and other issues that can be connected to perpetrator's behavior:
    - Trauma related symptoms and issues.
    - Aggression.
    - Depression.

- Developmental delays.

It is important to assess the following in order to determine the any safety and risk concerns related to the child(ren). The following points are taken directly from a 2002 article by Lundy Bancroft and Jay G. Silverman entitled, "Assessing Risk to Children from Batterers."[85] The full article is available at **http://www.vawnet.org/Assoc_Files_VAWnet/RisktoChildren.pdf.**

1. Level of physical danger to the mother.

The higher the severity or frequency of a batterer's level of violence, the greater the risk that he will physically abuse children (Straus, 1990). Level of violence is also an indicator of a batterer's likelihood to attempt to kill the mother (Websdale, 1999; Langford et al., 1999), or to carry out other continued assaults against her (Weisz, Tolman, & Saunders, 2000). His history of sexually assaulting the mother is correlated to overall level of physical danger (Campbell, Soeken, McFarlane, & Parker, 1998) and specifically to his likelihood of physically abusing children (Bowker, Arbitell, & McFerron, 1988). Threats of abuse are highly correlated with future physical violence (Follingstad et al., 1990) including post-separation violence (Fleury, Sullivan, & Bybee, 2000). Any history of violence to the mother during her pregnancies also indicates an increased risk to commit frequent or severe violence (Campbell et al.). Evaluators should note that both threatened and actual homicide attempts may take place in cases where the batterer's previous history of violence had not been severe (McCloskey et al., 1995), and that the woman's own assessment of the likelihood of future violence by a batterer may be more accurate than any other predictor (Weisz et al.).

Questions to Determine Level of Physical Danger to the Mother

- Has the batterer ever choked the mother?
- What types of injuries has he caused?
- Has he ever violated a restraining order?
- Has he made lethal threats against her or the children?
- Has he killed or attacked pets?
- Is he extremely jealous or possessive?
- Does he have access to weapons?
- Is he depressed, despondent, or paranoid?
- Does he stalk her?
- Is he escalating?
- What is his criminal record?
- Does he chronically abuse substances?
- Has he been violent towards the children, or towards nonfamily members?

[85] Bancroft, L. & Silverman, J. G. (2002). Assessing Risk to Children from Batterers. Vawanet.org

- Does he use pornography?

*These additional indicators of danger are based on Weisz et. al, 2000; Campbell et al., 1998; Holtzworth-Munroe & Stuart, 1994; Koss et al., 1994; Demare, Briere, & Lips, 1988.

2. History of physical abuse towards the children.

As discussed above, batterers are more likely than non-batterers to physically abuse children and this risk may increase post-separation. Thus it is important to evaluate a perpetrator's historical approach to discipline, including his/her reactions when angry at the children.

Questions about History of Physical Abuse towards the Children

- Does perpetrator spank the children?
- Has perpetrator ever left marks?
- Does perpetrator ever grab the children roughly?
- Has perpetrator been involved in fights (including any that appeared mutual) with his/her older children?
- Does perpetrator minimize or justify physically abusive behaviors he/she has used in the past?

*Bancroft, L. & Silverman, J. G. (2002). Assessing Risk to Children from Batterers. Vawanet.org

3. History of sexual abuse or boundary violations towards the children.

As discussed above, there is a substantial overlap between battering and incest perpetration. Evidence of sexual abuse should therefore should be treated with particular care in domestic violence cases. Subtler boundary violations can also be psychologically destructive, and can create a context for future sexual abuse or be signs of current undisclosed sexual abuse (Salter, 1995).

Questions about History of Sexual Abuse towards the Children

- Does the batterer respect his/her children's right to privacy, and maintain proper privacy himself/herself?
- Does perpetrator expose the children to pornography?
- Does perpetrator pressure the children for unwanted physical affection or engage them in inappropriate sexual conversation?
- Does perpetrator make inappropriate comments about the children's bodies or physical development?
- Are there indications of secret-keeping?

*Bancroft, L. & Silverman, J. G. (2002). Assessing Risk to Children from Batterers. Vawanet.org

4. Level of psychological cruelty to the adult survivor or the children.

Our clinical experience indicates that a batterer's history of mental cruelty towards the surviving parent or the children is an important indicator of how his/her conscience operates, and in turn of how safe children will be in his/her care. We also observe that the most psychologically abusive batterers sometimes can be especially determined to gain revenge against the surviving parent, using the children as weapons if necessary. Research indicates that the degree of emotional abuse in the home is an important determinant of the severity of difficulties developed by children exposed to domestic violence (Hughes, Graham-Bermann, & Gruger, 2001). A history of cruelty is overlooked in many evaluations, despite the fact that a majority of battered men/women report that the batterer's psychological abuse is even more destructive than his/her physical violence (Follingstad et al., 1990).

Questions about History of Psychological Cruelty towards the Surviving Parent and Children

- What have been perpetrator's most emotionally hurtful acts towards the surviving parent?
- What behaviors of his/hers have caused the greatest distress to the children?
- Has he/she ever deliberately harmed the children emotionally?

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5. Level of coercive or manipulative control exercised during the relationship.

We find that the more severely controlling our clients are towards their partners the more likely they are to draw the children in as weapons of the abuse, and the more likely they are to be authoritarian fathers/mothers. Additionally, a dictatorial level of control over children has been associated with increased risk of both physical abuse (review in Milner & Chilamkurti, 1991) and sexual abuse (Leberg, 1997; Salter, 1995).

Questions about Level of Coercive or Manipulative Control Exercised During the Relationship

- Has perpetrator interfered with surviving parent's social or professional contacts?
- Is perpetrator economically coercive?
- Does perpetrator dictate major decisions, showing contempt or disregard for survivor's opinions?
- Does perpetrator monitor his/her movements?

- Is perpetrator dictatorial or minutely controlling towards the children?

Manipulation as a form of control can be examined through such questions as:

- Does perpetrator play the role of victim in the relationship?
- Does perpetrator abruptly switch to kind and loving behavior when he/she wishes to achieve certain goals?
- Has perpetrator sown divisions within the family?
- Is there evidence that perpetrator is frequently dishonest?
- Is perpetrator described by his/her partner, children, or other witnesses as "crazy-making"?
- In cases where the perpetrator has a severe or chronic problem with lying, children's safety can be compromised by perpetrator's ability to cover up the realities of his/her parenting behavior.
- Such a perpetrator may also lie directly to the children about their fathers/mothers, which can create confusion for them or foster tensions in their relationships with their fathers/mothers.
- Those conducting assessments should thus always examine evidence of a perpetrator's credibility.

*Bancroft, L. & Silverman, J. G. (2002). Assessing Risk to Children from Batterers. Vawanet.org

6. Level of entitlement and self-centeredness.

"Entitlement" refers to a batterer's perception of himself/herself as deserving of special rights and privileges within the family (Silverman & Williamson, 1997; Pence & Paymar, 1993; Edleson & Tolman, 1992). It can be manifested through a selfish focus on perpetrator's own needs, the enforcement of double standards, a view of family members as personal possessions, or self-centered grandiosity regarding his qualities as a partner or as a parent that contrasts with evidence of perpetrator's abusiveness.

