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In 2013, DHS established a collective set of strategies to implement long-term, systemic reforms in Michigan's child welfare system. That set of strategies, commonly referred to as the Strengthening Our Focus on Children and Families approach includes three primary components: an enhanced, trauma-informed MiTEAM practice model, an overarching continuous quality improvement approach, and development of a performance-based child welfare system. Attached you will find a comprehensive document that provides a detailed explanation of the Strengthening Our Focus approach and includes the enhanced Michigan Practice Model Manual.

DHS is moving forward with a belief that safety, permanency and well-being outcomes for children and families in Michigan will improve significantly through: 1) defining these three components; 2) integrating them into one phased, integrated approach to implementation; and 3) relying on county and private agency leadership to drive implementation with support from the state office. This will serve as a foundation for child welfare services to be delivered in an environment where there are clear expectations about the way in which services are delivered and the existence of an administrative teaming structure capable of assessing the systemic needs, and as needed, making adjustments to meet the needs of children and families.

The attached materials are being used in the Champion Counties of Kalamazoo, Lenawee, Mecosta/Osceola, and Kent to guide their initial implementation of these strategies. The DHS and private agency staff in these four communities have been instrumental in not only developing these strategies alongside children's services staff from central office, but are also the first to test the strategies in practice over the course of the next year. The Children's Services Administration (CSA) and the child welfare staff in the implementing counties will assess the effectiveness of these efforts in order to modify and improve the plan for implementation for the rest of the state. These documents are being shared at this time to document the comprehensive strategies that will be utilized for initial implementation with the first counties. Lessons learned yet this year will also assist the CSA contemplate ways to accelerate implementation statewide and as such, will cause an update to this document and quite possibly the Michigan Practice Model Manual sometime early next year.

While Kalamazoo, Lenawee, Mecosta/Osceola, and Kent are implementing these new strategies and revised materials, the rest of the state is expected to continue implementation of the MiTEAM case practice model since the core activities in MiTEAM will still be applicable in the enhanced MiTEAM roll-out. It is anticipated that as local DHS and private agency leadership and staff become familiar with the Strengthening Our Focus strategies and Practice Model Manual, new opportunities will be created to share and begin development of

some of the most basic elements prior to formal implementation in each county. Within the next couple of months, we intend to begin engaging leadership and staff in non-implementing counties to participate in pre-planning phase activities to help prepare them to move forward with efficiency during their actual planning and implementation phases.

It is important to recognize that DHS is paying particular attention to the process of implementation and utilizing the guidance of national child welfare experts, trauma experts, and current research in implementation science and continuous quality improvement to ensure these efforts are sustainable and contribute to the enhancement of core child welfare practice. The development and planning that has occurred over the last two years has placed high priority on building upon the strengths of the already existing MiTEAM practice model and valuing and prioritizing the input of front line child welfare professionals. The leadership and dedication from the DHS and private agency staff, managers and directors in Kalamazoo, Lenawee, Mecosta/Osceola, and Kent counties have been crucial to this endeavor and will serve as a model to the rest of the state and the nation as child welfare professionals take notice of the innovations and resulting outcomes in Michigan.

These materials will be posted on the internal and public DHS websites for future reference. You can also see a brief video from CSA Director, Steve Yager, on this topic at is http://youtu.be/kB_fUnA2krA.

Attachments:

- *Strengthening Our Focus on Children and Families: Michigan's Approach to the Implementation of MiTEAM and Continuous Quality Improvement in a Performance-Based Child Welfare System (July 2014)*

Strengthening Our Focus on Children and Families:

Michigan's Approach to the Implementation of MITEAM and CQI in a Performance-Based Child Welfare System

Michigan Department of Human Services
Children's Services Administration
July 2014

Acknowledgments

The Michigan Department of Human Services would like to acknowledge the involvement and participation of the many public and private agency child welfare professionals across the State of Michigan who made the creation of this document possible. State office staff in the department's Children's Services Administration provided the necessary leadership and oversight and the specific assistance offered by front line child welfare staff in Kalamazoo, Kent, Lenawee, Mecosta, and Osceola counties was invaluable in the development and finalization of the content contained here.

The department would also like to acknowledge the significant contributions of experts in the field of human services and child welfare, the Center for the Support of Families (CSF) and the Children's Trauma Assessment Center (CTAC) at Western Michigan University. The Michigan Federation for Children and Families also provided assistance with the graphic arts contributions of Rose Homa.

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Overview

The Michigan child welfare system has been operating under a federal consent decree since 2008, resulting from a class action lawsuit brought against the state by Children's Rights, Inc. in 2006. In July 2011, following changes in the Department of Human Services (DHS) administration, DHS was successful in renegotiating the Consent Decree through a court-approved modified settlement agreement (MSA). Although DHS had forward momentum in efforts to comply with early deliverables associated with the MSA and to organize tracking, programmatic, and support functions that focus on technical compliance with requirements, little headway was made in identifying the strengths and challenges of improving systemic and high-level outcomes for children and families served by the child welfare system.

In 2012, the DHS Children's Services Administration, in consultation with national health and human services experts at the Center for the Support of Families (CSF), determined that a modified focus and approach to improving the child welfare system in Michigan was necessary. Following a period of assessment, a conceptual framework was established to focus on the alignment of critical system domains.

During this time, DHS developed mission and vision statements to guide efforts to strengthen its focus on children and families involved in the child welfare system, as follows:

Mission: DHS 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 through a trauma-informed approach.

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.
- 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.

Starting with this clearly articulated vision of what the child welfare system would look like and then translating this vision into specific trauma-informed practices with children and families, Michigan defined expected outcomes of those practices and monitoring activities that would help leadership at all levels understand the extent to which these expectations would be met. Underlying the domains are the systemic supports needed to reinforce desired practice and outcomes and ensure that the vision drives practice and that measurement and monitoring reinforce it.

In 2013, DHS extended its collaborative efforts with CSF and established a collective set of strategies to implement long-term, systemic reforms in Michigan's child welfare system. That set of strategies, commonly referred to as the Strengthening Our Focus on Children and Families Approach, includes three primary components.

These are described in detail throughout the body of this document:

- MiTEAM Practice Model.
- Overarching Continuous Quality Improvement (CQI) Approach.
- Performance-Based Child Welfare System.

DHS is moving forward with a belief that safety, permanency and well-being outcomes for children and families in Michigan will improve significantly through: 1) defining these three components; 2) integrating them into one phased, integrated approach to implementation; and 3) relying on county and private agency leadership to drive implementation with support from the state office. It is the intent this will serve as a foundation for child welfare services to be delivered in an environment where there are clear expectations about the way in which services are delivered and the existence of an infrastructure capable of assessing the systemic needs, and as needed, making adjustments to meet the needs of children and families.

The implementation process itself is critical to ensuring that the reforms are implemented with fidelity to the desired model, that the groundwork and planning to support the reforms are integrated and in place, and the process of implementation occurs at a pace that allows for evaluation and adjustments along the way.

One of the primary assumptions undergirding the approach is that there will be a reliance on county leadership to drive county implementation. For the practice model to come to life for children and families, much of the work of implementation must happen on the county level. Most (90 percent might be a good estimate) of the impact on children and families will result from implementation efforts led by counties and private agencies that take advantage of support made available from the state office through kick-off sessions, coaching labs, help in establishing baseline measures, offering financial incentives for private agencies that improve outcomes, etc.

Each county has unique priorities, strengths, pressure points and areas of vulnerability that must be understood before establishing a theory of change or the set of assumptions that undergird the pathway to change for children and families who have come to the attention of the foster care system in that county. Here is an example.

> *County A posits that when children in foster care have regular, natural and ongoing time with their birth parents and formal and informal supports are competently identified and engaged to be a part of planning efforts, children will return home more often and more quickly than in the past.*

Once a theory of change or set of assumptions is agreed upon, each county will need to consider: 1) what it will take to make this happen for children and families with a high level of quality; and 2) how they will know (i.e. Quality Service Review (QSR), fidelity measures, key performance indicators and outcomes) they are doing so with a high level of quality and how often they will know it. This will require considerable effort on the part of the county implementation team and subteams to identify the strategies and action steps that will allow these improvements to happen for all children and then document these decisions in the county implementation plan. Particularly for the data measures, especially during the early implementation of MiSACWIS, it will require close collaboration between the county CQI/data analysis subteams and the state level CQI/MiTEAM subteam to ensure data needs are being agreed upon and met.

Caseworkers and supervisors may be asked to participate in county efforts to plan for implementation. This may mean, for example, being a member of a county-subteam, helping to develop a county implementation plan or theory of change.

The figure below depicts the role of county and private agency leadership in leading the effort to bring the practice model to life for children and families within their own area of the state.

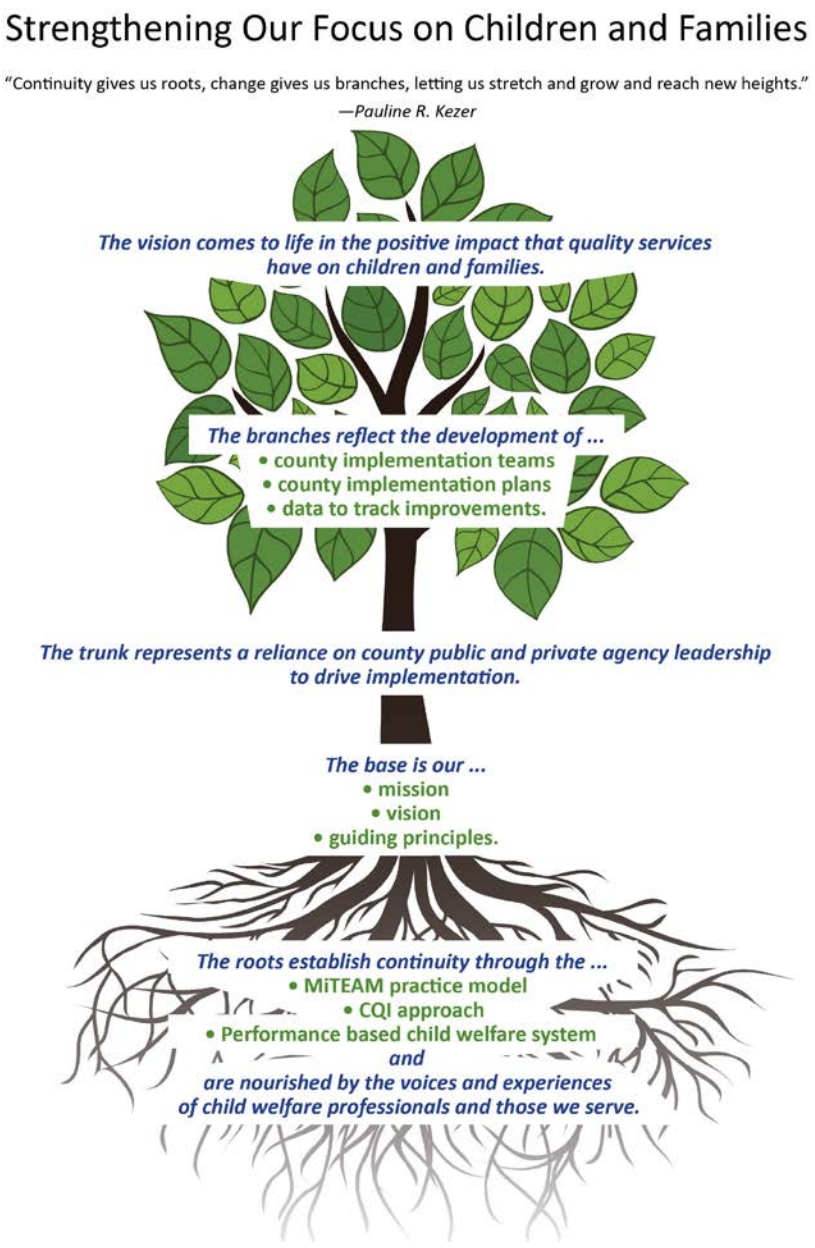
The roots establish continuity through the practice model, CQI and a performance-based child welfare system and are nourished by the voices and experiences of child welfare professionals and those we serve. The state in partnership with child welfare professionals at all levels has spent a good amount of time underground -- to use the analogy of roots underneath a tree –- developing a clear and strong practice model, approach to continuous quality improvement and a performance-based child welfare system. These roots establish the continuity and consistency needed related to what is to be implemented throughout Michigan. Much of this work has happened without much, if any at all, direct impact on children and families. Roots without growth, development and evolution are not seen or felt or experienced in the world.

The base is our mission, vision and guiding principles. The development of the practice model, approach to continuous quality improvement and a performance-based child welfare system were based on the overall mission, vision and guiding principles.

The trunk represents a reliance on county public and private agency leadership to drive implementation. The state has also developed one phased, integrated approach - represented as the trunk of the tree -- to implementation for each of these components that relies heavily on public and private agency leadership on the county level to bring these components to life for children and families.

The branches reflect the development of county implementation teams, county implementation plan and data to track improvements. Implementation efforts within each county are structured around county implementation teams, county implementation plans and data to track improvements (or lack thereof).

The vision comes to life in the positive impact that quality services have on children and families. This is where much of the growth and development will occur, where children and families will begin to feel impact. All of this work will be happening with support from the state as described above underneath the effort known as Strengthening Our Focus on Children and Families in Michigan.



Through this process, DHS will reestablish focus on fundamental social work practice skills, create routine opportunities to support caseworkers as they apply those skills in everyday child welfare activities, develop an organized approach to the collection and analysis of child welfare data and information, and implement an overarching process in which the success of child welfare interventions and outcomes for children and families can be assessed and effectively targeted for improvement when necessary.

This document was designed to offer a detailed overview of the approach Michigan is taking to improve outcomes for children and families. The teaming structure, practice model, approach to CQI and performance-based child welfare system are all described in the first part of the document. The last part of the document outlines the phased, integrated approach to implementation.

I. Teaming Structure

The following discusses an underlying component of the approach DHS is taking, which will be referenced throughout the remainder of this document. While a specific section regarding the overarching implementation plan of this approach is presented later, certain aspects are referenced throughout this document and therefore a description of the teaming structure is offered here.

The child welfare teaming structure is designed to provide DHS with a structure for addressing compliance with the modified settlement agreement (MSA) requirements, along with other issues/initiatives that fall within the scope of work for DHS over time. The rationale for creating such a structure and process is that DHS is responsible for a wide variety of work and initiatives, many of which cross the lines of the various organizational units and require more broad-based participation. The priorities for work to be accomplished or goals to be achieved may change over time. One objective of this structure is to avoid DHS being in an ongoing reactive mode to emerging concerns and instead have a proactive, standing process for addressing priorities and new concerns. Therefore, the priority issues and goals that are identified for attention below may change as these issues and goals are addressed, but the structure and process for dealing with them will remain constant.

A. State Teams

DHS has aligned leadership activities by developing an advisory council and planning structure that can oversee state and local teams and plans. The Strengthening Our Focus Advisory Council (SOFAC) is comprised of DHS senior staff and headed by the Children's Services Administration (CSA) director to direct the overall implementation effort. This includes the work of subteams that address issues identified in the following areas: permanency, safety, well-being, placement, training, caseloads and staffing, MiTEAM/CQI, MiSACWIS, resource development and communications.

The figure below depicts the teaming structure on the state level.

The SOFAC is comprised of the co-chairs of the subteams as well as a senior staff person from Bureau of Children and Adult Licensing (BCAL). Senior staff from the CSA lead or co-lead each of the subteams. The work of the SOFAC is to convene at regular intervals to approve/modify/disapprove of subteam recommendations, monitor activities and progress, and ensure regular status reports are available for state and local subteams[1].

The work for individual subteams is to address current issues needing attention and may change as the department's focus of attention changes. The teaming structure in place will allow a means for the department to proactively address issues in a coordinated and dynamic manner. It is expected that each subteam will convene at regular intervals to

[1] At the time of initial implementation, the only local subteams will be those in identified champion counties of Lenawee, Kalamazoo, Mecosta/Osceola, and Kent.

develop recommendations, monitor activities and progress and ensure regular status reports are generated for the SOFAC and state and local subteams. The subteams will be responsible to reach out to other stakeholders, subteams or other resources as may be needed and appropriate to make progress in assigned areas of attention.

Although the structure delineates work for individual subteams, coordination of work across teams will be essential. For this reason, a coordinator for the SOFAC and subteams ensures that related assignments and/or activities requiring attention across subteams are carried out effectively and in a coordinated manner. Similarly, with the SOFAC assigning activities to the subteams, facilitating communication between and among the teams is essential, and is different from the communication and messaging functions of the Communication Subteam.

The SOFAC does not replace the work that currently takes place within DHS organizational units/divisions or the advisory functions of the County Director Advisory Council (CDAC). The SOFAC will primarily address broader, cross-cutting areas. The structure of the SOFAC and subteams is based on organizational needs identified and focuses on addressing those needs, rather than focusing on more immediate, time-limited deliverables.

The representation in subteams was informed by the primary responsibilities[2] assigned to the subteams at the time of initial implementation of this structure. While the composition of the team members may vary over time, depending on the responsibilities assigned to the team, at no time will it exceed a total of 10, unless approved by the SOFAC. The subteams are responsible for developing and monitoring the implementation and oversight of plans and strategies related to the following areas of practice. The primary strategies for each subteam are documented and updated in Michigan's Implementation Plan matrix.