Self-centeredness has been shown to increase the chance of violent reoffending in batterers (Saunders, 1995; Tolman & Bennett, 1990). Furthermore, our clinical experience is that the batterer who is particularly high in entitlement tends to chronically exercise poor parenting judgement and to expect children to take care of his/her needs.

These observations are also consistent with indications that propensity to perpetrate incest is linked to self-centeredness (Leberg, 1997; Bresee, Stearns, Bess, & Packer, 1986), a view of the children as owned objects (Salter, 1995), and attitudes of paternal entitlement (Hanson, Gizzarelli, & Scott, 1994).

Questions about Level of Entitlement and Self-Centeredness

- Is the perpetrator frequently and unreasonably demanding, becoming enraged or retaliatory when he/she is not catered to?
- Does perpetrator define the victim's attempts to defend himself/herself as abuse of the perpetrator?
- Does perpetrator have double standards regarding his/her conduct and that of other family members?
- Does perpetrator appear to view the children as owned objects?

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7. History of using the children as weapons, and of undermining the survivor parent's parenting.

We have observed that perpetrators who have histories of chronically using children as weapons against the survivor parent, or of deliberately undermining his/her parenting, usually continue or intensify those behaviors after the relationship breaks up; post-separation improvement in this regard is rare. Change is more common in the other direction, unfortunately, where some perpetrators who did not use the children as weapons while the couple was together may begin to do so post-separation in response to losing other avenues to control or harass the father/mother.

Questions about Using Children as Weapons and of Undermining the Survivor Parent's Parenting

- Is the perpetrator frequently and unreasonably demanding, becoming enraged or retaliatory when he/she is not catered to?
- Does perpetrator define the victim's attempts to defend himself/herself as abuse of perpetrator?
- Does perpetrator have double standards regarding his/her conduct and that of other family members?
- Does perpetrator appear to view the children as owned objects?

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8. History of placing children at physical or emotional risk while abusing their father/mother.

We find that a perpetrator's behaviors that have the effect of harming or endangering children during partner abuse, even if the children were not intended targets, can demonstrate that his/her determination to abuse the other parent sometimes overrides

his/her use of safe parenting judgement. This type of reckless insistence on gaining retribution against the other parent increases post-separation in some cases, with attendant augmented risk to children. Perpetrators who are violent in the presence of children have also been found to be more physically dangerous (Thompson, Saltzman, & Johnson, 2001).

Questions about History of Placing Children at Physical or Emotional Risk While Abusing their father/mother

- Has the male perpetrator been violent or mentally cruel during any of the mother's pregnancies?
- Has perpetrator been violent in the presence of the children, assaulted survivor parent while a child was in their arms, or pushed a child out of his way to get at survivor parent?
- Has perpetrator ever thrown objects in a way that has risked hitting the children?
- Has perpetrator verbally abused or humiliated the survivor in the children's presence?
- Has perpetrator neglected the children when angry at the survivor parent?

*Bancroft, L. & Silverman, J. G. (2002). Assessing Risk to Children from Batterers. Vawanet.org

9. History of neglectful or severely under-involved parenting.

A perpetrator's history of lack of proper attention to his children's needs is particularly relevant in the post-separation context. In our clinical experience and current research, we observe that a perpetrator who has shown little interest in their children may do poorly at protecting their health and safety during visitation, and may fail to meet even their basic emotional needs. In addition, studies indicate that a father's/mother's very low involvement in parenting during a child's early years increases his statistical risk of perpetrating incest (review in Milner, 1998).

Questions about History of Neglectful or Severely Under-Involved Parenting

- Does the perpetrator have a history of disappearing for hours, days or weeks at a time?
- Has perpetrator ever refused to attend to children's medical needs?
- Has perpetrator's lack of attentiveness ever put the children in danger?
- Has perpetrator shown an abrupt interest in the children, perhaps including seeking custody, in response to the dissolution of the parental relationship?

Perpetrator's own knowledge and compassion regarding the children should be tested with such questions as:

- Can you tell me the names of your children's current and past teachers?
- Could you describe each child's infancy?
- What are each child's particular interests, likes, and dislikes? What struggles is each child currently encountering?

- What kind of involvement do you maintain with any children you have from past relationships?

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10. Refusal to accept the end of the relationship, or to accept the father's/mother's decision to begin a new relationship.

A perpetrator's refusal to accept the partner's decision to leave him/her, which often is accompanied by severe jealousy and possessiveness, has been linked to increased dangerousness in perpetrators (Weisz et al., 2000), including danger of homicide (Websdale, 1999), putting children at increased risk. We have observed clinically that those perpetrators who have high levels of these tendencies often also show increased use of children as tools of abuse or control post-separation. They may perceive the children as owned objects and therefore become intimidating if they learn that there is a new man/woman in their children's lives. Finally, even those perpetrators who welcome the end of a relationship should be evaluated for their level of desire to punish the father/mother for perceived transgressions from the past, or to establish paternal dominion over the children.

Questions about History of Placing Children at Physical or Emotional Risk While Abusing their parent

- Is the perpetrator depressed or panicked about the break-up, or insisting that the relationship is not over?
- Is perpetrator stalking the surviving parent?
- Did perpetrator abruptly demand custody or expanded visitation upon learning that the surviving parent had decided definitively not to go back to the perpetrator, or when he/she began a new romantic involvement?
- Has perpetrator ever threatened or assaulted a new partner of the surviving parent, or warned the surviving parent not to let any man/woman other than the perpetrator be around the children?
- Has perpetrator attempted to frighten the children about the surviving parent's new partner, or to induce guilt in them for developing an attachment to the new partner?

*Bancroft, L. & Silverman, J. G. (2002). Assessing Risk to Children from Batterers. Vawanet.org

11. Level of risk to abduct the children.

The elevated risk of abduction by a perpetrator, particularly in cases where the perpetrator has made related threats, is described earlier. Even in the absence of threats, evaluators should investigate indications such as abrupt passport renewals or efforts to get the

children's passports away from the perpetrator, surprise appearances at the children's schools, job seeking in other states or countries, or unexplained travel plans.

12. Substance abuse history.

Perpetrators who abuse substances are an increased risk to physically abuse children (Suh & Abel, 1990), to reoffend violently against the father/mother (Gondolf, 1998; Woffordt et al., 1994), and to commit homicide (Websdale, 1999; Campbell, 1995). Substance abuse has also been linked to increased risk to perpetrate sexual abuse (Becker & Quinsey, 1993).

Even in cases where the perpetrator states that he/she has overcome substance abuse, evaluators need to carefully examine the length and depth of the perpetrator's recovery, including his/her level of insight regarding the addiction, and should make sure that proper ongoing treatment and self-help are in place. Additionally, any tendency on the perpetrator's part to blame his/her violence on the addiction should be treated as a sign of risk for the future even if the perpetrator is in recovery.

13. Mental health history.

Although mental illness is found in only a minority of batterers (Gondolf, 1999), even among those who kill (Websdale, 1999), such problems when present can increase a batterer's dangerousness (Websdale; Campbell et al., 1998) and resistance to change (Edleson & Tolman, 1992). Certain diagnoses, such as anti-social personality disorder, obsessive/compulsive disorder, major depression, and borderline personality disorder have been important contributors to danger in some of our cases. A mentally ill batterer needs proper separate interventions for his abusiveness and for his psychological difficulties.