Permanency: Federal permanency outcomes and key performance indicators (KPI) regarding timeliness and permanency of reunification and adoption; timely and thorough case plans; children's visits with their parents; discharge planning for children aging out of foster care. With regard to the MSA, it will address visits between worker and child/parents, between parents and children and among siblings separated into foster care.

Safety: Federal safety outcomes and KPI related to face-to-face contacts with children in investigations and ongoing caseworker visits with children in foster care; major practice/systemic issues within the MSA including timely initiation of investigations.

[2] At initial implementation, primary responsibilities include federal outcomes (safety & permanency), the seven KPIs, and areas of concern identified in the MSA.

Well-Being: Practice/systemic areas within the MSA pertaining to the use of psychotropic medications for children in foster care and the provision of timely medical, dental, and mental health examinations and treatment; other child and family well-being issues that arise going forward.

Placement: Plans related to the KPI on placement of children in unlicensed placements; areas within the MSA pertaining to foster parent licensing, relative licensing and placement exceptions.

Training: Practice/systemic areas within the MSA pertaining to supervisory training and mentoring and licensing workers qualifications and training.

Caseloads: Practice/systemic areas within the MSA pertaining to caseloads of supervisors, Children's Protective Services (CPS), foster care, adoption, licensing and DHS monitors.

MiTEAM/CQI: Plans related to expanding MiTEAM and the ongoing implementation of the model statewide; monitor implementation of the statewide CQI plan and ensure coordination between MiTEAM and CQI; serve as resource for local MiTEAM and CQI subteams in ensuring fidelity to the model and appropriate implementation county to county; work with the state DCQI to plan for a baseline review of counties beginning the initial implementation phase of MiTEAM; consult with DCQI on planning ongoing reviews of implementing counties at intervals to be determined.

MiSACWIS: Monitor the implementation of the system and ensure that implementation activities/processes are consistent with needs associated with MiTEAM and CQI processes.

Resource Development: Address the development and implementation of a performance-based child welfare system and funding models, expected to affect outcomes and indicators in a variety of areas; this work will be done in close coordination with the Child Welfare Partnership Council. Identifying and developing the resources needed to implement MiTEAM effectively.

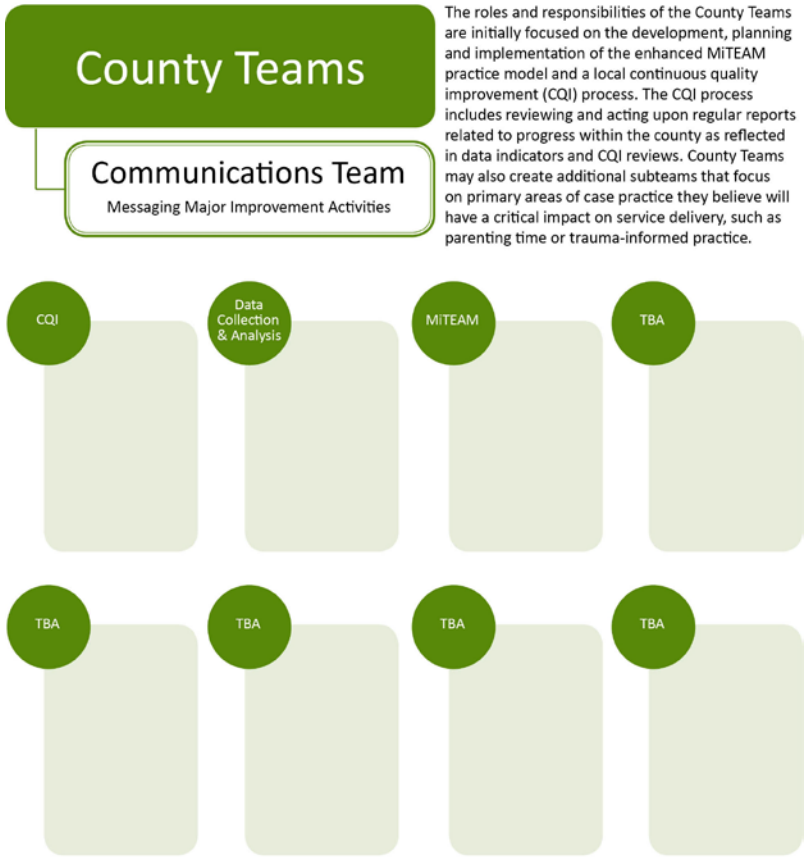
Communications: Ensure and facilitate messaging about implementation plans and activities within DHS and eternally among key stakeholders whose engagement is essential to effective implementation. It is critical that all parties have a consistent understanding and expectations with regard to major improvement initiatives. Communication should not be viewed as a singular or point-in-time event, but an ongoing process designed to engage, encourage and clarify for all involved participants.

B. County Teams

There are differences among the counties in the state. The strengths and needs of staff, communities, stakeholders and other entities are not the same and, therefore, a county-level structure is needed to successfully implement and maintain MiTEAM and CQI. Therefore, county teams are being established to guide and sustain implementation

efforts, address barriers and help ensure fidelity to the MiTEAM and CQI models throughout all phases of implementation.

The figure below depicts the teaming structure on the county level.



1. The County Team Structure and Functions

It is critical that the county teams include representatives from the department and other stakeholders who have an important role in improving outcomes for and with children and families. Staff from private agencies and the court system, foster parents, relative caregivers, birth parents, youth and other service provider organizations are all stakeholders. Each county team includes subteams that monitor and guide specific issues; such as CQI, data collection and analysis, MiTEAM implementation and other initiatives. Although some subteams will be standard for all implementing counties, each county has the flexibility to create subteams that address issues of particular interest or concern to them.

County teams initially should be chaired by the county director (or the director's designee) and include, at a minimum, the following representatives:

- Supervisory and front-line staff of the county department.
- County staff with CQI responsibilities.
- Peer coaches.
- Private agencies (to be determined by the county director).
- Representatives of other public agencies, such as mental health, health, education, etc./
- Representatives of service providers that serve the county.
- Legal/judicial representatives.
- Foster parents and/or relative caregivers/
- Chairs of the county subteams.

County leaders have the flexibility to identify other participants on the county team or its subteams, depending upon needs within the county. The number and focus of county subteams will be subject to county discretion, with the exception of CQI, data collection and analysis, and MiTEAM subteams. Guidelines for membership include:

- County staff that represent the issues of the subteam.
- Private agencies with a presence within the county that are able to address the issues of the subteam.
- Public agency representatives that are able to address the issues of the subteam.
- Consumer representatives, including parents served by the agency and former foster care youth.

For the CQI Subteam in particular, it is important to designate members who are willing to conduct or participate in regular case reviews and the review of data related to agency performance. This is a working team, rather than an advisory team, and will require members who are willing to devote time and effort to the work of the subteam.

The need for a county communications team may depend, in part, upon the size and complexity of the county in which implementation activities are occurring. For example, a team that covers more than one county or a team in a larger metropolitan county may need a communications team whereas a smaller one-county team may not need the extra team in order to ensure effective communications.

Given the importance of understanding trauma-informed practice, secondary traumatic stress and organizational stress for implementing the Strengthening Our Focus on Children and Families Approach it is recommended that counties also consider the creation of a trauma subteam.

2. Roles and Responsibilities of the County Team and Subteams

The primary role of the county team is to develop and ensure the ongoing implementation of county implementation plans. Reviewing and acting upon regular reports related to progress within the county as reflected in data indicators and CQI reviews are key responsibilities of the county team. County teams should report regularly to the Strengthening Our Focus Advisory Council (SOFAC) and subteams on issues within the scope of responsibility of those teams. For example, county CQI subteams should routinely report to the State MiTEAM/CQI Subteam on the results of case reviews, status of data measures and review-related activities that emerge throughout implementation. The SOFAC will be responsible for coordinating with the implementing counties to establish guidance on the specific mechanisms for effective communication between the county and state teams.

County teams may, at their discretion, have a communications team that sits organizationally between the county team and subteams in order to facilitate messaging within the county department and among external stakeholders with regard to the goals, plans, activities, and time frames associated with implementation efforts. For example, ensuring that private agencies serving a county are well apprised of implementation goals and strategies with regard to the expanded MiTEAM and CQI will be essential in promoting their engagement in implementation efforts. Likewise, providing private agencies and other key stakeholders with a means of giving feedback and input into implementation activities will be important in building a shared sense of commitment to improvement efforts and strategies.

Roles and responsibilities of the county subteams will generally include the following:

- ***CQI Subteam:*** This subteam is responsible for developing and monitoring the implementation of plans related to implementation of the CQI processes within the county and linking CQI implementation activities with practice model implementation. In general, the CQI subteams are working teams that engage in a regular schedule of county case reviews and debrief with appropriate staff to identify strengths and needs in practice. The CQI Subteam, in collaboration with DCQI and the State MiTEAM/CQI Subteam, will engage in a baseline review of the county's status as it begins the initial implementation phase and in subsequent reviews designed to evaluate progress going forward.
- ***MiTEAM Subteam:*** This subteam is responsible for developing and monitoring the implementation of plans related to implementing the practice model within the county. This subteam is responsible for ensuring fidelity of casework activities to the practice model. This subteam will also be responsible for reviewing and evaluating the progress of practice model implementation within the county.
- ***Data Collection and Analysis Subteam:*** This subteam is responsible for reviewing and evaluating regular data reports related to progress within the county toward

improving outcomes for children and families, examining progress related to the KPIs, CFSR/MSA outcomes, and other practice-related indicators. This team will provide analysis of data and other information to the other subteams and to the county implementation teams for their use in ongoing monitoring and evaluation activities.

It is important that a designated individual in implementing counties be responsible for coordinating implementation activities, including coordinating the county team structure. The implementation of practice model activities, including training and coaching, along with implementing CQI activities, must proceed in a highly-coordinated manner for maximum effectiveness. Similarly, with county teams assigning activities to subteams, facilitating inter-team sharing of information will be essential. Examples of coordinating activities at the county level include the following:

- Facilitating the development of the county implementation plan.
- Scheduling and convening county team and subteam meetings.
- Ensuring that issues needing attention are routed to the correct teams for action.
- Monitoring and tracking progress on activities and implementation efforts identified in the county implementation plan.
- Monitoring and tracking training and coaching activities for the practice model, for example, to ensure that all staff receive needed training and coaching.
- Monitoring and tracking the implementation of CQI activities, such as case reviews, engagement of external stakeholders and distribution of reports.
- Collection, review and distribution of reports and minutes generated by teams.
- Facilitating inter-team communication and sharing of information on work underway or planned, between and among the county team and subteams.
- Facilitating evaluation of the teaming and planning structures.
- Coordinating initiatives and efforts among subteams and the county team that otherwise might not be well-coordinated or effectively implemented.

An additional task of the county teams is to track the implementation process itself and evaluate the effectiveness of implementation activities. They may choose to do this in several ways, including:

- Regularly reviewing data and other information that raise questions about which factors are driving either the progress made over time or lack of progress, such as the adequacy of training, coaching or the pace of implementation.
- Conducting interviews or surveys with staff implementing the practice model and CQI activities to determine their preparedness/skill levels in their areas of responsibility and barriers and successes in implementation activities.
- Reviewing supportive functions necessary for effective implementation, such as caseload/staffing levels, quality of supervision, community/agency support and engagement and available resources and services.

Each subteam should also have an assigned individual to serve as a chairperson who will have responsibility for ensuring that the specific functions are addressed and appropriate communication and coordination with the other subteams and county team is regularly occurring. There may also be co-chairs who are designated to support the subteam to carry out its responsibilities and to manage activities including:

- Assisting the chairperson in the scheduling and convening of subteam meetings.
- Determining agenda items, preparing for and facilitating subteam meetings.
- Maintaining necessary documentation of agendas, minutes and reports and providing these to the larger county team.
- Representing the subteam at county team meetings, when needed.
- Communicating with subteam members and other internal and external stakeholders to further the coordination of overall goals and priorities as identified in the county.

3. County Implementation Plans

One of the key tasks of each county team is the completion of the county implementation plan during the planning phase of implementation. Each county will begin in the planning phase of implementation.

A template for the county implementation plans, which is similar to the format utilized for the state implementation plan, will be provided to assist the county teams in identifying key areas/issues to be addressed as the plan is developed. Additionally, the county team and subteams should use the county plan/matrix to identify/track/update their work plans and progress going forward. There are major tasks and activities identified in the SOFAC master plan/matrix and the expanded CQI plan which are directly applicable to county implementation efforts. These major tasks and activities should inform the development of a county implementation plan.

4. Schedule of Convening the Teams

As each county team is responsible for the development of the plan to guide implementation efforts from the beginning of the initial implementation period, it will be advantageous for the team, at its inception, to meet at least once every two weeks to establish a clear set of expectations and working agreements for carrying out the roles and responsibilities of the team. Meetings should be of sufficient duration and frequency to ensure that members are able to review reports from subteams, monitor progress in implementing required activities and make decisions needed to support county implementation efforts. Subteams will need to determine the frequency of meetings needed to ensure timely and effective work on subteam assignments, and generally should meet no less frequently than monthly.

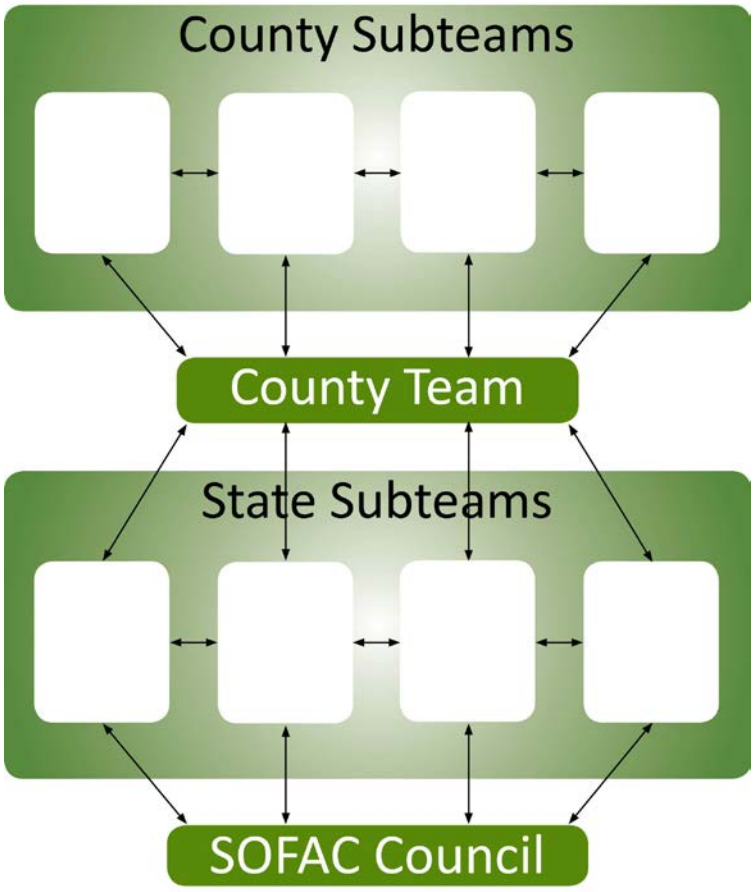
Calendars should be prepared for the county team and subteam meetings to coordinate schedules and establish regular meeting times.

5. Cross-Team Communication and Problem-Solving

To solve problems and address system barriers, there needs to be a clear process for where and how to address certain issues and a reporting process for ensuring that information is provided among teams. At a minimum, monthly reports should provide updates on progress, challenges and anticipated next steps. Also, minutes from team and subteam meetings should provide an accounting of meeting actions and should be distributed timely to all team members as a means of confirming decisions and actions.

For reporting between the county and state teams, SOFAC in coordination with the initial implementing counties is responsible for establishing communication guidelines between the state and county teams to ensure the SOFAC is apprised of county progress in implementation activities. The guidelines should include consistent protocols and reporting tools to provide updates on progress, challenges and anticipated next steps.

The figure below depicts the manner in which problem-solving and reporting should happen among county and state teams.



II. MiTEAM Practice Model

The MiTEAM Practice Model is an approach to case practice that incorporates the vision, guiding principles and key caseworker activities needed to successfully implement the mission of DHS.

The practice 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. A child welfare trauma-informed approach understands and recognizes that the vast majority of children in foster care have experienced complex trauma, which can significantly harm individual and familial development. In response, trauma-informed child welfare systems educate 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. MiTEAM builds on recent research revealing that traumatic stress can have serious physiological, psychological and relationship consequences on child and youth development.[3]

The practice model is a vehicle for unifying practices with private agencies, tribal partners, policies, training and other organizational resources within DHS. It provides consistent direction to child welfare agency staff and other stakeholders on casework activities and services to children and families utilizing a trauma-informed approach. It links the organizational values and guiding principles of DHS to specific interventions and activities that all children and families should experience, such as comprehensive assessments of their strengths, traumatic exposure to stress and needs, meaningful involvement in case planning, and effective services tailored to their needs.

With the overarching goal of improving safety, permanency and well-being outcomes for children and families, the trauma-informed practice model is comprised of four core competencies; engagement, teaming, assessment (case planning, plan implementation and placement) and mentoring.

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[3]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

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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

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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

Twenty-nine key caseworker activities have been identified to help caseworkers and supervisors understand what it means to implement these core competencies and to 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. Outlined below is a summary of each competency and the corresponding key caseworker activities.

A. MiTEAM 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.

Here are the key caseworker activities to implement the engagement competency.

Activity 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.

Activity 2 Engagement:

Search for and engage parents, family members and other support persons from the child's community in the family team process.

B. MiTEAM 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.

Here are the key caseworker activities to implement the teaming competency.

Activity 3 Teaming:

Form a family team.

Activity 4 Teaming:

Prepare members of the family team for participation on the team and for upcoming decisions.

Activity 5 Teaming:

Ensure members of the team meet and participate in shared decision-making on a regular basis.

C. MiTEAM 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 potential impact of traumatic stress on children and parents is a part of this assessment process, so that it can be addressed in case planning. *Four **assessment**-related key caseworker activities are identified below*.

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 end-point outcomes necessary for exiting the system.

Also derived from the assessment process, caseworkers must engage the team in the process of **planning** for safety, permanency and well-being that is built on resiliency, documenting this plan and **implementing** the plan. *Five **case planning**-related key caseworker activities and six **case plan implementation** key caseworker activities are identified below.* 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 child welfare system involvement and linkages between the identified needs, desired changes and use of family strengths to meet case planning goals.

*Six **placement**-related key caseworker activities are identified below*. 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 or parent. Supervisors will educate, coach and model key caseworker activities in assessment, planning, implementing, and tracking practices.

Here are the key caseworker activities to implement the assessment competency.

Activity 6 Assessment:

Use formal and informal assessment techniques to collect information.

Activity 7 Assessment:

Collaborate with team members to identify child and family strengths, trauma histories and needs.

Activity 8 Assessment:

Organize and analyze all information that is collected to develop a comprehensive family assessment.

Activity 9 Assessment:

Update comprehensive family assessment on a regular basis and prior to case closure.

Activity 10 Case Planning:

Involve families and other team members in a case planning process with a long-term view toward safety and permanency.

Activity 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.

Activity 12 Case Planning:

Develop plans that have behaviorally specific and achievable goals and action steps.

Activity 13 Case Planning:

Use visits with the child and parents to make progress on goals and action steps.

Activity 14 Case Planning:

Track progress on case plan implementation and adjust as needed.

Activity 15 Case Plan Implementation:

Engage with service providers.

Activity 16 Case Plan Implementation:

Clarify specific service needs when making referrals.

Activity 17 Case Plan Implementation:

Provide services promptly and on an ongoing basis to increase safety, reduce risk, address well-being and promote timely permanency.

Activity 18 Case Plan Implementation:

Use caseworker visits to mobilize services.

Activity 19 Case Plan Implementation:

Evaluate the appropriateness and effectiveness of services.

Activity 20 Case Plan Implementation:

Provide services at the time of discharge and case closure.

Activity 21 Placement:

Assess whether potential relative or kin caregivers are willing and able to safely care for children and youth.

Activity 22 Placement:

Work closely with members of the family team to make initial placement decisions, support those placements and plan for transitions.

Activity 23 Placement:

Use assessment information to match children and youth to the most suitable placements.

Activity 24 Placement:

Use visits to preserve connections, strengthen relationships and make progress on identified goals.

Activity 25 Placement:

Facilitate parent involvement with their children.

Activity 26 Placement:

Help children stay connected to their siblings.

D. MiTEAM 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, 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.

Activity 27 Mentoring:

Promote growth through coaching.

Activity 28 Mentoring:

Create a learning environment through observation and feedback.

Activity 29 Mentoring:

Support change through building honest and genuine relationships.

III. Continuous Quality Improvement

A. Introduction

Continuous Quality Improvement (CQI) is a means by which all components of the child welfare system have a clear understanding of the DHS child welfare vision; working continuously and collaboratively to achieve and sustain improvements in practice and outcomes. The CQI vision supports both the DHS child welfare vision that DHS will lead Michigan in supporting our children, youth and families to reach their full potential and the department's mission, which is that child welfare professionals will demonstrate an unwavering commitment to engage and partner with families to ensure safety, permanency and well-being. Through CQI the department prioritizes areas of improvement to create a manageable process for moving toward a more completely reformed child welfare system in a logical, effective manner. At the present time, the priority areas of improvement are: achieving conformity with nationally recognized child welfare outcomes for children and families,[4] demonstrating the ability of DHS to make sustained improvements in other key performance indicators (KPIs)[5] and demonstrating conformity with the proposed fidelity measures[6] that capture critical practices specified in the practice model as particularly relevant to the competencies of engagement, teaming, assessment (including case planning and implementation and placement decision), and mentoring.

B. Scope of CQI Functions

CQI functions are dependent upon the active engagement and participation of staff at all levels of the child welfare system (public and private), as well as children, youth, families (birth, relative and caregivers), and stakeholders. The department's overarching CQI approach envisions that CQI functions will be carried out in a manner that engages a broad

[4] The Federal Child and Family Service Review (CFSR) identified certain national outcomes for children and families in the areas of safety, permanency and well-being, which were consistent across states for the second round of CFSRs. In Michigan, the MSA has adopted the same second round CFSR outcomes.

[5] DHS has adopted a set of seven KPIs that it will focus on during the implementation of the further developed MiTEAM Practice Model.

[6] The MiTEAM/CQI Sub-team of the State Implementation Team is currently considering a proposed fidelity instrument to be utilized during the implementation of MiTEAM developed by the MiTEAM Fidelity Instrument workgroup.

range of partners in the process of continually improving outcomes for children and families. These partners include but are not limited to the following:

- DHS Division of Continuous Quality Improvement (DCQI).
- Public and private child placing agencies (CPA) (from case managers to County/Executive Directors).
- Child Welfare Field Operations Administration (CWFO).
- Office of Child Welfare Policy and Programs (OCWPP).
- Bureau of Child and Adult Licensing (BCAL).
- Office of Workforce Development and Training (OWDT).
- American Indian Tribes.
- Other stakeholders.

There are several key CQI functions involving the above broad range of partners that inform the department's overarching CQI approach. Initially, this includes the CQI function of communicating and re-enforcing key performance indicators (KPI) and outcomes associated with the practice model. There is also a CQI function to inform OWDT, supervisors, peer coaches, and MiTEAM analysts about strengths and needs of child welfare practice in the field to strengthen the training and support provided regarding the practice model. There are clear CQI functions associated with various case review processes such as:

- Public/Private Child Placing Agency Review Processes – Ongoing Internal Case Reviews.
- BCAL Consolidated Monitoring – Provider Specific Reviews.
    - Review of Licensing Requirements.
    - Review of Contract/Policy Requirements.
- DCQI
    - Quality Service Reviews (QSR).
    - MSA Targeted Case Reviews.
    - CPS Central Intake Reviews, CPS Investigation Reviews and CPS Maltreatment in Care Reviews.
    - Other reviews as determined by CSA.

There are also CQI functions associated with collection, analysis and reporting of aggregate data with implications for: SWSS/Info View; MiSACWIS; BCAL; DCQI; AFCARS/NCANDS; and other aggregate data sources.

C. Connection Between CQI functions and the Practice Model

The practice model is the basis upon which CQI is built. As it is implemented, CQI will consistently monitor and assess the extent to which the model is being implemented one caseworker after another, one county after another primarily relying on the QSR and fidelity assessment process. The impact on children and families will be assessed through the key performance indicators and outcomes.

CQI processes will be developed around the practice model in alignment with the DHS vision and the KPIs. For example, the DCQI QSR instrument is being developed in partnership with stakeholders, using the practice model as a basis for the tool, and is being refined in a coordinated manner with the further development of the practice model. DCQI began utilizing the QSR instrument with the first phase of champion counties. In addition to the case-specific reviews, the QSR process relies on input from stakeholders who are receiving services as well as those providing services. This combination of case-specific reviews, interviews and stakeholder/focus groups allows for a robust assessment of practice that is focused on quality (practice and results), rather than strictly on compliance with policy or funding requirements.

Fidelity to the practice model is the responsibility of all members of CSA (public/private), beginning at the service delivery level (case manager), carrying through to the local office/private agency and to county/executive director, and encompassing all program areas that support the provision of services. DCQI is responsible for aggregating information to provide a report of performance on KPIs that reflect successful implementation of the practice model. The department has developed a Fidelity Instrument (see appendix) that will be tested in the champion counties as a means of demonstrating case manager conformity with critical practices specified in the Practice Model Manual. In addition, the QSR is anticipated to be one of the primary means of informing workers in the champion counties on the effectiveness of implementing the model during their work with children and families.

D. Overarching CQI Approach

The DHS overarching CQI approach incorporates the CQI functions within all of DHS, not solely the Division of CQI (DCQI). The overarching CQI approach is comprised of the following components: structure of the CQI process; data plan; case review plan; review of systemic factors; reporting and feedback plan; and program improvement activities. The overarching CQI approach is designed to align with federal guidance contained in ACYF-CB-IM-12-07, “Establishing and Maintaining CQI Systems in State Child Welfare Systems.”

E. Structure of the CQI Process

As described in the teaming structures section above, the overarching CQI approach is embedded in the implementation team and planning structure at the state and local levels

for the champion counties and future implementing counties. Here we outline the structure of DCQI and BCAL in regards to staff CQI responsibilities and possible structured activities of private agency CQI processes.

DCQI is structured to complete activities related to targeted case reads, QSR development and implementation, CFSR support functions, data management functions, and statistical analysis. BCAL is structured to complete activities related to licensing/contract monitoring, foster home monitoring, and to provide DCQI, the State MiTEAM/CQI Subteam, and county level CQI Subteams with information from BCAL reviews.

Many private agencies have CQI processes that align with Council on Accreditation (COA) requirements. These CQI processes are similar to DHS CQI processes and may be structured to carry out the following types of activities: satisfaction surveys, quality focus groups, case record reviews, training compliance assessment, risk management, best practice reviews, and outcome measurement. The department is coordinating DHS CQI requirements to be complementary with COA requirements.

F. Data Plan

This component of the overarching CQI approach provides a blueprint for the CQI tasks of data identification, collection, analysis, and interpretation.

To ensure the continuous quality improvement of a system, it is critical to have ongoing accurate information about how that system is operating. The type of information needed is driven by the system's goals, objectives and desired outcomes, with the overarching questions being: (1) is the system achieving its goals, objectives and desired outcomes?; and (2) if not, what must be done to correct the system so that it does achieve its goals, objectives and desired outcomes? The State MiTEAM/CQI Subteam and county CQI Subteams will implement the following steps to address these overarching questions on an ongoing basis.

- Identify areas of inquiry that require attention and the types of information needed, such as trends in performance over time, compliance concerns or effectiveness of program improvement efforts.
- Formulate data questions with regard to each area of inquiry and types of information needed and operationalize the questions into measures with specified data elements.
- Identify potential data resources available for the specified data elements and assess the quality of the data.
- If information on specific data elements is not readily available, determine procedures for collecting that information in the most efficient and effective manner.

- Determine the most appropriate data analyses (quantitative, qualitative or a combination of both) based on the data question and the type of data that is available or was collected to answer the question;

- Analyze the data and prepare a report that answers the question being investigated and can be easily understood by all stakeholders.

- If the analyses indicate that in a particular area, the system is not achieving its objectives or desired outcomes, assist stakeholders at state and/or local levels in using available data, existing research and/or anecdotal evidence to understand the possible reasons why this problem is occurring and to develop improvement efforts that will address the problem.

- Conduct ongoing monitoring and testing of program improvement efforts to assess whether the efforts are resulting in the desired improvements.

The following discussion delineates these specific activities and identifies issues that will be necessary to consider in implementing each of the steps provided above.

1. Identify Areas of Inquiry and Types of Information Needed

A CQI data plan must be responsive to various areas of inquiry and types of information. Some information needs pertain to the department achieving conformity with nationally recognized child welfare outcomes for children and families.[7] Other information needs pertain to trends in performance over time on KPIs that the department believes are (1) essential to child safety, permanency and well-being, and (2) will support sustained positive outcomes for children and families. There are also information needs regarding additional child welfare practice and systemic areas that will support better outcomes for children and families that are included in the MSA. Finally, some information needs concern whether program improvement efforts are producing desired results.

The State MiTEAM/CQI Subteam and county CQI Subteams should be responsive to the range of information needs at any given time. Specifically, with regard to the types of information needed, the State MiTEAM/CQI Subteam and county CQI related Subteams should:

- Monitor KPIs to assess system performance before, during and after implementation of the MiTEAM practice model.

[7] The Federal Child and Family Service Review (CFSR) identified certain national outcomes for children and families in the areas of safety, permanency and well-being that were consistent across states for the second round of CFSRs. In Michigan, the MSA has adopted the same second round CFSR outcomes.

- Monitor outcomes and objectives to assess compliance with MSA requirements.
- Monitor outcomes and practice to assess conformity with CFSR-PIP requirements.
- Monitor improvement efforts to determine effectiveness.

The department has identified seven KPIs as the initial practice areas of inquiry for the CQI process. Additional performance indicators may be added as the department moves forward with implementation of the expanded MiTEAM model and as data regarding specific areas of inquiry, such as educational performance, become more accessible. The seven KPIs are as follows:

- 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.

The KPIs were selected as the initial focus of the CQI data efforts because the department believes that they reflect the core practices that are central to achieving broader outcomes. The CQI effort also will focus on areas of inquiry that pertain to key practices and outcomes relevant to the CFSR and the MSA. These include the following.

- Timely initiation of investigations.
- Children entering care based on child abuse/neglect reports.
- Child fatalities.
- Recurrence of maltreatment.

- Incidence of child abuse and/or neglect in foster care.
- Permanency goals for children in care.
- Number of placement settings.
- Number of removal episodes (re-entries into custody).
- Children placed in residential care.
- Number of children in care 15 of the most recent 22 months.
- Median length of stay in foster care.
- Length of time to achieve permanency.
- Timeliness and permanency of reunification.
- Supervisory training.
- Mentoring of new workers.
- Licensing workers' qualifications and training.
- Caseloads for foster care, adoption, licensing, and DHS monitors.
- Visits between worker/child, worker/parents, parents/child, and siblings.
- Licensing of foster homes.
- Relative licensing issues.
- Placement exceptions (proximity, sibling separations, number of children in the home, limitations on emergency placements, number of emergency placements);.
- Use of psychotropic medications.

2. Formulate and Operationalize Data Questions

Formulate data questions with regard to each area of inquiry and types of information needed and operationalize the questions as measures with specified data elements. The critical feature of a measurable question is that it defines all data elements necessary to answer the question. Some examples of the data elements that may be included in a measurable question are:

- The specific time frame that the measure will incorporate (e.g., the first quarter of the state fiscal year or a specified MSA period).
- Specific definitions of terms (e.g., maltreatment defined as a substantiated report, recurrence defined as more than one substantiated report occurring at a different time, face-to-face contact defined as a child welfare professional in physical contact with a child who is the subject of a maltreatment report or a member of a family in which one of the children is the subject of a maltreatment report).
- Both the denominator and the numerator (if the expected result is a percentage), for example, of all maltreatment reports that were received and assigned for an investigation during the first quarter of the state fiscal year (denominator), what percentage had a face-to-face contact between the child welfare professional and all of the children in the family within the time frame required by policy (numerator).

3. Identify Available Data and Assess Quality

Identify potential resources available for specified data elements and assess the quality of the data. If information on the specific data elements is not readily available, determine procedures for collecting that information in the most efficient and effective manner. The State MiTEAM/CQI Subteam and county CQI Subteams are responsible for determining whether data are available for any particular measure and assessing the quality of the available data. Data quality assessment would incorporate the following:

- Validating the data from automated data systems by comparing the data in the aggregated reports with case record information.
- Determining completeness of data in automated data systems or case files, i.e., is the data element reported consistently across child welfare professionals and over time? (This lack of completeness, for example, often pertains to caseworker-child visits or parent-child visits, which may not always be recorded in the automated system).
- Observing the consistency of the data for a particular indicator over time to identify unusual or unexpected patterns that may suggest data quality issues rather than actual changes in performance.
- Observing the consistency of the data for a particular indicator across counties and between counties and private providers.

Most of these quality assessments pertain to SWSS, which previously was Michigan's child welfare automated data system, and MiSACWIS, the automated data system that was implemented in 2014.

The State MiTEAM/CQI Subteam and county CQI Subteams are also responsible for determining that data systems are collecting and storing data in a manner that permits the generation of the correct metric to answer the question.

If data for a measure are not available from the automated system, the State MiTEAM/CQI Subteam and county CQI Subteams will identify alternative resources, such as case record reviews, interviews with key stakeholders, BCAL data, Foster Care Review Board (FCRB) reports, observation of practice in natural settings, and supervisory logs. In these situations, it may be necessary for the State MiTEAM/CQI Subteam and county CQI Subteams to triangulate data sources (validate data through cross verification from two or more sources) when the automated system does not have the data or when there are concerns about completeness, consistency and accuracy of data from the automated system.

When necessary, the State MiTEAM/CQI Subteam and county CQI Subteams will decide whether sampling is necessary and how to sample based on the availability of data and the type of question being addressed. Levels of confidence and error intervals will be established for each measure to determine an appropriate sample size.

It is expected that when MiSACWIS is fully functional, the need for alternative data resources will be diminished since the department has made concerted efforts to ensure that the range of data elements necessary for a fully functioning CQI system has been incorporated into MiSACWIS. A fully functioning MiSACWIS also will resolve some of the data consistency issues that may have arisen between data supplied by private agencies and data collected at the local county levels.