The absence of mental illness or personality disorder, however, reveals little about a batterer's likelihood to be a safe or responsible parent. Psychological tests and valuations do not predict parenting capacity well even in the absence of domestic violence (Brodzinsky, 1994). Furthermore, mental health testing cannot distinguish a batterer from a non-batterer (O'Leary, 1993), assess dangerousness in batterers (APA Presidential Task Force on Violence and the Family, 1996), or measure propensity to perpetrate incest, (Milner, 1998; Myers, 1997). Psychological evaluation with batterers is therefore useful only for ruling out psychiatric concerns. (For case examples illustrating the above 13 areas to be explored, see Bancroft & Silverman, 2002.)

Once you have information about the perpetrator’s pattern, the survivor’s protective capacities, and the impact of the perpetrator’s pattern on the child, go back to the Safety and Risk Assessment guidance in the MiTEAM manual on page 13. You will use the information you have gathered to make determinations about safety and risk.

Making Safety and Risk Decisions

The information gathered during initial interviews should be used with the MiTEAM Manual Assessment section. The information gathered should be evaluated and criteria applied (i.e. definitions) for each factor to determine the presence of safety and risk concerns to the child and adult. A safety decision will be made and the level of risk to the child will be determined.

Safety Planning

Regardless of the safety and risk decisions, it is important to collaborate with the survivor to build on what they have been doing to promote safety for the survivor and the children. A vast majority of survivors are actively engaging in activities to promote their own safety and the safety of the children. Most survivors use a combination of what is sometimes referred to as "traditional and non-traditional safety planning". Traditional safety planning includes using law enforcement; obtaining an order of protection; leaving/ending the relationship; and going into a domestic violence shelter. Non-traditional safety planning includes placating the perpetrator; having a plan with the children to get away from the abuse; drawing the perpetrator away from the children if he becomes violent; using family, friends, and neighbors; hiding weapons; saving money and/or placing important papers or documents with family, etc.

The beginning of the safety-planning process with a survivor should start always start with something like:

"Can you tell me about some of the things you have done to keep you and the children safe? What has been helpful? What has not?"

As the goal of any safety plan is to achieve child and family safety, it is imperative that each safety plan be individualized to the perpetrator's behaviors and what is likely to work. For instance, if a survivor lives in a very rural community in which it may take a long time for law enforcement to arrive, calling the police may not be something that increases safety. Or, if a perpetrator has a history of violating restraining orders, asking a survivor to obtain an order also may not increase safety.[86]

Some additional tips for safety planning:

[86] Domestic violence advocacy agencies can be an excellent resource for tips on effective safety planning, as well as connecting survivors with services and/or resources. The Michigan Coalition to End Domestic and Sexual Violence (mcedsv.org) can be a helpful resource in locating a center near you.

- Know that as perpetrators often change their behaviors in response to system interventions, adult survivors may change their safety planning efforts. Understand that safety-planning is dynamic and continue to check in with adult survivors about their safety efforts throughout the life of the case.
- Always have separate safety plans for survivors and perpetrators.
- Discuss with your supervisor how best to include documentation involving safety planning in the case record so that is not disclosed to the perpetrator or negatively impacts child/adult survivor safety. Additionally, discuss with legal staff about what can be redacted if the perpetrator requests the record.
- Always ask a survivor if a perpetrator owns or has access to weapons.
- Geography or ending the relationship does not always equal safety. For many survivors, leaving can be the most dangerous time. Always ask if a perpetrator has made threats to kill or harm, or if the survivor has concerns own safety or the children's safety if leaving the house is a part of the safety plan.

Relative Assessment and Placement

As noted in the manual, it is imperative to thoroughly assess relatives and other support persons to determine whether placement/maintaining contact is in the child's best interest. Caseworkers must thoroughly evaluate the potential traumatic impact to children if placed with relatives who may not have protected them from harm, colluded with parents in the harm, disparages a parent or caregiver to the child or interferes with the relationship between the child and caregiver, or may not be able to ensure the physical and psychological safety of the children given their own histories.

Use the detailed practice guidance in the engagement section of the MiTEAM Manual to appropriately assess and engage family members and other support persons.

Documentation

While thorough documentation is a standard in all cases, there are some special considerations in cases involving domestic violence. The Critical Components can be helpful in providing a framework for documentation.

1. Clearly document the perpetrator's pattern of coercive control and group the behaviors together. For example:

Mr. Smith has a history of engaging in a pattern of coercive control and violent behaviors against Ms. Smith and their children, Jaden (8) and Ava (5). Mr. Smith's behaviors have included:

- *Physical abuse, including punching Ms. Smith in the face on numerous occasions, strangling her to the point of her losing consciousness, biting, kicking pushing and restraining her on numerous occasions. Ms. Smith has sustained visual injuries on more than one occasion. Both Jaden and Ava have witnessed their father's physical abuse of their mother and their mother's injuries. In the most recent incident Jaden tried to intervene and Mr. Smith hit him in the face, causing a laceration, swelling, and a black eye.*
- *Controlling behaviors, including controlling all of the finances and giving Ms. Smith an "allowance" even though she is also employed; only allowing the family to interact with his family for holidays and special occasions; not allowing Ms. Smith to participate in work social events*
- *Jealousy and possessiveness, including not allowing Ms. Smith to have a phone; constantly accusing her of cheating if she talks to any male.*
- *Threatening, including threatening to get custody of the children if she leaves.*
- *Verbal abuse, including calling Ms. Smith "fat", "a whore", "a bitch", "trash" and "stupid". Both Jaden and Ava have witnessed their father's verbal abuse.*
- *Emotional abuse, including telling Ms. Smith that she is "just like her mother" (her mother was an addict and died from an overdose when Ms. Smith was 16); that she is "fat and stupid and no one will ever want her" and that the "kids are embarrassed to have her as a mom"*
- *Using systems to "punish" Ms. Smith, including calling the police on her for domestic violence because she scratched him while he strangled her. The police arrested both Mr. and Ms. Smith.*
- *Interfering with employment, including causing Ms. Smith to have to leave at least three jobs due to constant calling and not being home to watch the children, causing her to miss work.*
- *Undermining parenting and authority, including calling Ms. Smith "stupid" in front of the children and undermining daily routines, including bedtime, and rules around homework, TV, and foul language.*
- *Involving his family in the abuse, including PGM routinely calling Ms. Smith a "horrible mother" and a "slob"*

2. Clearly document the actions the perpetrator has taken to harm the children and the adverse impact of the behavior on the children:

Mr. Smith has exposed his children to his physical, verbal, and emotional abuse of his wife. He has also impacted the children by interfering with Ms. Smith's employment that impacted finances and limited the children's access to extra-curricular activities and undermining Ms. Smith's parenting and authority with the children so that now they won't listen to her and tell her that "they're going to tell on her to Daddy".