4. Analyze Data and Prepare Reports

Determine the most appropriate data analyses, analyze the data and prepare a report that answers the questions being investigated that can be easily understood by all stakeholders. The State MiTEAM/CQI Subteam and county CQI Subteams should ensure appropriate data analyses are conducted depending on the type of CQI issue being addressed and the data collection process. The data analyses should incorporate the following procedures:

- Data analyses will be conducted to answer the "what" questions – i.e., what does performance look like on the measure?
- Data analyses will be conducted to examine the "why" questions – why does performance on the measure look a particular way – e.g., at, below, or above expectations?
- Data analyses will be conducted to examine the "how well" question – what is the quality of the work being done? (In most instances this will require some qualitative review to augment the quantitative analysis.)
- Members of the State MiTEAM/CQI Subteam and county CQI Subteams will examine statistically the various factors that may be correlated with performance and conduct analyses to determine the strength of these relationships.
- The State MiTEAM CQI Subteam and county CQI Subteams will access alternative sources of data that may provide potential explanations for performance, such as stakeholder interviews, case record reviews and research findings of empirical studies.

When the analyses are completed, the MiTEAM/CQI Subteam and county CQI Subteams will prepare reports that present the data in a variety of formats, including tables and graphs that are easily readable and clear. The reports will include a statement about the specific questions addressed in the analysis and an interpretation of the data in a manner that is consistent with the methodology and answers the specific questions addressed by the analyses. The interpretation will take into account the types of data collected, the quality of data collection, the kinds of analyses conducted, and the data collection process,

particularly if sampling was involved. The reports will specify any caveats that may pertain to data interpretation.

5. Use Data to Assist in the Program Improvement Process

When appropriate, the State MiTEAM/CQI Subteam and county CQI Subteams should incorporate information regarding strengths and areas needing improvement in the reports with regard to specific issues and these subteams will generate potential hypotheses regarding the possible causes of the strengths and areas needing improvement. When it is clear that there is an area needing improvement in the system, the State MiTEAM/CQI Subteam and county CQI Subteams will provide additional data to enhance an understanding of the causes of the problem and to assist key stakeholders in developing improvement efforts to resolve the problem.

After the state or local stakeholders have identified a program improvement effort that they want to implement, the State MiTEAM/CQI Subteam and county CQI Subteams will monitor implementation at an early stage, and then on an ongoing basis to determine if the program improvement effort is effective. If monitoring data indicate early on that the program improvement effort is not likely to be effective, the State MiTEAM/CQI Subteam and county CQI Subteams will report this to stakeholders and re-engage them in the process of identifying an alternative improvement effort.

G. Case Review System

This component of the overarching CQI approach addresses the CQI activity of case reviews as a specific type of data collection requiring analysis and interpretation.

1. Key Components of a Case Review Process

A primary CQI function involves conducting case reviews when relevant. The State MiTEAM/CQI Subteam and county CQI Subteams will engage in the following activities either before or during implementation of a case review process:

a. Assess the appropriateness of a case review to answer a particular CQI question and the types of case reviews that are available or feasible.

b. Identify the specific goals of the case review, the information to be collected and the questions to be answered by the case review.

c. Develop a case record review protocol (if one is not readily available) to extract data from case records and/or key stakeholder interviews and test the efficacy of the protocol prior to full use.

d. Determine the types of cases to be reviewed (i.e., whether the review will target particular types of cases), the number of cases to be reviewed, the manner of selecting

cases for review, and the implications of both the number and selection process for generalizing findings to the "population."

e. Ensure that trained staff are available or are recruited to conduct the case reviews.

f. Report findings of the case reviews in a timely manner so that strengths and areas needing improvement are identified and communication with all key stakeholders is facilitated.

g. When relevant, engage with stakeholders to develop program improvement plans to address identified areas needing improvement.

2. Assessing the Appropriateness of a Case Review

The State MiTEAM/CQI Subteam and county CQI Subteamswill determine whether answering a particular CQI issue or question requires a case review. Case reviews may be an appropriate data collection method if: the existing system-wide databases do not have data pertaining to the particular issue/question; DHS staff have concerns that the existing data in the department's automated information system are not of sufficient quality to provide a reliable answer to the particular question or it is determined by DHS staff that the information from the department's automated information system does not provide a sufficiently comprehensive assessment of the issue to permit identifying possible program improvement strategies. Once it is determined that a case review is needed, the State MiTEAM/CQI Subteam and county CQI Subteams will determine the type of case review needed (e.g., a CFSR type review, a QSR review, a general QA review, a BCAL review, etc.).

3. Preparing a Plan for the Case Review

The State MiTEAM/CQI Subteam and county CQI Subteams will ensure that a plan for the case review is developed that identifies the specific goals of the case review and the information to be collected in accordance with the questions to be addressed by the case review. Prior to implementing a case review, the State MiTEAM/CQI Subteam and county CQI Ssubteams will ensure a document is prepared identifying the initial plan for the case review, including the goals of the case review and the information to be collected. The initial plan should include specifics on selecting or developing a case record review protocol, determining the types of cases to be reviewed and the availability of trained staff to conduct the case review. County CQI Subteams should solicit feedback from key stakeholders on the initial plan and make appropriate revisions to the plan.

4. Developing or Selecting a Case Record Review Protocol

If answering a particular CQI issue or question requires a case review, the State MiTEAM/CQI Subteam and county CQI Subteams will need to either develop a case record review protocol or select an existing protocol to (1) extract data from case records, (2)

conduct key stakeholder interviews (including all individuals involved in the case), and/or (3) conduct observations of children and families in natural settings. It will be critical to test the efficacy of the protocols on a few cases prior to full use. The State MiTEAM/CQI Subteam and county CQI Subteams will test the efficacy of any new protocol by assessing (1) whether it is useful in obtaining the desired information (utility), (2) whether different users of the protocol produce similar information under similar circumstances (inter-rater reliability), and (3) whether the information collected through the protocol is sufficient to answer the questions being assessed (validity). For example, DHS is currently intensely involved in the development of the QSR case review process in part to assess the fidelity of MiTEAM.

5. Determining the Types and Number of Cases to Be Reviewed

When answering a particular CQI issue or question by conducting a case review process, the State MiTEAM/CQI Subteam and county CQI Subteams will ensure steps are taken to determine the types of cases to be reviewed (i.e. whether the review will target particular types of cases or issues), the number of cases to be reviewed, the manner of selecting cases for review, and the implications of both the number and selection process for generalizing findings to the "population." Depending on the goals of the review, the question being addressed and the types of information needed, the State MiTEAM/CQI Subteam and county CQI Subteams will determine whether the case review will focus on a particular type of case (i.e. children 14 and older, children with a permanency goal of adoption, children served by private and public agencies). Targeted case reviews that focus on a specific area, such as education or health services or engagement of parents in case plan, will have a population of the entire number of children in foster care because these areas apply to all children. However, if just targeting one area, then fewer resources will be necessary because the review process will be faster. Targeted case reviews that focus on specific types of cases will have smaller populations from which to sample, so there will be fewer cases needed in the sample (although often not that much fewer), but the reviews may take longer because a range of issues may be assessed. Since most case reviews involve selecting a sample, the State MiTEAM/CQI Subteam and county CQI Subteams will determine the number to be selected and how the sample will be selected, such as a random sample of the population (which may be a target population), a purposeful sample (selecting a sample for a particular issue) or a stratified random sample. When relevant and considering the nature of the CQI issue or question being addressed by a case review process, the State MiTEAM/CQI Subteam and county CQI Subteamswill make a determination regarding the desired confidence level and report confidence interval to establish for the sample to generalize sample findings to the populations. The State MiTEAM/CQI and county CQI Subteams will have to assess available resources for conducting case reviews and make decisions regarding moving forward with case reviews accordingly.

6. Ensuring Availability of Trained Staff to Conduct Case Reviews

When answering a particular CQI issue or question by conducting a case review process, the State MiTEAM/CQI Subteam and county CQI Subteams will ensure a cadre of staff is trained to both conduct various aspects of the case review (including extracting information from case files, interviewing stakeholders, and conducting observations in natural settings) and as necessary provide training to others who may be involved in conducting the case review process (train-the-trainer model). The State MiTEAM/CQI Subteam and county CQI Subteams will also ensure there are periodic monitoring activities to ensure that reviewers are conducting the case reviews in accordance with the protocols.

7. Case Reviews at the State Level and Local Levels

DCQI is implementing the QSR process, which provides a case-based appraisal of frontline practice. The QSR offers an opportunity to learn how well children and their families are benefitting from services received and how well locally coordinated services are working together to meet their needs. The QSR includes a review of open cases and focuses on current practice, looking back no more than 90 days. Core practice functions, based on the practice model, establish the basis for the review. The state level QSR process includes an in-depth review of no fewer than 12 cases per site, interviewing the focus child or youth, parent, caregiver and many other individuals involved in the child's life. It is most common to interview 10 to 12 people per case.

Implementing county CQI Subteams will engage in a regular schedule of county case reviews and debrief with appropriate staff to identify strengths and needs in practice. DCQI and the MiTEAM/CQI Subteam will develop guidance regarding these county CQI Subteam case reviews.

H. Review of Systemic Factors

This component of the overarching CQI approach addresses the CQI function of evaluating the capacity of the child welfare "system" (state and local levels) to support implementation of MiTEAM. To implement this function, the State MiTEAM/CQI Subteam and county CQI Subteams will ensure that the following primary systemic factors are assessed:

- Training for public and private agency staff.
- Caseloads.
- Court processes (including legal support from county prosecutors).
- Recruitment, licensing and retention of foster and adoptive parents.
- Service array (including public/private partnership).

- Statewide information system/SWSS/MiSACWIS.
- Oversight and monitoring (including supervision, coaching, and CQI processes at the state and local level).

DCQI is implementing the QSR process, which includes the review of systemic factors. Implementing county CQI Subteams will gather and analyze information regarding the systemic factors listed above. DCQI and the MiTEAM/CQI Subteam will develop guidance regarding county CQI Ssubteams gathering and analyzing information regarding the systemic factors. Possible methods include surveys, focus groups connected with the QSR process, stakeholder interviews, data reports, and other tools. For example, the QSR process gathers information about the influence of systemic issues through a series of focus groups with agency staff at different functional levels, with staff and administrators from partner agencies in the community (such as schools, mental health, housing, domestic violence services and the courts), with informal community partners such as faith community, with a range of service providers, with foster parents, with advocates such as guardians ad litem and court-appointed special advocates, and at times with specific groups of clients such as youth transitioning to adulthood, teen parents or parents recovering from substance abuse. A review of the primary systemic factors listed above should be a component of the baseline review in champion counties prior to implementation of MiTEAM and during ongoing annual reviews of implementing counties. Champion county CQI Subteams will need to understand any current private agency methods for gathering information regarding these primary systemic factors and consider how these methods and resulting information may be utilized while developing a plan for reviewing the systemic factors.

I. Reporting and Feedback Plan

This component of the overarching CQI approach involves two critical tasks for a CQI system: (1) reporting the findings of CQI inquiries to all relevant stakeholders, and (2) assisting stakeholders in interpreting the findings of CQI inquiries and relating those findings to the stakeholders' area of concern.

The State MiTEAM/CQI Subteam will develop a template for the major CQI reports. The template will be structured in the following manner for each CQI finding:

- A statement of the measureable question or questions addressed in the CQI inquiry (including questions about particular systemic factors).
- The data source or data collection method and the type of analysis.
- Any concerns about the quality of the data or the reliability of the data collection method (including consistency, accuracy, sampling error, etc.).

- A presentation of data in the clearest format possible (e.g., tables, graphs, charts), sometimes employing multiple presentations to ensure clarity.
- An interpretation of the data as it pertains to the measurable question, taking into account possible caveats related to data quality and sampling procedures.

If any given inquiry results in a concern regarding practice or outcome performance, the State MiTEAM/CQI Subteam and county CQI Subteams will incorporate in the report information that may enhance an understanding of the possible factors that may explain less-than-expected performance with regard to a practice or outcome. This may involve providing additional data pertaining to the area of inquiry. For example, if placement stability is not at expected levels, the State MiTEAM/CQI Subteam or county CQI Subteam may provide data in the report that presents information about placement stability for different age groups, different ethnic groups, sibling groups of various sizes, or children with identified disabilities. This will allow stakeholders to begin to think about possible program improvement efforts. (This area is covered more specifically in the section of this plan focused on program improvement activities.)

The selection of stakeholders to receive specific reports will depend on the topic of the study, the nature of the study and the relevance of the study to various stakeholders. Final determinations on the stakeholders who are to receive certain, identified reports will be made by state and local administrators. Some examples of potential stakeholders include the following:

- CSA divisions, county child welfare agency directors, and Child Placing Agency administrators.
- The MMT, when the information is relevant to the MSA.
- The federal government when the information relates to the CFSR or PIP.
- State Implementation Team and county implementation teams.
- State MiTEAM/CQI Subteam and county CQI Subteams.

Other recipients would include, but not be limited to, ombudsmen, foster care review boards, the Court Improvement Project director and managers, tribes and relevant state tasks forces pertaining to child welfare. Depending on the type of inquiry, reports also may be disseminated to mid-level managers and unit supervisors.

Depending on the complexity of the situation, the State MiTEAM/CQI Subteam and county CQI Subteams may follow up the dissemination of reports with conference calls with key stakeholders to assist in interpreting findings and the relevance of findings for the stakeholders and tribes. In addition, the State MiTEAM/CQI Subteam and county CQI Subteams will solicit feedback from recipients of each report using a standard feedback form to allow recipients to commentt. Subteams will make changes in the report to align with feedback.

The State MiTEAM/CQI Subteam and county CQI Subteams will establish the time intervals for reports on specific KPIs and outcomes and on program improvement efforts. The State MiTEAM/CQI Subteam and county CQI Subteams also will ensure that time intervals are consistent with the implementation of MiTEAM and any other program improvement efforts that are implemented. It is expected that the monitoring and reporting on KPI performance will occur more frequently than outcome performance since the former are practice related and thus are more likely to exhibit change over short periods of time.

J. Program Improvement Activities

A fundamental purpose of a CQI system is to provide information that can be used to validate effective practice and to improve services and outcomes for children and families. Information gathered must be documented in comprehensible and useable reports, and disseminated to administrators, supervisors and staff to ensure promising practices can be identified and replicated, and areas needing improvement can be targeted for attention. This component of the overarching CQI approach provides information on the structure to support program improvement activities in relation to the integrated implementation of MiTEAM and CQI.

The implementation team and planning structure DHS has established at the state and local levels for the champion counties and will establish for future implementing counties is the primary structure to support program improvement activities. The State MiTEAM/CQI Subteam and county CQI Subteams will play a primary role in the identification and prioritization of areas needing improvement that should be addressed by the State Implementation Team and the local county implementation teams. The baseline reviews in champion counties prior to implementation of MiTEAM, the regular schedule of county case reviews and ongoing reviews of implementing counties on the same baseline measures will be important sources of information regarding strengths and areas needing improvement. The information regarding areas needing improvement obtained during the baseline reviews (inclusive of KPI and outcome information, QSR findings, and information regarding systemic factors) and other CQI activities should inform the State Implementation Team and local county implementation teams in their exploration of possible solutions to be incorporated into the state and/or county implementation planning process. Incorporating possible solutions into the implementation planning process will follow a Plan – Do – Study – Act cycle so possible solutions can be thoughtfully selected and tested within a reasonable amount of time to determine how to proceed with the improvement activity.

IV. Performance-Based Child Welfare System

Michigan's child welfare system is state-administered but relies on county-level DHS and contracted private child placing agencies to implement programs, coordinate service delivery and supervise out-of-home placements. Michigan's ability to effectively allocate resources, promote local innovation, create program efficiencies, and incentivize and assure accountability for achievement of performance standards and outcomes is constrained by many factors including the following:

- Restrictions on how federal funds may be used. Federal funds reimburse the state for a portion of the costs of placing eligible children in foster care, which limits the tools the state and counties can use to manage resources and innovate. This creates an increased burden on state and county funds for child welfare services.
- Inefficient and inequitable funding for case management and program delivery for public and private agencies.
- A case assignment and management system that does not promote continuity of service provision to children and families and does not support accountability for outcomes.
- Funding and payment structure that does not incentivize desired outcomes for children and families.
- Lack of clearly defined and universally agreed upon statewide performance indicators.
- Unreliable data collection system and oversight tools.

Public Act 59 of 2013, Section 503 required DHS to review the feasibility of establishing performance-based funding for all public and private child welfare services providers. In response, DHS convened a Performance-Based Funding Task Force that met in 2013-2014 and included representatives from the department, private child placing agencies, private child caring institutions, and Michigan courts and county administrations. The task force examined prior attempts at similar models in Michigan and other states; identified the population subject to the model; identified the continuum of child welfare services desired; examined current and potential funding models and barriers; and potential performance indicators and outcomes that would be used to determine success.

The Performance-Based Funding Task Force issued a final report and findings to the department and Michigan Legislature in February 2014. The report concluded that a performance-based model was feasible and offered a roadmap for implementation in a phased, integrated approach. The task force's Final Report can be found at http://www.michigan.gov/documents/dhs/CWPBF_Final_Report_2_24_14_448934_7.pdf

Key components of the proposed performance-based child welfare system include:

- Lead agency responsibility for placement, case management and full-family service delivery for the life of the case, from referral for out-of-home placement through permanency.
- Public and private agencies are subject to the same consistent performance indicators and outcomes. Objective performance measures will be defined and measured using data derived from MiSACWIS and other data sources within the state's continuous quality improvement system.
- The lead agency is responsible for coordinating and paying all services needed to support the family and/or carry out the case plan.
- Independent, third-party evaluation, including process evaluation, achievement of established outcomes, and cost benefit analysis.
- Develop and modify funding and rate-setting methodologies by involving relevant stakeholders and the professional, expert services of an actuary. Given the findings of the task force and similar models in other states, effort will be made to research and develop a methodology that operates a prospective, case rate funding structure for potential use in certain areas of the state.
- Ensure Budgeting/funding models for contracted agencies and public sector allocations that equitably:
    - Accommodates the distinctions presented when delivering services to the specific geographic area and the attributes of the populations served. For example, public and private agencies serving a smaller population, with limited service providers, in a large geographical area (like that in the Upper Peninsula) must be considered in budgeting resources and rates.
    - Funds necessary to meet the needs for children and families as assessed in tiers or levels of care (low to high). Universal assessments will be used to place each case in one of several tiered rate structures that accommodate different levels of services based on varying needs. In funding structures that require it, there will be the creation of a defined mechanism that may be applied for atypical cases with complicated health and/or treatment needs.
    - Ensures provision of funds necessary to provide a defined range or bundle of services for children and families.
    - Creates flexible and integrated funding and resource allocation strategies from existing categorical fund sources such as titles IV-E, IV-B, and XX; Medicaid, TANF, state general fund, County Child Care Fund, and state ward board and care.

While the task force's Final Report provides an initial framework for a performance-based child welfare system, additional program design and implementation planning remain. Next steps in the development include:

- Continuing stakeholder meetings of the Child Welfare Partnership Council (CWPC) to provide broad strategy, development and oversight of the model.
- Convening several workgroups to develop detailed program components.
- Establishing a state contract for actuarial services and funding mechanisms.
- Agreement by stakeholders on defined performance measures and objective methods of measurement.
- Establishing a state contract for an independent third-party evaluator.
- Hiring a project management team to facilitate the performance-based child welfare system's initial design and implementation plan.
- Collaborating with counties/regions willing to participate in initial implementation of the model.

V. Phased, Integrated Approach to Implementation

DHS is using a phased, integrated approach to implementation of MITEAM and CQI in a performance-based child welfare system using a limited set of performance indicators and groupings of counties to lay the foundation for improved practice and systemic capacity, leading to full-scale statewide implementation. This implementation effort is being guided by leadership at all levels through the implementation teaming structure.

Transition to the new teaming structure on the state level began in January 2014 and will remain in initial implementation through July 2014. Subteams now convene at regular intervals each month[8] and each subteam is responsible to identify its own methods for scheduling meeting times/locations, communications, and ensuring the completion and submission of a formal report to the SOFAC Implementation Plan matrix by the last business day of each month.

The Strengthening Our Focus Advisory Council (SOFAC) convenes at least once every six weeks to review and direct the work of the subteams. Co-chairs for each subteam provide a summary of their efforts and identify specific aspects of the subteam's strategies that require decision or input from the entire SOFAC. Although subteam members do not actively participate in the SOFAC meetings, they are encouraged to join the meeting as observers to allow for greater, first-hand sharing of information.

MITEAM and CQI will be implemented following an agreed upon schedule in groups of counties over a five-year period, although a more rapid plan for deployment will continuously be pursued if possible. Requests for proposals to contract for the performance-based contracts with private agencies will be issued for one group of counties/private agencies after another, ultimately for every county in the state, to coincide with completion of the planning phase of implementation of MITEAM and CQI. The first group of champion counties (Kalamazoo, Mecosta, Osceola, and Lenawee) has completed the planning phase of implementation of MITEAM and CQI and will commence initial implementation in July 2014.

Planning has already begun in Kent County for the implementation of MITEAM and CQI. Initial implementation in Kent County is scheduled for October 2014. Initial implementation in Kent County will be from October 2014 to September 2015. Pending approval of recommendations from the Michigan Child Welfare Performance-Based Funding Final Report, the time period of October 2014 to September 2015 would be an intensive planning year for the development of a performance-based child welfare system, which would include an assessment of children currently in the system in that area to understand

[8] Subteams may need to convene workgroups or other meetings in between formal subteam meetings as needed.

distribution of cases from the perspective of case complexity and the issuance of an RFI and RFP to the private agencies in the champion counties. The first performance-based model and contracts would be in place beginning on October 1, 2015, with all of the private agency entities that were competitively selected through the RFP process in these counties.

The five- year phased implementation of MiTEAM, CQI and performance-based child welfare system would follow this same model. Generally following the schedule outlined below, DHS will proceed with the MiTEAM and CQI implementation to be followed by the issuance of an RFI and RFP in that area of the state to coincide with the completion of the planning phase of MITEAM and CQI implementation. It should be noted that since the MITEAM, CQI and performance-based child welfare system are all expected to benefit from lessons learned in early design, development and initial implementation efforts, final and overarching plans for implementation are subject to change.

This incremental approach to implementation will provide an opportunity to train an initially small number of caseworkers and supervisors to begin implementation, use lessons learned in their experience to refine the implementation process, and use that information in training and supporting increasingly larger numbers of staff to participate in the implementation process. This process of phasing implementation will afford time to refine DHS' implementation skills and capacity while building local implementation capacity in an informed manner, ideally using lessons learned from the earliest implementation efforts. The process will also permit DHS to identify systemic barriers to effective implementation in a controlled setting before attempting to implement improvement strategies statewide, encountering barriers that will be more difficult to surmount. Although the phased approach may take a bit more time to implement fully, taking the time to do things correctly initially will help compensate for backtracking later when implementation moves forward without the benefit of knowledge and experience.

Successful implementation efforts that have an impact on practice with children and their families must be carefully planned and orchestrated. Melissa Van Dyke explained part of the reason for this during the 2011 Global Implementation Conference in Washington, DC.

> *New practices generally do not fare well in existing organizational structures and systems. During this time of early learning, caseworkers, supervisors and staff at all levels can feel uncomfortable or awkward as they try new approaches to practice. It is important to help them manage the discomfort of this stage and expectations for what can be accomplished. It is normal to not get it right. Resistance can be a signal that staff may not have been adequately prepared or that there is a need to change*

implementation strategies. Providing information, reflecting concerns and rolling with some of the resistance can help build needed buy in throughout implementation.[9]

The timeline below illustrates the core tasks according to the implementation phases – planning; initial implementation; assessing readiness; and full, sustained implementation - at the county level. With the addition of a development phase, the state overall will be following the same implementation phases.

Although the timeline illustrates what appears to be a linear process, the implementation process is rarely linear in nature. At any point in the process, lessons learned may trigger a return to an earlier phase for modification, clarification or adjustment. This could occur at the statewide or county level. The department expects implementation will be dynamic, will take full advantage of information obtained from CQI reviews and other sources of information, and will make necessary adjustments to the content of what is being implemented and the implementation process itself to improve outcomes for children and families.

For statewide activities, the state will be completing activities associated with development of what is to be implemented, with the planning needed for initial implementation and for moving into statewide full, sustained implementation. For example, the state has agreed on a set of key performance indicators to measure progress and has begun to make progress on establishing a set of baseline measures for the key performance indicators. These activities are designed to build DHS' capacity to support and sustain statewide implementation. Similarly, counties entering the implementation process will all need to go through a planning phase of approximately six months to lay the foundation for initial implementation within the counties, and will then proceed through an initial implementation phase before proceeding to full, sustained implementation. Data tracking will occur for at least one year following the first year of full, sustained implementation.

Simply put, the purpose of rolling out in champion counties first is to help leadership: 1) assess the quality and quantity of the content in the practice model; 2) evaluate the extent to which the training, coaching and other implementation supports have been effective; 3) understand the extent to which the practice model has been implemented as designed; and 4) assess the extent to which KPIs and outcomes for children and families are showing early signs of improvement. Beyond Kalamazoo, Lenawee, Mecosta, Osceola and Kent counties, determinations have not been made about the next grouping of counties to begin implementation, which is a priority activity for the MITEAM/CQI subteam of the Strengthening Our Focus Advisory Council (SOFAC). The timeline below offers a general

[9] Van Dyke, Melissa. (2011) *Active Implementation Frameworks to Integrate Science and Practice,* Global Implementation, Conference, Washington, DC.

depiction what will happen during each phase of implementation for each county or set of counties involved in this approach.

Although the state has projected anticipated timeframes for each implementation phase, critical tasks and benchmarks of progress have been identified within each phase that should be achieved at the statewide and county levels before either one can move to the next phase. While all tasks listed within each phase are important and essential to the ultimate success of the implementation process, there are certain critical tasks that must absolutely be achieved before moving to the next phase. For example, if a county does not have the basic staffing and caseload ratios during the planning phase, it should not move into initial implementation until those ratios are in place. Otherwise, the likelihood of the county's success in achieving the next set of activities will be seriously compromised.

The tasks identified in the charts below represent the major, overarching tasks that are associated with each implementation phase. The tasks for implementing MiTEAM and CQI in a performance-based child welfare system must be integrated during implementation, so the chart incorporates them in that manner. For example, MiTEAM needs to be supported and reinforced by the CQI process. Each task must be broken out into more specific action steps and included in the appropriate state or county level implementation plan. The department has already identified progress to date in relevant areas.

A. Development Phase

This is the phase in which the state, in partnership with key stakeholders, has been determining what is to be implemented and how it will fit into the existing system.

The development phase includes assessing the strengths and needs in the child welfare system, defining the teaming structure for engaging and convening key stakeholders, conceptualizing a model of practice, prioritizing key performance indicators and developing a plan for continuous quality improvement. During this phase, the state finalized the vision, mission and guiding principles, defined a teaming structure to support implementation, developed a master statewide plan, further developed the content of MITEAM, expanded the CQI plan, defined key performance indicators and agreed on criteria for selecting practice model counties. The state is already moving into the planning phase.

Development Phase Tasks	Responsible Entity
Finalize master statewide implementation plan and work plans for the SOFAC subteams.	SOFAC and SOFAC Subteams
Define the relationships among the SOFAC, the DHS/CSA administrative structure, and the business service centers for managing county and private agency operations.	SOFAC
Identify the MiTEAM fidelity measures, key performance indicators (KPIs) and outcomes that will be tracked. Determine how these data will be tracked, and relate to and inform MiTEAM and CQI implementation.	SOFAC, DCQI, and MITEAM/CQI Subteam
Finalize the revision to the content of the practice model.	MiTEAM/CQI Subteam
Secure broad statutory authority to manage and fund the PBF model, which includes capacity to braid federal, state and local funding sources into one cohesive source. • Resolve specific issues related to county child care fund.	CWPC

Development Phase Tasks	Responsible Entity
• Initial authority for at least Kent County.	
Hire a qualified project management director and team for development and initial implementation of the PBF model.	DHS and CWPC
Procure qualified actuarial and rate-setting services for cost analysis and other associated needs in development of the PBF model.	DHS and CWPC
Ensure systematic collection of data to measure performance of public and private agencies in regards to the PBF model. • Implement MiSACWIS. • Develop transparent reporting capacity on a set of agreed upon outcomes and indicators of performance.	CWPC,MiTEAM/CQI, and MiSACWIS Subteams
Develop a performance evaluation management function and implementation plan to assess public and private agency performance with PBF-defined outcomes and the State CQI plan.	CWPC and MiTEAM/CQI Subteam
Procure qualified project evaluation services for initial and full implementation of PBF model.	DHS and CWPC
Develop communication plan with the goal of ensuring that state office, county and private agency staff and other key stakeholders clearly understand the approach.	DHS, CWPC, and State and County Communication Subteams
Develop a process for ensuring that each county has the service array to meet the needs of children and families as identified in the practice model.	Resource Development Subteam
Develop guidance regarding county CQI subteams engaging in a regular schedule of county case reviews and debriefing with appropriate staff to identify strengths and needs in practice.	DCQI and MiTEAM/CQI Subteam
Develop guidance regarding county CQI subteams gathering and analyzing information regarding the primary systemic factors.	DCQI and MiTEAM/CQI Subteam
Provide information to the MiTEAM/CQI Subteam and County CQI subteams regarding	DCQI and BCAL

Development Phase Tasks	Responsible Entity
the key DHS case reviews: description of areas covered by reviews; type and number of cases reviewed; sampling strategy; frequency of reviews/schedule for conducting reviews; makeup of case review teams and necessary supports for the review team such as training and coaching; description of process to ensure inter-rater reliability and quality of case reviews; and description of how information is reported and utilized.	
Develop guidance regarding an approach for testing solutions in response to identified areas needing improvement in a reasonable amount of time and with a limited number of cases (i.e. usability testing, Plan-Do-Study-Act).	MiTEAM/CQI Subteam

B. Planning Phase

This is the phase in which DHS will determine how to proceed with implementation and ensure needed supports are in place for that implementation to succeed.

Moving into this second phase of implementation with clear agreement on what is to be implemented and the structure for doing so, DHS will be assessing readiness to implement and identifying potential barriers, understanding trauma-informed organizational readiness for change, developing implementation plans, putting into place key systemic supports (i.e. training, policy, caseloads and staffing), preparing stakeholders for implementation, testing certain critical components of the practice model and obtaining reliable baseline data.

Each county must be sure that the necessary support infrastructure is in place to begin initial implementation. Caseload sizes and supervisory ratios must meet agreed- upon standards to ensure that the county has the staffing capacity to support implementation. There must be a functioning county implementation team with key stakeholders meaningfully engaged in the process as well as a finalized county implementation plan with sufficient resources to support its implementation. There must be baseline data on the each of the agreed-upon key performance indicators for that county.

It is important to note that even though the state may move to initial implementation once the three champion counties begin implementation, the state must continue to carry out planning phase activities as new counties enter the implementation cycle, such as ensuring full staffing and compliance with caseload standards for incoming counties.

Planning Phase Tasks	Responsible Entity
Implement communication plan with the goal of ensuring that state office staff, county, private agency staff persons and other key stakeholders clearly understand the approach.	DHS, CWPC, and Communications Subteam
Develop content and approach to kick-off sessions for MiTEAM.	State MiTEAM/CQI and Training Subteams, Office of Workforce Development & Training (OWDT), CTAC
Complete Trauma Readiness Assessment (TISCI) by county and meet with DHS administrators and supervisors to discuss results.	CTAC and County Teams
Meet with private agency supervisors, leadership and key staff to identify organizational challenges and barriers that negatively impact culture that undermines workforce psychological safety.	CTAC and County Teams
Provide half-day Trauma 101 Training	CTAC
Develop content and approach to MiTEAM coaching labs.	State MiTEAM/CQI and Training Subteams, OWDT, CTAC
Identify membership of county implementation teams in each of the champion counties to provide overarching leadership and guidance for development, planning and implementation of MiTEAM/CQI.	SOFAC, county directors and local private agency directors operating in each county
Identify membership and scope of county subteams in the champion counties for four core areas needed for initial implementation: Communication, CQI, Data Collection/Analysis, MiTEAM (and subsequently in other implementing counties).	SOFAC and County Teams
Identify membership and scope of county subteams in the champion counties for a limited set of other priority practice/systemic areas identified by the champion counties. Examples may include Training, Family Visitation, Secondary Trauma, or Staff Retention. Note: This action allows counties to target and immediately impacting critical issues that impact child and family outcomes in the county.	SOFAC and County Teams
Convene county subteams and develop strategies that address each subteam's scope/focus, including how each subteam functions with one another and similar state subteams (and	County and Subteams

Planning Phase Tasks	Responsible Entity
subsequently in other implementing counties).	
Develop a clear understanding of the already existing CQI processes (public and private agencies) operating within the county.	County CQI Subteams
Seek the following information from the relevant private agencies regarding case review processes currently being utilized: description of areas covered by reviews; type and number of cases reviewed; case review protocols utilized; frequency of reviews; and description of how information is reported and utilized.	County CQI Subteams
Seek information from the relevant private agencies to understand any current methods for gathering information regarding the primary systemic factors.	County CQI Subteams
Develop measures and process for gathering for fidelity to MiTEAM.	MiTEAM/CQI Subteams
Validate all KPI data reports and take action to address identified data quality concerns.	DCQI and County CQI/Data Collection & Analysis Subteams
Collect and analyze data on the KPIs to establish baseline measures in the implementing counties prior to initial implementation.	DCQI and County CQI/Data Collection & Analysis Subteams
Collect and analyze data on the outcomes to establish baseline measures in implementing counties and for the performance-based system.	DCQI and CWPC
Establish a schedule for generating data reports for the KPIs and outcomes (e.g., KPIs may need to be reported on more frequently than outcomes since they are practice-related indicators).	DCQI and CWPC
Ensure an adequate and valid reporting process is in place for the KPIs and outcome measures.	MiTEAM/CQI Subteam and CWPC
Building on the existing resources available through the MiTEAM analysts, CQI analysts and peer coaches, define and agree on the training, coaching and ongoing support that will be made available to help staff and partners in the targeted sites and ultimately statewide build skills in using MiTEAM and associated CQI activities. Hire and train these resources.	MiTEAM/CQI Subteam
Test certain, identified critical components of MiTEAM and the CQI plan and revise as may be	MiTEAM/CQI Subteam

Planning Phase Tasks	Responsible Entity
needed.	
Obtain reliable baseline information in the champion counties (and subsequently in other implementing counties) on key areas to be measured. Develop a plan for a baseline review of counties beginning in the initial implementation phase of MiTEAM to provide a standard against which to measure progress going forward. Key issues to be considered include: how will KPIs and outcomes be measured; how will QSR information be utilized; should practice observations and case reviews in addition to the QSR be utilized; and how will systemic factors be evaluated?	MiTEAM/CQI Subteam, DCQI and CWPC
Develop a reporting template for the findings of the baseline reviews to be conducted in champion counties.	MiTEAM/CQI Subteam, DCQI and CWPC
Develop a plan for ongoing annual reviews of implementing counties utilizing the same measures and methods as the baseline reviews.	MiTEAM/CQI Subteam, DCQI and CWPC
Develop a reporting template for the finding from the annual ongoing reviews to be conducted in implementing counties following the baseline review.	MiTEAM CQI Subteam, DCQI and CWPC
Develop a process to ensure that the SOFAC and county implementation teams receive information regarding areas needing improvement from the baseline reviews and other CQI activities.	MiTEAM/CQI Subteam and SOFAC
Define the key performance indicators and systemic supports that implementing counties must achieve/have in place by the end of the initial implementation phase.	MiTEAM/CQI Subteam
Create a communications plan to establish and implement internal and external communication strategies to engage child welfare professionals and stakeholders during implementation and beyond.	County Communication Subteam (See Kalamazoo County Communications Plan as example)

C. Initial Implementation Phase

During the initial implementation phase, each county, guided by its own implementation plan, will begin to put MITEAM and CQI into place with children and their families. Kickoff

sessions, trauma framework preparation sessions and coaching labs are the primary methods the practice model will be delivered in each county. All DHS and PAFC case and non-caseload carrying staff will have a brief introduction to what it means to begin initial implementation, the CQI process and an introduction to the key concepts in the practice model. These kickoff sessions will be held in the locations identified by county implementation teams and are scheduled to last at least two hours. All child welfare staff persons will be involved as participants and/or discussion leaders, including top administrators within the county from DHS and PAFC agencies, supervisors, caseworkers and administrative assistants. The agenda will include a welcome from the county director or other top administrators, an introduction to the practice model, an overview of the upcoming trauma prep sessions, coaching labs and wrap up.