Jaden:

- *Jaden was physically injured when he tried to intervene. He received a cut, swelling and black eye. Jaden said he was scared his mom would die and that his eye hurt. He also said he was embarrassed to go to school because "everyone would know". As a result of his injury, Jaden missed two days of school.*
- *Jaden said he loves his dad but "sometimes he's not nice to my mom".*
- *Jaden said his mom should "keep herself up better for my dad".*
- *Jaden is worried that his dad will go to jail and that they will be "out on the street".*
- *According to his teacher, Jaden's grades have fallen and he frequently acts up in class. She reported he used to play basketball, but stopped because he told her "my mom won't pay for it".*

Ava:

- *According to the police report, Ava was crying when they arrived at the most recent incident.*
- *Ava said she thought her dad was "going to hurt my mom bad". She said she was scared and cried.*
- *Ava said her dad is "mean to mom, but nice to us" and "gives us pizza".*
- *Ava said her grandmother (PGM) told her that her mom was "stupid and fat" and not to be like her.*
- *Ms. Smith reported that after the latest incident Ava won't go to sleep in her own bed and has had daily tantrums over "small things" and that she is hard to soothe after.*

3. Clearly document the adult survivor's strengths and protective efforts as they relate to the children:

Despite Mr. Smith's pattern of abusive behaviors, Ms. Smith has engaged in numerous actions to provide safety, stability and nurturance for her children, including:

- *Ms. Smith has attended 2 years of college and has plans to finish her degree so that she can be a "good role model for my children".*
- *Ms. Smith is the primary caretaker for the children and the children are medically up to date. She decorated the children's rooms with their favorite colors and let them pick out comforters.*
- *Ms. Smith was cooperative with this worker and allowed me to talk with the children.*
- *Ms. Smith has a history of employment and despite Mr. Smith's attempts to sabotage her jobs, she has been at her current job for 9 months. She said that her boss and co-workers know about her husband's behaviors and put plans in place.*
- *Ms. Smith talks to her sister when she's at work and her sister brings her things at lunch, including clothes for the children and a cell phone.*
- *Ms. Smith appears knowledgeable about parenting, her children, and basic child development. She talked about how she was trying to cook healthier and that she tries*

to keep the children on the same routines. She said she talks to the kids and tells them to go their rooms and not come out when their dad "gets crazy".

- *She attends church with the children as "often as he'll let me".*
- *She said she has been letting Ava sleep with her since the incident and she sings to her and "cuddles".*
- *She said she is worried about Jaden, and that she was "sick" that he got hurt. She said she worries that Jaden thinks he is "the man now". She said she talked with the school to have the school social worker connect with him and she asked her pastor for help in getting Jaden back in basketball.*
- *Ms. Smith has a history of safety planning for herself and her children, by:*
    - *Talking to her boss about her concerns about her husband getting her fired or coming to the workplace. Her boss put a plan in place for Ms. Smith's safety.*
    - *Trying to placate Mr. Smith by trying different things, including soothing, trying to change the subject, agreeing with him, and getting him a beer. She said when she feels things are "starting in" she tells Jaden to take his sister to the other room. She said she told Jaden to "never, ever" try to intervene again.*
    - *Calling the police on more than one occasion and teaching Jaden how to call 911*
    - *Talking to an advocate and getting information about resources.*
    - *Putting money away in case she needs it.*
    - *Giving in to his sexual advances because she didn't him to "go crazy and wake up the children".*
    - *Talking with her sister about caring for the children if she leaves because she doesn't want them to be in a shelter or "shitty apartment". Jaden and Ava spend every Fri and Sat with their aunt and cousins.*

4. Clearly document any substance abuse, mental health or other factors that may be present in the family:

- Finances are a somewhat of a concern with this family and while both parents are employed and have stable housing, they are living "paycheck to paycheck" and Ms. Smith is concerned that if she leaves, she will not be able to afford housing or food.
- Ms. Smith stated she sometimes has bad days where she feels really "hopeless" and "sad".
- Mr. Smith has had a problem with alcohol in the past. Ms. Smith says he's "not as bad now" but he's "gets mean when he drinks".
- Mr. Smith has a history of being abusive to past partners and has been arrested for his abusive behaviors. Mr. Smith has a son by an ex that he has not seen for nine years and does not provide any financial support.

Some additional tips for documentation include:

- Discuss with your supervisor how and where to document specific information regarding survivor's safety-planning so that you both demonstrate that survivor is engaging in protective efforts and the information is not discoverable or unable to be redacted.

- Avoid language that "lumps" the perpetrator and survivor together like "this couple has a history of domestic violence" or "dysfunctional relationship".
- Focus on behaviors and be as specific as possible. It paints a much more accurate picture to say: "He strangled her and bruises of his hand prints were visible on her neck" vs. "Physical abuse".
- Case planning goals should focus on specific behaviors rather than completion of a service a program.[87] What behaviors need to be different in order for the children to be safer?

Teaming

Formation: Safely Form a Family Team

In domestic violence cases, safety is paramount. Whether there are separate or joint meetings, any team members should be carefully selected so as not to compromise ongoing safety or hold adult survivors accountable for perpetrator's behaviors. Safety planning should happen throughout the process. Review information to determine if information gathered from the adult and child survivors can be presented safely to the perpetrator. Look for third party sources, e.g. police report, prior documented CPS history, PPO statements and the perpetrator's own statements as additional or alternative sources of information. Ensure that concerns about the domestic violence perpetrator's behavior are expressed as the agency's concerns instead of a "he said, she said." Partnership with the adult survivor means giving survivor input into how issues of safety and confidentiality are approached.

The following is an adaptation of Family Team Conferences in Domestic Violence Cases: Guidelines for Practice written by Lucy Salcido Carter.[88] Much of the language in this section of the manual was taken word-for-work from "Family Team Conferences in Domestic Violence Cases: Guidelines for Practice".

In creating the family team, one of the primary questions in a domestic violence case is whether it is safe to involve the perpetrator in the meeting. To make this determination, it is important to use the information gathered while assessing the Perpetrator's Pattern. Below are questions that can help with that decision.

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[87] Although referral to treatment or programs may be included as part of a case plan, they should be supportive of the overall goal of behavioral change.

[88] Salcido Carter, L. Family Team Conferences in Domestic Violence Cases: Guidelines for Practice, http://www.childwelfaregroup.org/documents/FTMinDVCasesFVPF.pdf

Key Questions to Determine Perpetrator Inclusion in the Family Team Meeting

- Is the adult survivor and/or children stated that they are afraid of the abuser or demonstrated that they are fearful?
- Will the presence of the perpetrator limit the survivor's, children's, family or friend's ability to freely and actively participate?
- Will the perpetrator's presence influence the survivor to take blame for the perpetrator's behaviors?
- Is the abuser threatening to harm the non-offending parent, the children, other family or friends or self?
- Is the severity and frequency of the violence escalating?
- Has the perpetrator threatened to harm the children or take them away from the survivor?
- Does the abuser or survivor have access to weapons?
- Have weapons been involved in prior assaults?
- Has the criminal justice system been involved? If so, are there pending charges or is there a probation or parole officer assigned to the case?
- Is there a current order of protection in place?
- Has the perpetrator been cooperative with CPS? Is perpetrator able to talk about own behaviors and how perpetrator behaviors have impacted the children in any way? Has perpetrator expressed a willingness to change own behaviors?
- If the abuser has participated in some type of education or treatment program, how has he responded to that intervention?
- Is the abuser or survivor currently using substances?