A three-hour Trauma Framework Prep Session will occur afterward and will cover the key components of what it will mean to implement a trauma-informed practice model. These components will include:

- Secondary traumatic stress (STS)/organizational stress.
- Impact of traumatic stress on children, parents and caregivers.
- Trauma screening.
- Resiliency-based case planning.

The next step will be to begin the coaching labs. The purpose behind the coaching labs and small group sessions with supervisors is to guide and support the professional development of staff and facilitate change in work with children and families. To accomplish, practice coaches will take the following steps:

1. Work with supervisors in small groups to get a baseline assessment of practice before each coaching lab and prepare them for each coaching lab.
2. Use each half-day coaching lab sessions with DHS and private agencies supervisors and caseworkers to build skills, strengthen the unit and model a learning culture. These sessions will have no more than 15 to 20 participants, although it will depend on the size of the county.
3. Units will then implement the development plan that they each created in the half-day coaching lab session.
4. Bring supervisors back together in small groups to recognize progress and build supervisory skills to continue the development of caseworkers.

These steps will be taken for each of these key competencies of the practice model:

- Engagement
- Teaming
- Assessment
- Case Planning
- Case Plan Implementation
- Placement
- Mentoring

Each county will spend close to one year in this phase.

Each county will move into this initial implementation phase understanding what is to be implemented, how and with what supports it will be implemented and how its progress (or lack thereof) will be measured. Everyone must understand what persons at all levels will be doing and saying differently when implementation has occurred. A baseline will have already been established, which will be used to measure progress on agreed-upon performance indicators during initial implementation. The teaming structure to support implementation will be functional. These performance indicators will help determine if the county is heading in the right direction and inform the extent to which adjustments are needed to the implementation plan, including needed supports and other resources.

The overall purpose of this phase is to understand how to implement certain, identified components of the practice model and the extent to which the implementation supports and the data collection processes are working. This is an opportunity to maximize learning from the fewest possible examples, quickly detect challenges, make revisions and retest to see if results improve and stabilize the full intervention package.

To move into full, sustained implementation, each county office must have ensured that the following have happened within its own county:

- Supervisors and caseworkers have received the agreed-upon training.
- Supervisors and caseworkers are receiving the agreed-upon coaching.
- Reports on agreed-upon key performance indicators, fidelity measures and outcomes are being provided regularly as a part of the CQI process, and sufficient progress is being made.
- The county has maintained a functioning implementation team, including county CQI subteams during initial implementation.
- The county has developed an updated implementation plan to reflect areas of focus for improvement in full, sustained implementation phase.
- The county has maintained adequate staffing/caseload/supervisory ratios during the initial implementation phase.

Initial Implementation Phase Tasks	Responsible Entity
Implement communication plan with the goal of ensuring that state office, county and private agency staff persons and other key stakeholders clearly understand the approach and change process.	State and County Communications Subteams
Develop, implement, document strategies that address scope of each subteam. Note: documentation is to occur on at least monthly basis in State Implementation Plan matrix.	All State Subteams
Deliver MiTEAM kickoff sessions	MiTEAM/CQI Subteam
Deliver trauma informed prep sessions.	MiTEAM/CQI Subteam, CTAC
Deliver trauma-infused, MiTEAM coaching labs	MiTEAM/CQI Subteam
Design and implement a plan to utilize already existing, modified or new CQI processes operating within the county.	Champion County CQI Subteams
Design and implement a plan to conduct case review process that includes a description of areas covered by reviews; type and number of cases reviewed; case review protocols utilized; frequency of reviews; and description of how information is reported and utilized.	Champion County CQI Subteams
Design and implement a plan to gather and analyze information regarding the primary systemic factors.	Champion County CQI Subteams
Operationalize county implementation plans in the champion counties (and subsequently in other implementing counties).	County Implementation Teams
Generate data reports for the champion and comparison counties for each KPI.	DCQI
Validate all KPI data reports and take action to address identified data quality concerns.	DCQI and County CQI/Data Collection & Analysis Subteams
Operationalize data reporting for outcomes and KPIs in each county according to an established schedule and protocol.	DCQI and MiTEAM/CQI Subteam
Implement the plan for ongoing annual reviews of implementing counties utilizing the same	MiTEAM/CQI Subteam and DCQI

Initial Implementation Phase Tasks	Responsible Entity
measures and methods as the baseline reviews.	
Implement the process to ensure that the SOFAC and county implementation teams receive information regarding areas needing improvement.	MiTEAM/CQI Subteam and SOFAC
Use lessons learned during the initial implementation phase to define the key performance indicators and systemic supports that all implementing counties must achieve/have in place by the end of the initial implementation phase.	MiTEAM/CQI Subteam
Align roles of the permanency resource monitors, health liaison officers and educational planners to support MiTEAM.	DHS and SOFAC
Modify policy to align with MiTEAM and to ensure workers understand their roles in placing children and youth with relative caregivers.	OCWPP and Placement Subteam
Modify training to align with MiTEAM and the placement process.	OWDT and Training Subteam
Ensure that county recruitment and retention plans include strategies for conducting targeted and child-specific recruitment of homes for identified children and youth who need more appropriate placements.	OCWPP and Placement Subteam
Identify and as applicable enact strategies to address resource development needs in the champion counties (and subsequent implementing counties) to strengthen implementation of MiTEAM.	Resource Development Subteam

D. Full, Sustained Implementation Phase

Most children and families will be engaged with caseworkers practicing in accordance with MITEAM during the full, sustained implementation phase. Data tracking will occur for one year following the first year of full, sustained implementation to track progress over time and ensure that practice improvements are being sustained.

Michigan Practice Model Manual

Department of Human Services
Children's Services Administration

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I. Introduction

A. Purpose of the Practice Model Manual

The MiTEAM Practice Model is an approach to case practice that incorporates the vision, guiding principles and key caseworker activities needed to implement the mission of the Michigan Department of Human Services (DHS) successfully. This Practice Model Manual provides general and detailed practice guidance for caseworkers and supervisors on how to implement the core competencies, a summary of key requirements, a summary of relevant policies and additional resources to support implementation.

The MiTEAM Practice 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. A child welfare trauma-informed approach understands and recognizes that the vast majority of children in foster care have experienced complex trauma, which can significantly harm individual and familial development. In response, trauma-informed child welfare systems educate 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. MiTEAM builds on recent research revealing that traumatic stress can have serious physiological, psychological and relationship consequences 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

The Practice Model Manual is a vehicle for unifying practices with private agencies, tribal partners, policies, training and other organizational resources within DHS. It provides consistent direction to child welfare agency staff and other stakeholders on casework activities and services to children and families utilizing a trauma informed approach. It links the organizational values and guiding principles of DHS to specific interventions and activities that all children and families should experience, such as comprehensive assessments of their strengths, traumatic exposure to stress and needs, meaningful involvement in case planning, and effective services tailored to their needs.

B. Methodology

The manual has been developed to build upon prior MiTEAM implementation efforts, address feedback from DHS staff, core team members and additional external stakeholders, and to accomplish the DHS goal of further developing the content of MiTEAM. DHS and the Center for the Support of Families (CSF) partnered to determine a methodology for the further development of MiTEAM. The agreed upon approach focused on the desire to include broad stakeholder input in the development of this manual. The methodology used to develop this manual during the period of June 2013 to May 2014 included the following:

- **Establishing core teams:** Core teams were established to focus on areas that had been identified by DHS staff and external stakeholders as needing further development. These areas included the assessment, engagement, case planning and 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, child protective services and placement.

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

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

Engagement Core Team:

Brandi Campbell	Ingham County DHS
Theodore Jay	Clinton County DHS
Jennifer Parks	Ingham County DHS
Royanda Amos	Kalamazoo County DHS
Laura Lovell	Mecosta/Osceola County DHS
Candice Stokes	Orchards Children's Services
Danielle Lawler	Lutheran Social Services of Michigan
Bob Davis	Lenawee County DHS

Assessment Core Team:

Hollie Hosford	Bethany Christian Services
Shay Mavis	Foster Care Source
Jamie Lovelace	Clinton-Gratiot County DHS
Jennifer Ryckman	Ingham County DHS
Wiley Boulding	Kalamazoo County DHS
Carie Marvin	Mecosta/Osceola County DHS
Melanie Rand	Ingham County DHS
Deb Disler	D.A. Blodgett
Deborah Palaszek	Foster Care Source

Case Planning and Plan Implementation Core Team:

Jaclyn Caroffino	Jackson County DHS
Scott Campau	Clinton-Gratiot DHS
Kevin Sellers	Lenawee County DHS
Courtney Villarreal	Lenawee County DHS
Lori Curry	DHS Washtenaw County

Angela Mitchell	Bethany Christian Services

Placement Core Team:

Lalemma Hudnell	Kent County DHS
Lesa Brenner	Kalamazoo County DHS
Lori Curry	Washtenaw County DHS
Kevin Sellers	Lenawee County DHS
Courtney Villarreal	Lenawee County DHS
Angela Mitchell	Bethany Christian Services
Jamie Dillon	Lenawee County DHS
Jaclyn Caroffino	Jackson County DHS
Audrey Dodgson	D.A. Blodgett
Rebecca Rasmussen	Mecosta/Osceola County DHS
Vicki Orleans	Orchards Children's Services

Central Office Participants:

Wendy Campau	DHS Central Office
Nancy Rostoni	DHS Central Office
Tracie Kress	DHS Central Office
Jemar Sutton	DHS Central Office
Phil Dickinson	DHS Central Office
Wende Abernathy-Perkins	DHS Central Office
Monica Sturdivant	DHS Central Office
Rose Clyne	DHS Central Office
Kelly Sesti	DHS Central Office
Sasha Furney	DHS Central Office
Suzanne Stiles-Burke	DHS Central Office

Harmony Scalet	DHS Central Office
Ellicia Jackson	DHS Central Office
Anna Donaldson	DHS Central Office
Renee Gonzales	DHS Central Office
Bill Johnson	DHS Central Office
Colin Parks	DHS 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

Children's Trauma Assessment Center Participants:

James Henry	Children's Trauma Assessment Center
Amy Perricone	Children's Trauma Assessment Center

- **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.

C. Mission, Vision and Guiding Principles

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

Mission: DHS 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.

The vision and mission are achieved through the following guiding principles:

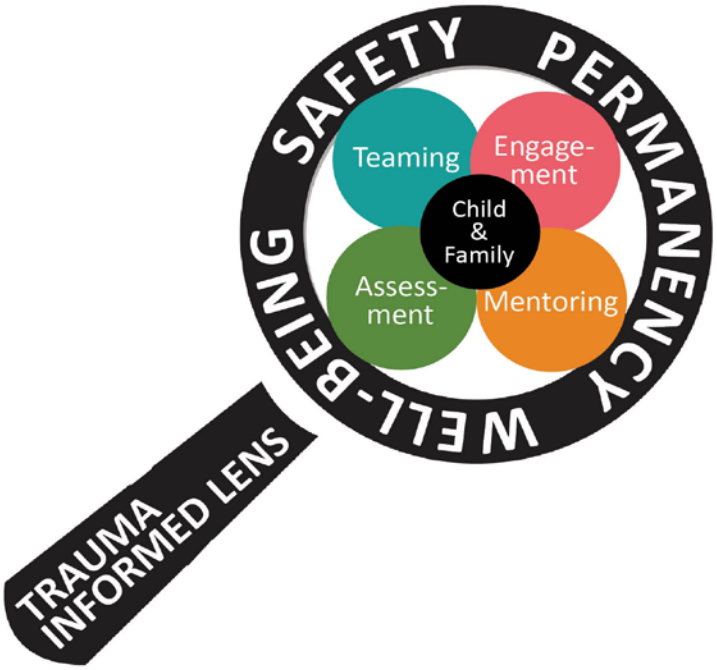
- Safety is the first priority of the child welfare system.
- Families, children, youth and caregivers will be treated with dignity and respect while having a voice in decisions that affect them.
- The ideal place for children is with their families; therefore, we will ensure children remain in their own homes whenever safely possible.
- 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.

The practice model has four core competencies that align with Michigan's mission, values and guiding principles. The four core competencies of MiTEAM are: teaming, engagement, assessment and mentoring. Child welfare professionals will implement these guiding principles through a demonstration of these core competencies in everyday practice with children, youth and their families.

D. 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; engagement, teaming, assessment (case planning, plan implementation and placement) and mentoring.



Twenty-nine (29) key caseworker activities have been identified to help caseworkers understand what it means to implement these core competencies and to 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. Outlined below is a summary of each competency and the corresponding key caseworker activities.

MiTEAM Competency 1: 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.

Here are the key caseworker activities to implement the engagement competency.

Activity 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.

Activity 2 Engagement:

Search for and engage parents, family members and other support persons from the child's community in the family team process.

MiTEAM Competency 2: 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.

Here are the key caseworker activities to implement the teaming competency.

Activity 3 Teaming:

Form a family team.

Activity 4 Teaming:

Prepare members of the family team for participation on the team and for upcoming decisions.

Activity 5 Teaming:

Ensure members of the team meet and participate in shared decision-making on a regular basis.

MiTEAM Competency 3: 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 potential impact of traumatic stress on children and parents is a part of this assessment process, so that it can be addressed in case planning. *Four **assessment**-related key caseworker activities are identified below*.

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 end-point outcomes necessary for exiting the system.

Also derived from the assessment process, caseworkers must engage the team in the process of **planning** for safety, permanency and well-being that is built on resiliency, documenting this plan and **implementing** the plan. *Five **case planning**-related key caseworker activities and six **case plan implementation** key caseworker activities are identified below.* 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 child welfare system involvement and linkages between the identified needs, desired changes and use of family strengths to meet case planning goals.

*Six **placement**-related key caseworker activities are identified below*. 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 or parent. Supervisors will educate, coach and model key caseworker activities in assessment, planning, implementing, and tracking practices.

Here are the key caseworker activities to implement the assessment competency.

Activity 6 Assessment:

Use formal and informal assessment techniques to collect information.

Activity 7 Assessment:

Collaborate with team members to identify child and family strengths, trauma histories and needs.

Activity 8 Assessment:

Organize and analyze all information that is collected to develop a comprehensive family assessment.

Activity 9 Assessment:

Update comprehensive family assessment on a regular basis and prior to case closure.

Activity 10 Case Planning:

Involve families and other team members in a case planning process with a long-term view toward safety and permanency.

Activity 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.

Activity 12 Case Planning:

Develop plans that have behaviorally specific and achievable goals and action steps.

Activity 13 Case Planning:

Use visits with the child and parent to make progress on goals and action steps.

Activity 14 Case Planning:

Track progress on case plan implementation and adjust as needed.

Activity 15 Case Plan Implementation:

Engage with service providers.

Activity 16 Case Plan Implementation:

Clarify specific service needs when making referrals.

Activity 17 Case Plan Implementation:

Provide services promptly and on an ongoing basis to increase safety, reduce risk, address well-being and promote timely permanency.

Activity 18 Case Plan Implementation:

Use caseworker visits to mobilize services.

Activity 19 Case Plan Implementation:

Evaluate the appropriateness and effectiveness of services.