*Salcido Carter, L. Family Team Conferences in Domestic Violence Cases: Guidelines for Practice, http://www.childwelfaregroup.org/documents/FTMinDVCasesFVPF.pdf

Note that if either the facilitator or adult survivor believe that it is too dangerous to conduct the meeting with the perpetrator present, it should not be done.

Family Team Meeting (FTM) without the Perpetrator

If it is not safe to include the perpetrator, use the key questions above to fully understand and plan for the consequences of that decision. It is crucial to understand how might the perpetrator react to the decision and determine if he/she may try to railroad or undermine decisions made during the meeting. It is also important to think about whether the goals of the meeting be accomplished without the perpetrator's input.

It is possible for the perpetrator to participate without being in the actual meeting. These options include:

- Two separate meetings may be conducted, one with the adult survivor and the children, if appropriate, and another with the perpetrator.
- A service provider who has worked with the abuser may attend the meeting as perpetrator's representative with permission.
- The perpetrator may write a letter, responding to the questions being asked in the conference, to be read by a representative.
- Perpetrator may videotape own response to the questions being asked in the conference, and inform the participants of desires and wishes.

If the perpetrator will be present for the meeting, it is critical to prepare in advance using the key questions above.

Preparing with the Adult Survivor

A facilitator with training in domestic violence should work with the adult survivor prior to the meeting to assess the level of danger and to help the survivor make a plan to protect self and the children. The following are questions that should be explored with the adult survivor prior to the meeting:

Key Questions to Help Prepare the Adult Survivor

- Are there any specific topics to avoid?
- Does the survivor have safety concerns about anyone else who may also be attending the meeting, such as survivor's child or the child welfare worker?
- Does survivor want to discuss the domestic violence in the FTM?
- How safe does survivor feel discussing the domestic violence with the abuser present?
- If the children will be present, does the survivor want to discuss the violence?
- What does survivor want to do if the children or other parties bring it up?
- What has survivor already discussed with the children regarding the violence?
- How have the children been impacted by the violence?
- What will the impact be on the children if their parent's violence is discussed in the conference without parent present? With parent present?
- How will the perpetrator react if own violence towards survivor is brought up? By survivor? By others?
- What has happened in the past when perpetrator's violence has been discussed?
- Are there other community or family members that perpetrator will want at the meeting? How does the survivor feel about that?
- Does survivor want someone who is an expert in domestic violence, such as a domestic violence victim advocate, or a perpetrator treatment counselor who is working with the abuser, present at the conference? If so, how might the abuser react?

- Does survivor feel that he/she can safely speak out about own wishes and concerns if they are different from those of the abuser?
- How will the facilitator know if the survivor begins to feel afraid during the conference? Can they plan to signal each other if the survivor does begin to feel afraid?
- Of all the people survivor wants to invite to the conference, with whom has survivor discussed the domestic violence? What have their reactions been?
- What does survivor think the reaction of people at the conference will be to disclosure of the violence? Will they support survivor need to be safe and perpetrator need to be non-violent?
- What does survivor fear could go wrong in the FTM? What would be the consequences?
- To avoid surprises, what else does the facilitator need to know about survivor and survivor's family? If, for example, an aunt is invited, what might she tell the group that would be a surprise?

Preparing with the Perpetrator

Similarly, a facilitator trained in perpetrator accountability should work with the perpetrator prior to the FTM to determine the extent to which perpetrator has taken responsibility for own actions and to understand the degree of entitlement as it relates to perpetrator's behavior, the children, and the adult survivor. If there is no facilitator trained in perpetrator accountability, the facilitator should consult with a batterer intervention program prior to this discussion and prior to the FTM (if the perpetrator will be attending the meeting).

If it is determined that the perpetrator will participate in the FTM with the survivor, the questions below will help the facilitator determine if and how the perpetrator can be a constructive participant in the FTM.

Key Questions to Help Prepare the Perpetrator

- Are there any specific topics to avoid?
- Would it be helpful if a perpetrator intervention program staff person attended the meeting?
- If the survivor wants to discuss the domestic violence, how will perpetrator manage that discussion?
- Are there other community or family members that he wants at the meeting? How does perpetrator think the survivor will react to that? Will these other people support survivor's need to be safe and perpetrator's need to be non-violent?
- Have any of the people attending the meeting seen perpetrator escalate situations when disagreements arose in the past? Will this be a fear or concern of other meeting participants? How can that concern be addressed?

- How can perpetrator let the facilitator know that perpetrator needs a break during the meeting because of topics being discussed?
- If it has been agreed that domestic violence will not be discussed, how will perpetrator respond if another party brings it up?
- What has happened in the past when the violence has been discussed?
- What has perpetrator discussed with the children regarding the violence?
- How have the children been affected by the violence?
- What might the impact be on the children if the violence is discussed in their presence in the meeting?
- How can perpetrator convey to the survivor that survivor can safely speak out about own wishes and concerns if they are different from perpetrator?
- What does perpetrator fear could go wrong in the FTM? What might the consequences of this be?
- To avoid surprises, what else does the facilitator need to know about perpetrator and his family?

*Salcido Carter, L. Family Team Conferences in Domestic Violence Cases: Guidelines for Practice, http://www.childwelfaregroup.org/documents/FTMinDVCasesFVPF.pdf

If the perpetrator does not participate in the meeting, it is still important to keep perpetrator visible in the life of the case by continuing to engage with perpetrator around case-planning and safety planning, support positive parenting/visitation (if applicable) and be clear about expectations for behavioral change and the timelines involved.

Preparing other Participants

In domestic violence cases, it may be helpful to talk with the perpetrator and survivor about having an advocate for domestic violence survivors at the table and a provider of perpetrator intervention services. These service providers have unique expertise and may be able to offer solutions to problems, provide services, and participate in case planning activities. Note that it is important to assess the situation before inviting an advocate. Survivors may not want an advocate present and some advocates may disprove of the process to such a degree that their presence could complicate the meeting and make it more difficult to facilitate.

The Perpetrator Intervention Program Staff's Role:

- Work with the facilitator to prepare the perpetrator for the meeting, if abuser is going to attend.
- If the family is known to the staff person, provide information about the situation and the perpetrator's progress in any intervention programs he is attending.
- Provide facilitation support as needed, and especially if the conflict escalates
- Model respectful listening of the survivor's needs and goals.

- Offer follow-up services for the perpetrator.

The Advocate's Role:

- Support the goals of the FTM.
- Support the survivor.
- If the family is known to the advocate, provide information about the situation.
- Debunk misinformation that might come up in the meeting regarding domestic violence.
- If the abuser attends the meeting, work with the facilitator and survivor to watch for warning signs of escalating conflict in the FTM.
- Provide follow-up support to the survivor and her children.

Preparing for the FTM

The process of assessing participants individually to determine their ability to support the specific goals of the FTM will provide an opportunity to learn more about the family and about the domestic violence dynamics. This will make the facilitator better prepared for whatever happens in the meeting.