Activity 20 Case Plan Implementation:

Provide services at the time of discharge and case closure.

Activity 21 Placement:

Assess whether potential relative or kin caregivers are willing and able to safely care for children and youth.

Activity 22 Placement:

Work closely with members of the family team to make initial placement decisions, support those placements and plan for transitions.

Activity 23 Placement:

Use assessment information to match children and youth to the most suitable placements.

Activity 24 Placement:

Use visits to preserve connections, strengthen relationships and make progress on identified goals.

Activity 25 Placement:

Facilitate parent involvement with their children.

Activity 26 Placement:

Help children stay connected to their siblings.

MiTEAM Competency 4: 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, 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.

Activity 27 Mentoring:

Promote growth through coaching.

Activity 28 Mentoring:

Create a learning environment through observation and feedback.

Activity 29 Mentoring:

Support change through building honest and genuine relationships.

E. Roles and Responsibilities to Support Implementation

Successful implementation will require coordination of child welfare professionals at all levels to support public and private agency caseworkers.

Supervisors will be responsible for:

- Reviewing caseworkers' performance for the quality and substance of their work with children and families.
- Providing direct and constructive feedback to caseworkers on the quality of their work.
- Monitoring the key caseworker activities.
- Modeling, observing and coaching staff persons in effective approaches and methods that are consistent with MiTEAM.
- Identifying and addressing secondary traumatic stress.
- Creating a safe and supportive environment to facilitate processing of secondary traumatic stress.

- Identifying systemic needs, including additional/different services that are essential for implementing and maintaining the practice model and advocating for those needs.
- Serving as part of the broader continuous quality improvement process.

Non case-carrying professionals (i.e. education planners, health liaisons, child welfare funding specialists, centralized intake, case aides) will be responsible for:

- Participating in MiTEAM educational activities and coaching labs.
- Utilizing and modeling the skills and techniques identified in the MiTEAM practice model in daily activities.
- Identifying systemic needs, including additional/different services that are essential for implementing and maintaining the practice model and advocating for those needs.

Program and section managers will be responsible for:

- Creating a safe and supportive environment to facilitate processing of secondary traumatic stress.
- Reviewing the performance of supervisors for the quality and substance of their work with caseworkers.
- Coaching, educating and modeling effective approaches and methods that are consistent with MiTEAM.
- Monitoring supervisors on the implementation of the practice guidance.

District managers will be responsible for:

- Serving as visible spokespersons and advocates.
- Leading the development of an organizational culture and climate that is proficient, engaged and functional.
- Providing needed support to section managers, supervisors and caseworkers with an emphasis on identification of and addressing secondary trauma.
- Leading the design and implementation of improvement efforts.
- Holding staff accountable in effective approaches and methods that are consistent with MiTEAM.

County and private agency directors will be responsible for:

- Serving as a visible spokesperson and advocate.
- Managing to the outcomes and monitoring data.
- Identifying the strengths and needs of the county/agency capacity to implement and maintain MiTEAM.
- Ensuring ongoing involvement of courts and other key community partners.

- Creating an office culture that supports the identification of and plans for addressing secondary traumatic stress.
- Pursuing strategies to reduce organizational stress.
- Leading the design and implementation of improvement efforts.
- Providing needed support to section managers, supervisors and caseworkers.
- Holding staff accountable.

Peer Coaches will be responsible for:

- Observing child welfare professionals during interactions with families and documenting those observations in a behaviorally specific fashion.
- Providing meaningful feedback to caseworkers and supervisors by utilizing the STAR/AR Feedback Process to connect how the caseworkers' behaviors will or will not lead to our key caseworker activities and/or core outcomes.
- Modeling suggested practice guidance to demonstrate to caseworkers how to complete the key caseworker activities. Processing the demonstration with the caseworker to ensure that they are aware of the behavior, helping them make connections so that they can retain the information, discussing how they can carry out the behavior and providing motivation by utilizing personal, social and structural motivational sources.
- Coaching the caseworkers on how the suggested practice guidance will lead to key caseworker activities and guide us to our core outcomes. Identifying goals with the caseworker around the key caseworker activities, assessing the current situation, identifying any obstacles or options and creating a plan for moving forward.
- Training and educating caseworkers and supervisors on the practice model, including the competencies, key caseworker activities and the suggested practice guidance.
- Identifying county needs that are essential for planning, implementing and maintaining the practice model and then advocating for those needs.
- Serving as a part of the broader continuous quality improvement process.
- Participating in the planning and implementation of improvement efforts.

MiTEAM Analysts will be responsible for:

- Supporting the design and implementation efforts.
- Helping to guide the phased approach to implementation.
- Coaching, educating and modeling for peer coaches.
- Serving as a broader part of continuous quality improvement efforts.
- Ensuring that training is skills-based and supports the needs of staff.
- Supporting the skill development of supervisors to develop a culture and climate that supports the implementation of the practice model.

Central Office:

- Developing the phased approach of the implementation of MiTEAM.
- Communicating messages to staff and stakeholders regarding the department's efforts to strengthen the focus on children and families in child welfare.
- Assessing county readiness for implementation.
- Identifying systemic needs, including additional/different services that are essential for implementing and maintaining the practice model and advocating for those needs.
- Examining funding and contracting procedures in ways that ensure the availability of needed services.
- Aligning continuous quality improvement efforts in support of MiTEAM implementation.
- Being informed of county initiatives prior to implementation to insure its alignment with the practice model.
- Ensuring policies and procedures are revised and aligned with MiTEAM.

F. 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.

DHS is initiating and implementing a plan to roll out MiTEAM in concert with key systemic supports and close monitoring of identified performance indicators in place in three champion counties. A phased approach will also be proposed for the entire state, but that approach will be informed by and finalized based on an assessment of the implementation in three champion counties. This limited rollout will demonstrate for the rest of the state what practice consistent with MiTEAM actually looks like, so that those champion counties can then serve as a model for other counties in the rollout 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 rollout of MiTEAM. Public and private agency staff in the champion counties will have opportunities for further input on the content of the manual during the early stages of implementation.

DHS, with input from external stakeholders, has identified key outcomes and indicators of performance that will be monitored during initial implementation.

DHS 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.

DHS is using the term "key performance indicators" (i.e., 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.

G. Use of the Practice Model Manual

There are three levels of information in this manual that have been written specifically for caseworkers and supervisors: 1) easy to read and access high level guidance in the form of practice guides; 2) deeper guidance on key caseworker activities in the form of detailed practice guides; and 3) a resource section that has select examples, papers or journal articles to give interested persons much more detailed information in each of the competency areas.

For example, in the practice guide for caseworkers on engagement, it is recommended that the caseworker conduct a diligent search for family members and other support persons. Clicking on a hyperlink allows an electronic user to access more detailed guidance on what it means for a

caseworker to conduct a diligent search. Then, in the resources section there is a third - even more detailed - level of guidance offered through a link to the Child Welfare Information Gateway regarding examples and models for engaging fathers, paternal relatives and children and youth in various states.

The seven practice guides for caseworkers and associated seven practice guides for supervisors have been developed so they can be utilized as stand-alone, easily accessible sources of MiTEAM guidance.

Certain choices related to language and term usage deserve clarification.

The term 'child welfare professionals' is used when referring to staff persons at all levels within DHS and private agencies contracting with the department.

In general, the term "caseworker" is used throughout the document to refer to direct services professionals having responsibility for cases involving children served by DHS. Caseworkers represent many areas of practice, including CPS, foster care, licensing, adoptions, residential staff and other non-case carrying child welfare staff.

The term "supervisor" defines a person who is directly responsible for monitoring and evaluating the work of a caseworker. These terms include staff directly employed by DHS and those who are employed by a private agency contracting with the department. Recommended key caseworker activities and detailed guidance offered in this document are also intended for private agency staff contracting with the department to provide services and assistance to children and families.

In most instances, "child" or "children" are used to represent young people over whom the juvenile court has jurisdiction in Michigan. 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.

The term "department" means the Department of Human Services in Michigan, specifically the Children's Services Administration.

"Family", when not accompanied by "foster" or "adoptive", refers to the birth or legal family of a child at the time he or she came to the attention of the department. When not accompanied by "foster" or "adoptive", the term "parents" means birth or legal parents at the time he or she came to the attention of the department. Unless otherwise noted, the term "caregiver" is used to describe the person currently caring for a child.

The term "fidelity measures" is being used to describe 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 will help staff at all levels understand the extent to which the practice model is being implemented.

The manual uses the term “key performance indicators” to describe the measures used to determine the extent to which key caseworker activities in the practice model are happening. One key performance indicator, for example, is the extent to which children in a champion county are visiting with their parents.

This manual uses the term “key outcomes” to describe 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 percent of children reunified within 12 months of date of removal who have a recurrence of maltreatment within six months.

This manual uses the acronym “DPG” for detailed practice guidance.

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 key caseworker activities of engagement.

This engagement section provides general practice guidance related to the key caseworker activities, 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 engagement practice with children and families.

2. Practice Guide for Caseworkers

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	• Respect: The caseworker honored the family's right to make their own choices. • Empathy: The caseworker communicated an understanding of the family's experiences or perceptions. • Genuineness: The caseworker gave the family full attention and presented as open and transparent. • Competency: The caseworker provided and welcomed feedback. • The caseworker clearly explained their role for the child and recognized the inherent tension in parent/worker power differential. • The caseworker asked the parents, child (if appropriate) and team members to identify relatives and people in the community who are part of their support network. • The parent, caregiver and/or child (if appropriate) were able to identify helpful activities of the caseworker. • The parent, caregiver and child (if appropriate) felt understood by caseworker. • The parent and child (if appropriate) reported the caseworker approached them from a position of respect and cooperation. • The parent, caregiver and/or child are satisfied with services offered/referred. • The caseworker recognized and acknowledged religious and cultural beliefs. • The parent described collaborative decision making occurred in the case. • The caseworker communicated an understanding of parental experiences and how trauma potentially affected perceptions of themselves and others. • The caseworker asked the parent about potentially traumatic events that the child or parent may have experienced. • The caseworker educated parents and caregivers about how their early traumatic experiences may impact parenting. • The caseworker addressed the impact of trauma on the child with the parent or caregiver.
REQUIREMENTS	• 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 (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 family members that a relation is in foster care until a child has achieved legal permanency.

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.

CASEWORKER ACTIVITIES	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE
ACTIVITY 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, really 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.
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. • 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.

3. Detailed Practice Guidance for Key Caseworker Activities

a. Create an environment of empathy, genuineness and respect 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.

MSA Requirements:

Section II, *MSA Principles* states that:

- Children's Needs: Whenever possible, children must have a voice in decisions that affect them, and DHS must consider the specific needs of each child as decisions are made on his or her behalf.
- Parents and Communities: Parents must be treated with dignity and respect, and, whenever possible, included in decisions that affect them and their children. DHS must actively partner with communities to protect children and support families when determining an intervention plan for the child.
- Services: When DHS intervenes on behalf of children it must strive to leave children better off than if there had been no intervention. DHS must tailor services to meet the unique needs of each family member and provide those services in a manner that is respectful of the child and parents.
- Family Engagement Model: DHS shall develop the policies, procedures and organizational structure necessary to implement a family engagement model, which shall include family engagement, child and family team meetings and concurrent permanency planning.

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

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[2] Masten (2010)

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

MSA Requirements:

Section D.2.b, *Foster Home Capacity and Placement Selection* states that:

- DHS shall ensure that relatives of children in foster care and non-relatives with whom a child has a family-like connection are identified and considered as potential foster home placement children.

Detailed Practice Guidance:

- Locate and contact absent mothers and fathers as soon as possible within the life of the case.
- Conduct a comprehensive archeological dig to identify as many family members and fictive kin for the child or young person as possible, 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. Exposure, even without physical harm, to domestic violence can be traumatizing to children. As a caseworker, it is not if you will be working with families where there is domestic violence, but when and how often. There is a strong correlation among domestic violence, physical abuse of children, and parental substance abuse (co-occurring in up to 66% of foster care cases). Given this, even in cases in which domestic violence has not been identified as a presenting issue, ongoing assessments of the signs and symptoms of domestic violence are best practice.

It is important to understand what survivors of domestic violence are feeling, what keeps them in an abusive relationship, what causes them to return and what unique barriers to self-sufficiency they may face. Imagine that this secret is always at the forefront of your mind – causing constant guilt, shame and fear. Imagine the terror of telling your secret for the first time. Imagine not being believed that your secret is true. Imagine your children being removed because of your secret. Imagine having to tell that secret over and over again as part of your children returning home. Imagine how this secret exacerbates earlier trauma and reinforces condemning, self-blaming messages. This is what it's like to be a survivor of domestic violence involved in the child welfare system. Often community members and professionals blame the survivor because they do not understand the underlying dynamics the survivor is experiencing.

Engaging with children, parents and families is at the core of casework practice; it is at the foundation of the helping relationship and a critical element that leads to safety, permanency and well-being for families. It is important for your personal safety and success as well as the safety and success of the children and families that you work with that you learn to recognize the signs of domestic violence and effectively engage with families when domestic violence is a concern.

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.

MSA Requirements:

There are no applicable MSA requirements.

Detailed Practice Guidance:

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

- Educate yourself on the dynamics and treatment interventions of domestic violence and local available resources to support family members. Recognize and assess the traumatic impact to children within the family exposed to domestic violence.
- Screen and determine if domestic violence is an issue within the family.
    - Review and determine if domestic violence allegations are part of the initial intake.
    - If allegations are not part of the initial intake, ask general questions of family members regarding the quality of their relationships. Do not judge their decisions.
    - Contact the police to see if they have responded to reports of domestic violence at the family member's address.

  - Conduct criminal record reviews. Information gleaned from the alleged offender's criminal record is extremely helpful for the investigator to have prior to making a home visit. The record helps the investigator determine the potential threats and design a safe approach for contacting the family.
- Plan for your safety.
  - Arrange for your supervisor, police escort, domestic violence expert or another caseworker partner to accompany you to visit and interview the alleged offender.
  - Arrange to meet with the alleged offender in a public place; do not meet with him or her alone. You may want to invite this person to meet you at your office.
  - Do not confront the alleged offender with information you have obtained; focus on information obtained in the initial intake or other third-party reports.
- Engage with the survivor and child to plan for their safety.
  - Consider the safety of family members when organizing, structuring and conducting interviews and meetings; make accommodations for needed security, ground rules and criteria for participation.
  - Assess the survivor's history of seeking help and positive changes he or she has made.
  - Screen for the potential traumatic stress to the children due to the exposure to domestic violence. Most often children believe that it is their responsibility to protect the parent victim from harm. The children often attempt or certainly want to intervene during the assault. When the children do not intervene or cannot stop the domestic assault they feel that they have betrayed the parent survivor, which can be extremely traumatizing to them.
- Assess the offender's willingness to engage in treatment and change behavior.

e. 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 at the Brief Family Therapy Center in Milwaukee, Wisconsin 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: DHS-189- Eco-Map; DHS 202-PSF-Personal Inventory; and the DHS 204-Family Portrait to assist in determining the family's strengths and needs.

MSA Requirements:

Section VII.D, *Family Engagement Model* states that:

- DHS shall develop the policies, procedures and organizational structure necessary to implement a family engagement model, which shall include family engagement, child and family team meetings and concurrent permanency planning.

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 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.

- Help rephrase or reflect back to the child or family member the content and feelings that were heard and experienced. *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?*

- 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?*

f. 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, 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?

Policy Requirements:

FOM 722-6A: 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.

MSA Requirements:

There are no applicable MSA requirements.

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.

g. 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. 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.

MSA Requirements:

There are no applicable MSA requirements.

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.
  - 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.

h. 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.[3]

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

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 develop their racial and ethnic identity and to also move towards a society that works against oppression and racism.[4]

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 he or she 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.[5]

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.

FOM 722-6: For American Indian 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

[4] Ibid.

[5] Ibid.

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.

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.

MSA Requirements:

Section II. B, *Children's Needs* states that:

- Whenever possible, children must have a voice in the decisions that affect them and DHS must consider the specific needs of each child as decisions are made on his or her behalf.

Section II. C, *Families and Communities* states that:

- Families must be treated with dignity and respect and, whenever possible, included in decisions that affect them and their children. DHS must actively partner with communities to protect children and support families when determining an intervention plan for the child.

Section II. F, *Services* states that:

- When DHS intervenes on behalf of children it must strive to leave children better off than if there had been no intervention. DHS must tailor services to meet the unique needs of each family member and provide those services in a manner that is respectful of the child and family.

Detailed Practice Guidance:

- Self-Reflection.
  - Define your own cultural, family beliefs and values.[6]
  - Define your own personal culture/identity: ethnicity, age, experience, education, socio-economic status, gender, sexual orientation, religion, etc.[7]

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

[7] Ibid.

- Are you aware of your own personal biases and assumptions about people with different values than yours?[8]
- Challenge yourself in not automatically identifying your own values as the "norm".[9]
- Develop skills for talking about race and ethnicity, addressing racism and discrimination, and integrate into day-to-day practice.[10]

- 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.[11]
  - 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.[12]
  - 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.[13]
  - 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.[14]
  - Be aware that different cultures/ethnicities may have very different views on what is considered appropriate discipline of a child, a 'clean' home and hierarchy of power within the household.
  - 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).

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[8] Ibid.

[9] Ibid.

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

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

[12] Ibid.