It is important to make an agreement with each participant regarding the ground rules for participation. If a family member wants to bring up domestic violence, but the survivor does not believe it is safe, the facilitator can acknowledge the family member's concerns but coach that family member not to bring up domestic violence in the meeting.

Involving the Children

To determine if children should participate in the meeting, the facilitator will need to assess whether:

1. The children are developmentally capable of participating.
2. The children will benefit from the FTM.
3. The meeting will cause further trauma to the children.
4. The children can help achieve the desired outcomes for the meeting.

The facilitator will also need to consider how the children's presence may inhibit honest conversation by the adults, and how the children will feel about discussing the violence in front of the perpetrator, if he/she is there. One option may be for the children to participate in only part of the meeting.

Follow-Up

There is always a risk of danger that domestic violence cases will escalate regardless of the pre-FTM assessment and meeting preparation. Therefore, it is important to follow up with both the survivor and the perpetrator following the meeting. The timing of the follow-up will depend on

the level of risk as assessed by the facilitator and the survivor. It is also important for someone who has expertise in working with abusers to check in to see how the perpetrator is faring after the meeting.

The caseworker and survivor should develop a plan for how the caseworker can get feedback after the conference about the survivor's safety. When possible, meaning the survivor says it is safe, a home visit can be made to make sure the survivor and the children are safe. Note that this should be done only in situations where the safety of the survivor, children and caseworker will not be compromised. Below are key follow up questions for the survivor:

Key Follow-Up Questions for the Adult Survivor

If the perpetrator was present at the FTM, and his violence was discussed, the caseworker should always call the survivor within 24 hours, and ask such questions as:

- Did you discuss the FTM with perpetrator?
- Have you been afraid of perpetrator since the FTM?
- Has he been or threatened to be violent since?
- What was the impact of the disclosure on you, on perpetrator, and on the children?
- If there have been negative repercussions from the disclosure of domestic violence in the FTM, how can the agency support you in increasing your and your children's safety?

*Salcido Carter, L. Family Team Conferences in Domestic Violence Cases: Guidelines for Practice, http://www.childwelfaregroup.org/documents/FTMinDVCasesFVPF.pdf

A face-to-face follow-up meeting with the perpetrator should also be held, especially if the perpetrator was present at the meeting. Questions to ask the perpetrator include:

Key Follow-Up Questions for the Perpetrator

- Did you discuss the FTM with your partner?
- Have there been any episodes of violence or threats of violence since the meeting?
- What was the impact on you of the disclosure of domestic violence? The impact on survivor? On the children?
- What aspects of the meeting worried you the most or made you feel the most uncomfortable?
- What has happened since the meeting to improve your situation? To worsen it?
- Was the plan that was developed put in place?
- Would you recommend this type of planning process to other families? Why or why not?

*Salcido Carter, L. Family Team Conferences in Domestic Violence Cases: Guidelines for Practice, http://www.childwelfaregroup.org/documents/FTMinDVCasesFVPF.pdf

The caseworker may also want to speak with the other participants to get their perspective on the meeting. A discussion of what worked and did not work can inform future FTMs with that family and can shape strategies for FTMs in other domestic violence cases, as well.

CASE PLANNING

The information in this section comes directly from a tool developed by David Mandel and Associates: "Case Planning with Domestic Violence Perpetrators in Child Welfare Cases."[89]

The following are items that could be part of case or safety plan with a domestic violence perpetrator involved with child welfare. This list is suggestive but not exhaustive. Other items, not included here, might also be useful for promoting the safety and well-being of the children and family. To be most effective in reducing danger and harm to the children, case plans should be specific to what is known about the perpetrator's behaviors and how those behaviors are impacting the family. This baseline helps determine the focus of behavior change expectations and provides the best chance for determining real behavior change.

Each item below is accompanied by a brief description of the item's purpose and a suggestion for evaluating achievement of the item. Please note the overall emphasis of the tasks is on behavior change, not simply on attendance or completion of a service.

To best ensure child and family safety, it is also suggested that any interventions and case planning with perpetrators should occur in partnership with the domestic violence survivor.

1. **Will demonstrate safe behaviors by ceasing any further physical violence and physically intimidating behaviors towards any member of the household (including pets).**

   Purpose: To set clear boundaries around future violence. To end physical harm and fear of further violence for all members of the household.

   Success: No reported violence by any member of household, extended family members or other witnesses, and no observed indication of violence, i.e. bruises, no new arrests.

2. **Will demonstrate safe behaviors by using non-violent, non-abusive and non-intimidating language towards any member of household. This includes verbal**

[89] David Mandel and Associates: "Case Planning with Domestic Violence Perpetrators in Child Welfare Cases."

threats (defined or undefined), yelling and screaming, put-downs, name-calling and foul language.

Purpose: To end climate of fear in the household.

Success: No reported intimidating or threatening behavior. No reported or observed damage to household, especially holes in wall, etc. The CPS Worker will look for missing or broken objects in household. Household members will be interviewed for presence of threats or intimidating behavior.

3. **Will create a safe environment by removing all weapons from the premises including guns, bows and arrows, shotguns, hunting rifles. The weapons will need to be sold or given to law enforcement for safekeeping.**

   Purpose: To reduce likelihood that identified weapons will be used to assault or intimidate members of the household.

   Success: Perpetrator will produce bill of sale or receipt from police.

4. **Will seek out an evaluation and comply with recommendations of domestic violence counseling to address issues of control and abuse. Anger management or couples' counseling will not be accepted as treatment in domestic violence cases. The treatment will have as its goals:**

   a. The cessation of violent, abusive and controlling behaviors towards the adult survivor.

   b. The cessation of violent and abusive behaviors toward any children in the home.

   c. Education about the effects of violence, abuse and controlling behaviors on family members.

   d. Collateral contact with the adult survivor and the referring agencies for exchange of information about the purpose and limitations of the counseling; the perpetrator's pattern of abuse and violence and other relevant information about the perpetrator.

   Purpose: To engage perpetrator in appropriate counseling with the goal of ending coercive control and physical violence over family. To obtain a professional evaluation of a perpetrator's motivation to change abusive behavior, and perpetrator's understanding of the impact of the abusive behaviors.

Success: Completion of required evaluation and (when recommended) counseling sessions. Reports from adult survivor and children that abusive behavior has ended. Victim reports greatly safety and freedom. Commonly recommended lengths of counseling range from six months to one year. Actual length of counseling determined on an individual basis.

5. **Will demonstrate safe behaviors by ceasing to use physical discipline with children and using discipline techniques that are non-abusive.**

   Purpose: To create clear boundaries around discipline in order to prevent child abuse.

   Success: No bruises or other indications of physical discipline. No reports from anyone in the family of further physical discipline.

6. **Will be able to acknowledge a majority of past abusive and violent behavior towards partner and children, which will include:**

   a. Detailing the abusive nature of specific actions, physical and non-physical.

   b. Display an understanding of the impact of these behaviors on his partner, children and himself.

   c. Display an ability to discuss his own abusive actions without blaming others or outside circumstances for his behavior.

   d. Be able to demonstrate non-abusive, non-violent behavior when in prior similar circumstances he would have become violent or abusive.

   Purpose: The perpetrator will be able to demonstrate to others, including caseworkers and family members, non-abusive behavior and a sense of responsibility for the abusive behavior.

   Success: Can do the above things.

7. **When needed, will seek and follow recommendations of a substance abuse evaluation.**

   Purpose: While substance abuse does not cause domestic violence, co-occurrence is often common. When substance abuse is suspected, it must be addressed through a separate evaluation and counseling process from the domestic violence. Active substance abuse may increase the perpetrator's dangerousness and/or inhibit ability to benefit from domestic violence counseling.

Success: When there is an identified substance abuse problem, the perpetrator remains clean and sober. The substance abuse evaluator indicates no need for substance abuse treatment.

8. **Will stay involved with any mental health counseling, and follow doctor's recommendations, including taking prescribed medications.**

   Purpose: While mental health issues (e.g. depression) do not cause domestic violence, they can co-occur with domestic violence in perpetrators. Untreated mental health concerns may increase the dangerousness of the perpetrator and/or hinder own ability to engage in domestic violence counseling.

   Success: The perpetrator maintains the recommended mental health treatment regimen, e.g. counseling sessions, medications.

9. **Will support the partner's parenting including not interfering with access to phone, vehicle or other forms of communication and transportation.**

   Purpose: The perpetrator cannot isolate the adult survivor/children from access to friends, family, and employment by controlling communication and transportation.

   Success: The adult survivor/children report access to existing communication and transportation resources. Social worker observes access to existing communication and transportation resources.

10. **Will share with partner all relevant information to income and family financial circumstances.**

    Purpose: This expectation is intended to reduce the perpetrator's financial control over his partner and the family.

    Success: The perpetrator provides the adult survivor with pay stubs and information on bank accounts and other assets.

11. **Will disclose to adult partner all information relevant to child abuse and domestic violence, including prior arrests, open cases with other children at the Department, and probation.**

    Purpose: In order to maintain control or avoid negative consequences, perpetrators will often lie or withhold information from partners. By requiring perpetrator to share information about perpetrator's prior criminal history, current criminal justice involvement, domestic violence and/or child abuse history will provide the partner with information relevant for survivor's risk analysis and safety planning.

Success: The survivor reports that the perpetrator has shared with the survivor all known information about perpetrator's prior criminal history, current criminal justice involvement, domestic violence and/or child abuse history.

12. **Respect partner's (and/or former partner's) boundaries including no unwanted or unexpected visits to survivor's home or office (can include survivor's family or other identified relatives).**

    Purpose: Perpetrators regularly attempt to pressure or coerce a partner who has left to return to perpetrator. This behavior can be very threatening and lead to physical violence.

    Success: No reports of threatening or harassing behaviors.

13. **Respect all existing court orders, including protective, restraining, custody and visitation and child support orders.**

    Purpose: Perpetrators often defy court orders. Including "respect all existing court orders" in child protection expectations underscores the importance of those orders to the safety and well-being of the children and emphasizes the need for the client to comply with other court orders as a condition of complying with the Department and/or juvenile court.

    Success: All reports (survivor, other courts) indicate that the perpetrator is complying with all existing court orders.

14. **In lieu of formal child support order, will maintain financial support for perpetrator's children regardless of whether perpetrator resides with them or not.**

    Purpose: To reduce the perpetrator's ability to control or coerce the partner through financial pressure. To articulate the expectation that the perpetrator will provide for the basic needs of the children regardless of the status of perpetrator's relationship with their other parent.

    Success: The CPS worker/Social Worker verifies that the perpetrator is maintaining perpetrator's financial support of the children.

15. **Will support all reasonable efforts to provide his child(ren) with appropriate services including childcare, healthcare (e.g. well-baby visits) and will not interfere with the other parent's efforts to seek out services for themselves and the children.**

Purpose: To articulate the expectation that the perpetrator will provide support for the physical and emotional needs of the children regardless of the status of perpetrator's relationship with the other parent and to prevent isolation of survivor and children from necessary services.

Success: The survivor/children report access to services.

CASE PLAN IMPLEMENTATION

The key principals of the *Safe and Together*™ approach have been addressed in the items above. These principles should be used in combination with the Case Plan Implementation section of the MiTEAM Manual:

1. Continually assess perpetrator patterns and behavior as you are working with the family.
2. Never forget that Domestic Violence is not caused by the survivor and cannot be solved by the survivor. You do, however, need to support the survivor, listen when survivor says feeling not safe, and hold the perpetrator accountable for own behavior in a way that will not put the adult or child survivors in danger.
3. If the perpetrator will not engage in case plan implementation, don't hold the survivor responsible.
4. Use the domestic violence and batterer intervention experts in your community for guidance if needed (as long as doing so is acceptable to the survivor and will not jeopardize survivor's safety or the safety of the children).
5. Safety plan, safety plan, safety plan.

Placement Planning

The key principals of the *Safe and Together*™ approach have been addressed in the items above. These principles should be used in combination with the Placement Planning section of the MiTEAM Manual.

There are a few specific items related to domestic violence and placement planning that are important to remember:

1. As part of the assessment of kin placement is a determination of the kin caregivers' ability to provide a safe stable environment for the children. For example, in domestic violence cases, placement with the family of the alleged domestic violence perpetrator must examined closely for safety, issues of access to the child by the perpetrator and denial of the adult survivor's access to the child by the perpetrator's kin.
2. Include the relative caregivers and foster parents in safety planning, including planning around their own safety.

Mentoring

The key principals of the *Safe and Together*™ approach have been addressed in the items above. These principles should be used in combination with the Mentoring section of the MiTEAM Manual. Being aware of the safety of the adult and child survivor are paramount. Therefore, when following the mentoring guidance in the MiTEAM Manual in cases involving domestic violence, remember to regularly check in with the survivor about safety.

Appendix B: Manual Development Stakeholders

Core teams were established to focus on areas that had been identified by MDHHS staff and external stakeholders as needing further development. These areas included the assessment, engagement, case planning, case plan implementation and placement processes. These core teams were comprised of public and private agency caseworkers, supervisors and section managers, as well as central office staff persons responsible for MiTEAM, continuous quality improvement, foster care and adoption, training, CPS and placement staff.

Engagement Core Team:

Brandi Campbell	Ingham County MDHHS
Theodore Jay	Clinton County MDHHS
Jennifer Parks	Ingham County MDHHS
Royanda Amos	Kalamazoo County MDHHS
Laura Lovell	Mecosta/Osceola County MDHHS
Candice Stokes	Orchards Children's Services
Danielle Lawler	Lutheran Social Services of Michigan
Bob Davis	Lenawee County MDHHS

Assessment Core Team:

Hollie Hosford	Bethany Christian Services
Shay Mavis	Foster Care Source
Jamie Lovelace	Clinton-Gratiot County MDHHS
Jennifer Ryckman	Ingham County MDHHS
Wiley Boulding	Kalamazoo County MDHHS
Carie Marvin	Mecosta/Osceola County MDHHS
Melanie Rand	Ingham County MDHHS
Deb Disler	D.A. Blodgett
Deborah Palaszek	Foster Care Source

Case Planning and Case Plan Implementation Core Team:

Jaclyn Caroffino	Jackson County MDHHS
Scott Campau	Clinton-Gratiot MDHHS
Kevin Sellers	Lenawee County MDHHS
Courtney Villarreal	Lenawee County MDHHS
Lori Curry	MDHHS Washtenaw County
Angela Mitchell	Bethany Christian Services

Placement Planning Core Team:

Lalemma Hudnell	Kent County MDHHS
Lesa Brenner	Kalamazoo County MDHHS
Lori Curry	Washtenaw County MDHHS
Kevin Sellers	Lenawee County MDHHS

Courtney Villarreal	Lenawee County MDHHS
Angela Mitchell	Bethany Christian Services
Jamie Dillon	Lenawee County MDHHS
Jaclyn Caroffino	Jackson County MDHHS
Audrey Dodgson	D.A. Blodgett
Rebecca Rasmussen	Mecosta/Osceola County MDHHS
Vicki Orleans	Orchards Children's Services

Central Office Participants:

Wendy Campau	MDHHS Central Office
Nancy Rostoni	MDHHS Central Office
Tracie Kress	MDHHS Central Office
Jemar Sutton	MDHHS Central Office
Phil Dickinson	MDHHS Central Office
Wende Abernathy-Perkins	MDHHS Central Office
Monica Sturdivant	MDHHS Central Office
Rose Clyne	MDHHS Central Office
Kelly Sesti	MDHHS Central Office
Sasha Furney	MDHHS Central Office
Suzanne Stiles-Burke	MDHHS Central Office
Harmony Scalet	MDHHS Central Office
Elaine Carpenter	MDHHS Central Office
Adiah Jones	MDHHS Central Office
Ellicia Jackson	MDHHS Central Office
Anna Donaldson	MDHHS Central Office
Renee Gonzales	MDHHS Central Office
Bill Johnson	MDHHS Central Office
Colin Parks	MDHHS Central Office

Office of Workforce Development and Training Participants:

Laura Schneider	Office of Workforce Development and Training
Michele Davenport	Office of Workforce Development and Training

Center for the Support of Families Participants:

Will Hornsby	Center for the Support of Families
Elizabeth Black	Center for the Support of Families
Cindi Manuel	Center for the Support of Families
Jerry Milner	Center for the Support of Families
Lori Woodruff	Center for the Support of Families
Danielle Nabinger	Center for the Support of Families
Marge Gildner	Center for the Support of Families
Tori Russell	Center for the Support of Families

Children's Trauma Assessment Center Participants:

James Henry	Children's Trauma Assessment Center
Amy Perricone	Children's Trauma Assessment Center

David Mandel and Associates Participants

David Mandel	David Mandel and Associates
Bridget Reilly	David Mandel and Associates

- **Developing materials to inform core team members:** Materials were developed to help ensure core team members were able to fully participate in an informed manner. These materials included a summary of current MiTEAM content in these core areas, Modified Settlement Agreement (MSA) and Child and Family Service Review (CFSR) requirements, a beginning idea of how caseworkers and supervisors would practice in each of these areas, an assessment of guidance available in each of these areas and the sufficiency of this guidance, as well as an assessment of what supervisors needed to do to support practice in each of these areas.

- **Convening meetings of each of the core teams to get feedback:** In-person meetings of each of the core teams were held in July and August 2013. Conference calls were held with each of the core teams in October. Valuable feedback was provided by core team members during each of these meetings.

- **Incorporating written feedback from core team members:** Core team members sent additional tools, forms, practice guidance and strategies to help guide the development of further content in each of these practice areas. Core team members were invited to submit written feedback in November, which many of them did.

- **Organizing in-person working sessions**: Working sessions were held in September and October 2013 with the primary persons responsible for further developing the content of MiTEAM. These were opportunities to discuss feedback from core team members, consider integration with the Quality Service Review (QSR), agree on the format and presentation for the content and delineate roles and responsibilities for content development, writing and editing.

- **Incorporating written material and feedback from the Children's Trauma Assessment Center:** Dr. Jim Henry developed content for the manual and reviewed and provided feedback on the entire draft manual between October 2013 and January 2014. Amy Perricone provided additional language for the manual. Proposed content and written feedback were incorporated into the manual between January 2014 and May 2014.

- **Incorporating written material and feedback from David Mandel and Associates:**

David Mandel and associates provided additional guidance using their The *Safe and Together*™ approach for how to better interact with perpetrators and survivors of domestic violence. The approach supports the MiTEAM competencies of engagement, teaming, assessment and mentoring as it relates to domestic violence.

- Phased, Integrated Approach to Implementation Using Key Systemic Supports, Outcomes and Performance Indicators

Leadership and staff at all levels have been working to ensure that key systemic supports are in place and that agreement has been reached on the key outcomes and indicators of performance that will be monitored and how these will be monitored during initial implementation.

MDHHS is implementing an enhancement to the original MiTEAM roll out in 2012 in concert with key systemic supports and close monitoring of identified performance indicators in place in four pilot counties. Enhancements are now being implemented statewide after piloting. The approach will be informed by and finalized based on an assessment of the implementation in the pilot counties. This implementation work will demonstrate for the rest of the state how practice is consistent with what MiTEAM actually looks like, so that those pilot counties can then serve as a model for other counties in the enhancement process. Progress is being made to ensure that key systemic supports are in place to support initial implementation. Implementation teams are forming, implementation plans and plans to regularly use data are being developed and ideas for training and coaching are being finalized. The manual is ready for distribution to support the phased enhancement of MiTEAM. Public and private agency staff in the pilot counties will have opportunities for further input on the content of the manual during the early stages of implementation.

MDHHS, with input from external stakeholders, has identified key outcomes and indicators of performance that will be monitored during initial implementation.

MDHHS is using the term “key outcomes” (i.e., recurrence of maltreatment within six months) to describe those outcomes that help the department understand safety and permanency outcomes for children and families involved in the system. These are outlined below:

- Recurrence of maltreatment within six (6) months.
- Maltreatment in foster care.
- Timeliness and permanency of reunification.
- Timeliness and permanency of adoption.
- Permanency for children who have been in foster care for long periods of time.
- Placement stability while in foster care.

MDHHS is using the term “key performance indicators” (KPIs) (e.g., children visiting with their parents) to describe the implementation of Key Caseworker Activities outlined in the manual that the department believes will help improve outcomes for children and families. These are outlined below:

- Child welfare professionals will ensure completion of the initial face-to-face contacts in a time frame required by policy for CPS investigations.
- Child welfare professionals will visit children assigned to their workload as required by policy.
- Child welfare professionals will ensure children placed in unlicensed, relative placements have timely initial home studies and licensing waivers.
- Child welfare professionals will ensure children in care are provided updated and current medical, dental and mental health examinations and when necessary, appropriate follow up treatment.
- Child welfare professionals will develop and complete timely and thorough trauma-informed and resiliency based case plans in cooperation with children and their parents and current caregivers.
- Child welfare professionals will ensure children with a reunification goal will visit with their parents, if those parents are available.
- Child welfare professionals will ensure older youth aging out of the foster care system are engaged in a formal 90-day discharge planning meeting to support their transition to independence.