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

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

- 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 – DHS 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.
    - 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.

4. Practice Guide for Supervisors

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	• Respect: The caseworker honored the family's right to make their own choices. • Empathy: The caseworker communicated an understanding of the family's experiences or perceptions. • Genuineness: The caseworker gave the family full attention and presented as open and transparent. • Competency: The caseworker provided and welcomed feedback. • The caseworker clearly explained their role for the child and recognized the inherent tension in parent/worker power differential. • The caseworker asked the parents, child (if appropriate) and team members to identify relatives and people in the community who are part of their support network. • The parent, caregiver and/or child (if appropriate) were able to identify helpful activities of the caseworker. • The parent, caregiver and child (if appropriate) felt understood by caseworker. • The parent and child (if appropriate) reported the caseworker approached them from a position of respect and cooperation. • The parent, caregiver and/or child are satisfied with services offered/referred. • The caseworker recognized and acknowledged religious and cultural beliefs. • The parent described collaborative decision making occurred in the case. • The caseworker communicated an understanding of parental experiences and how trauma potentially affected perceptions of themselves and others. • The caseworker asked the parent about potentially traumatic events that the child or parent may have experienced. • The caseworker educated parents and caregivers about how their early traumatic experiences may impact parenting. • The caseworker addressed the impact of trauma on the child with the parent or caregiver.
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.
ACTIVITY	WHERE IN THE LIFE OF THE CASE PRACTICE GUIDANCE

ACTIVITY 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 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.
ACTIVITY 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. • Educate, model and coach caseworkers on how to engage parents, child, community supports, 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, and 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.

5. 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.*"

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 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.

This teaming section provides general practice guidance related to the key caseworker activities, 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 Guide for Caseworkers

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	• Caseworker and parents placed an emphasis on parent and child strengths. • Caseworker identified and formed the family's team that included a qualified group of people – the 'right people' - who support the child, youth, and parent/caregiver in shared decision-making; the 'right people' provide technical and cultural competence for the family's needs. • The family's team met on an ongoing basis and the caseworker has a working relationship with the team that supports the family in achieving both near-term needs and long term goals. • The caseworker facilitated teamwork by preparing team members to plan, implement, monitor, modify and evaluate the family's progress. • The team shared a commitment and unity of effort. • The caseworker educated parents and other team members on the potential impact of trauma. • The team utilized an understanding of trauma to develop case planning for both the child and the parent. • The team addressed specific safety concerns of the child. • The team addressed specific permanency plans and issues of well-being for the child. • There is documented evidence that a team has been formed and is functioning. • Scheduled in-person contacts with the family (e.g. home visits or FTM) were preceded by a clearly documented preparation conversation between the caseworker, family and team members. • Documentation of in-person meetings with the family clearly documented family perspectives on safety, permanency, and well-being and the team's unified commitment for the family's short-term needs and long-term goals. • Documentation that the caseworker maintained contact with the family and support persons between in-person meetings. • The team utilized an understanding of trauma to develop case plans for the child and parent.
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 16 years old and occur once every six months for the purpose of discussing permanency goals and plans and identifying supportive adults. Meetings must be facilitated by someone other than the assigned caseworker. • 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 complete Form 1108 and discuss the purpose of the FTM, confidentiality, family story, strengths, proposed participants, non-negotiables and family needs.

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.	
ACTIVITY	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE
ACTIVITY 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 identity 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.
ACTIVITY 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 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 DHS. 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 considerations. • Create an agenda for the meeting with input and contributions 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.

ACTIVITY 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 need to 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 (i.e. provide transportation to meetings or 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.

3. Detailed Practice Guidance for Key Caseworker Activities

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 know and recognize what effective teaming practice looks like and to assess their 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 focus 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.

MSA Requirements:

Section VII.D.1, *Family Team Meetings* states that:

- Family team meetings shall be used to engage parents, children (when age appropriate) and other team members in case planning, safety planning and case progress assessment.

Detailed Practice Guidance:

- Use team for planning and guiding service delivery.
- Meet the family's linguistic and cultural needs through identifying 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.
- 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 family team meetings to ensure team members are engaged in important decisions.

Background:

DHS is committed to 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 the children served by DHS and make important decisions along the way. 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 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. Peer coaches, 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 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.

MSA Requirements:

Section VII.D.1, *Family Team Meetings* states that:

A family team meeting shall be offered to make or recommend critical case decisions. FTMs shall be led by a trained facilitator, and shall include written invitations in advance of FTM whenever possible to the parents, foster parents, children, family, friends and other supports identified by the parents and children, other service providers lawyer guardians ad litem (LGALs), parents' attorneys and the caseworker, with supervisory participation when necessary. At a minimum for in-home cases, the following shall trigger an FTM: 1) CPS case opening or transfer to ongoing worker; 2) case service plan development and identification of safety issues; 3) prior to removal or the earliest date possible after removal; and 4) case closure. At a minimum, the following events shall trigger an FTM for out-of-home cases: 1) case service plan development; 2) permanency goal change; 3) placement preservation or disruption; 4) permanency planning at six months in care; 5) annual transition planning for youth every six months from age 16 to case closure; 6) 90-day discharge planning for youth; and 7) case closure.

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 1108).

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.

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.

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.[15] Traumatic stress

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

can change the physiology of the brain, especially in children.[16] In the past 20 years research on child trauma[17] has revealed that child maltreatment is very likely to be traumatic to children likely resulting in compromised functioning in multiple developmental areas for children.[18] Children who have

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[16] 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

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

[17] 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

[18] 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

experienced chronic maltreatment since early childhood are likely to experience a number of different types of traumatic events. This phenomenon is defined as complex trauma.[19] 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. [20] 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.

Caseworkers have not consistently been trained to provide a trauma understanding to parents and their children. Utilizing a trauma perspective in child welfare is a change that caseworkers, supervisors, and

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[19]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

[20] 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

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.[21]

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 have initial resistance to 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. These concerns 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.

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[21] 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

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

While 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.

Policy Requirement:

There are no applicable policy requirements.

MSA Requirement:

There are no applicable MSA 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) or witnessed (i.e. domestic violence, parental substance abuse).

- 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.

- 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 oftentimes 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.

4. Practice Guide for Supervisors

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	• Caseworker and parents placed an emphasis on parent and child strengths. • Caseworker identified and formed the family's team that included a qualified group of people – the 'right people' - who support the child, youth, and parent/caregiver in shared decision-making; the 'right people' provide technical and cultural competence for the family's needs. • The family's team met on an ongoing basis and the caseworker has a working relationship with the team that supports the family in achieving both near-term needs and long term goals. • The caseworker facilitated teamwork by preparing team members to plan, implement, monitor, modify and evaluate the family's progress. • The team shared a commitment and unity of effort. • The caseworker educated parents and other team members on the potential impact of trauma. • The team utilized an understanding of trauma to develop case planning for both the child and the parent. • The team addressed specific safety concerns of the child. • The team addressed specific permanency plans and issues of well-being for the child. • There is documented evidence that a team has been formed and is functioning. • Scheduled in-person contacts with the family (e.g. home visits or FTM) were preceded by a clearly documented preparation conversation between the caseworker, family and team members. • Documentation of in-person meetings with the family clearly documented family perspectives on safety, permanency, and well-being and the team's unified commitment for the family's short-term needs and long-term goals. • Documentation that the caseworker maintained contact with the family and support persons between in-person meetings. • The team utilized an understanding of trauma to develop case plans for the child and parent.
REQUIREMENTS	• Youth 16 and older: 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 16 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. • 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: Initial meeting must occur in person; subsequent meetings may occur over the phone. The caseworker must complete the 1108 and discuss the purpose of the FTM, confidentiality, family story, strengths, proposed participants, non-negotiables and family needs.

ACTIVITY	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE
ACTIVITY 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 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.
ACTIVITY 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

ACTIVITY 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.

5. 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.dhhs.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.

C. Competency Three: Assessment (Case Planning, Plan Implementation and Placement)

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. The potential impact of traumatic stress on children and caregivers is a part of this assessment 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 end-point outcomes necessary for exiting the system.

Also derived from the assessment process, caseworkers must engage the team in the process of **planning** for safety, permanency and well-being that is built on resiliency, documenting this plan and **implementing** 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 child welfare system involvement and 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 key caseworker activities in assessment, planning, implementing and tracking practices.

This assessment section provides general practice guidance regarding the key caseworker activities, 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. Assessment Practice Guide for Caseworkers

Practice Guide for Caseworkers	
Assessment	
MITEAM COMPETENCY	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	• The caseworker asked the family what they thought were the primary issues and strengths identified. • The caseworker asked the family how s/he can be of assistance to the family. • The caseworker inquired about the child's perspective on their (physical and psychological) safety and well-being during visits with the child/ youth. • The caseworker inquired about the caregiver's perspective on the (physical and psychological) safety and well-being of the child/youth. • The caseworker requested family input to identify strengths, needs, and effectiveness of services. • The development of the comprehensive family assessment included input from service providers and other members of the team. The case file contained documentation of a trauma screening for the child. • The case file contained documentation of an age-appropriate, developmental questionnaire (e.g. ASQ-SE, Pediatric Symptom Checklist). • The case file contained a comprehensive family assessment on each family. • The agency (re)assessment of progress was written in a behaviorally specific manner. • The caseworker identified parental protective capacity and the parent's ability to safeguard their child. • The perspectives of the child, parent, caregivers, etc. were reflected in the case documentation. • The development of the family assessment included input from service providers and other members of the team. • The caseworker inquired about what the caregiver believes about the impact of traumatic events on the child.
REQUIREMENTS	Policy Requirements: • Conduct a thorough inquiry of family background. • Follow the Forensic Interviewing Protocol (DHS Pub 779) when interviewing children. • Complete a CPS safety assessment as early as possible in SWSS CPS 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 (DHS 258) as required. • Complete Foster Care Family Assessment/Reassessment of Needs and Strengths (DHS145) and age appropriate Foster Care Child Assessment of Needs and Strengths, (DHS-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 (DHS-147). • Complete the Foster Care Safety Assessment (DHS-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 (DHS-1927) within 45 calendar days of case acceptance. • Complete the Child Adoption Assessment Addendum (DHS-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 (DHS-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 (DHS-612) for approval of adoption when a specific child has been identified for a family. Modified Settlement Agreement: • Section VII. B. Supervisory Oversight of Assessment and Service Plans: Supervisors shall meet at least monthly with each assigned caseworker to review status and discuss case progress. • Section VII. C. Provision of Services: Determine the effectiveness of services.
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.

ACTIVITY	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE
ACTIVITY 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. • Explore American Indian heritage by asking the 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. • 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: o Parents' developmental expectations of children. o Parents' empathy of children's needs. o Parents' belief in the use of corporal punishment as a means of discipline. o Parents' roles with child. o 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. • Gather information on the child and family relationships/dynamics using eco-maps and genograms.
ACTIVITY 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.
ACTIVITY 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: o Patterns in abuse history for both the victim and the parent(s). o Parental compliance, participation and benefit of prior services. o 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.

ACTIVITY 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 circum-stances 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 DHS staff including safety and risk assessments, FANS and CANS. • 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. • 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.

3. Detailed Practice Guidance for Key Caseworker Activities

a. First conduct safety assessments to help understand the extent to which children and families are safe and the actions and/or services that may be needed to assure safety. Secondly, conduct risk assessments to estimate the likelihood of future harm to children in the household thus determining which families need ongoing services and when case closure is possible.

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 inquires 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.[22] 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 Child Protective Services face-to-face contacts, safety factors and protective interventions are to be assessed. A safety assessment must be completed and, if required, complete a new safety assessment at other key decision points and update the safety assessment narrative to reflect what child safety planning occurred.

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

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

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.

MSA Requirements:

Section VII. A, *Assessment & Service Plans,* states that:

- DHS shall complete a written assessment of child and family strengths and needs, designed to inform decision making about services and permanency planning, within 30 days after a child's entry into foster care, and shall update the assessment at least quarterly thereafter.

Section VII. B, *Supervisory Oversight of Assessment and Service Plans,* states that:

- Supervisors shall meet at least monthly with each assigned caseworker to review the status and progress of each case on the worker's caseload.

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.
  - 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, general outlook on life and outlook on their role as a parent and education.
  - Use MiSACWIS/SWSS 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.
- 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.

MSA Requirements:

Section VII.D, *Family Engagement Model,* states that:

- DHS shall develop the policies, procedures and organizational structure necessary to implement a family engagement model, which shall include family engagement, child and family team meetings and concurrent permanency planning.

Detailed Practice Guidance:

The steps outline how caseworkers can reduce the trauma of investigation, removal and initial out-of-home placement.[23]

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

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[23] 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.

  - 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.

b. 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, previous 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. 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 CFA 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 child protective services 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.

MSA Requirements:

Section VII. A, *Assessment & Service Plans* states that:

- DHS shall complete a written assessment of child and family strengths and needs, designed to inform decision-making about services and permanency planning, within 30 days after a child's entry into foster care, and shall update the assessment at least quarterly thereafter.

Section VII. B, *Supervisory Oversight of Assessment and Service Plans* states that:

- Supervisors shall meet at least monthly with each assigned worker to review the status and progress of each case on the worker's caseload.

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.[24]

- Conduct Research.
  - Review prior substantiations, services, court documents, 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[25] (see Resources Section) to determine where family members are in accepting the reality of

[24] 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.

[25] 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.
- 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 strength and needs as well as the development of the case plan.

- Continuously assess safety. When required, complete (DHS-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 (DHS257) as required.
- Complete the CPS Family Assessment of Needs and Strengths (DHS259) 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 (DHS145) 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, the safety of the child - that might affect parenting time must be identified and evaluated.
- Complete the FC Family Assessment of Needs and Strengths (DHS-145).

- Complete the age-appropriate FC Child Assessment of Needs and Strengths, (DHS-432, 433, 434, 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 (DHS-147).
- Complete the FC Safety Assessment (DHS-149).
- Provide an accurate and full description of the child, including the child's special needs and history by completing the Child Adoption Assessment (DHS-1927) within 45 calendar days of case acceptance.
- Complete Preliminary Adoptive Family Assessment (DHS-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 (DHS-612) for approval of adoption when a specific child has been identified for a family.

4. Assessment Practice Guide for Supervisors

Practice Guide for Supervisors		
Assessment		
MITEAM COMPETENCY	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	• The caseworker asked the family what they thought were the primary issues and strengths identified. • The caseworker asked the family how s/he can be of assistance to the family. • The caseworker inquired about the child's perspective on their (physical and psychological) safety and well-being during visits with the child/ youth. • The caseworker inquired about the caregiver's perspective on the (physical and psychological) safety and well-being of the child/youth. • The caseworker requested family input to identify strengths, needs, and effectiveness of services. • The development of the comprehensive family assessment included input from service providers and other members of the team. The case file contained documentation of a trauma screening for the child. • The case file contained documentation of an age-appropriate, developmental questionnaire (e.g. ASQ-SE, Pediatric Symptom Checklist). • The case file contained a comprehensive family assessment on each family. • The agency (re)assessment of progress was written in a behaviorally specific manner. • The caseworker identified parental protective capacity and the parent's ability to safeguard their child. • The perspectives of the child, parent, caregivers, etc. were reflected in the case documentation. • The development of the family assessment included input from service providers and other members of the team. • The caseworker inquired about what the caregiver believes about the impact of traumatic events on the child.	
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 caseworkers ability to relate all interactions as times to collect information, which helps in determination of safety/risk.	
ACTIVITY	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE
ACTIVITY 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, child vulnerabilities and 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.

ACTIVITY 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.
ACTIVITY 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.
ACTIVITY 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.

5. Case Planning Practice Guide for Caseworkers

Practice Guide for Caseworkers		
Case Planning		
DEFINITION CASE PLANNING	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	• The caseworker incorporated relevant team member perspectives when developing and adjusting the plan. • Parental protective capacity and ability to safeguard their child was discussed with the family and providers. • The treatment plan identified the needs of the child to achieve well-being and resiliency. • The case file contained documentation of family participation in and agreement to the treatment plan (i.e. signed PATP). • The treatment plan addresses traumatic stress, promotes well-being and resiliency to meet the needs of the child.	
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.	
USE YOUR SUPERVISOR	• Schedule, prepare and actively participate in regular case conferences with your supervisor to discuss: o 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. o What has been completed, the outcome of that effort, pending activities and possible next steps to support the case planning process. o 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.	
ACTIVITY	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE
ACTIVITY 10 CASE PLANNING ***Involve parents and other team members in the case planning process with a***	• Within first 30 days of placement • Every 90 days after initial case opening	• Conduct diligent search 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 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,

long-term view toward safety and permanency.		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 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.
ACTIVITY 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.
ACTIVITY 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 as well as supervision of child and activities to promote educational stability and success.
ACTIVITY 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. • 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.
ACTIVITY 14 CASE PLANNING ***Track progress on case plan implementation and adjust as needed.***	• Reassess-ment • 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 time frames. • 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.

6. Detailed Practice Guidance for Key Caseworker Activities

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.

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 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.

MSA Requirements:

Section VII.D.1.a. *Family Team Meetings* states that**:**

- At a minimum, the following events shall trigger family team meetings for in-home cases: 1) CPS case opening and transfer to an ongoing worker; 2) case service plan development and identification of safety issues; 3) prior to removal or at the earliest possible date after removal; and 4) case closure.

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.
- Specify exactly who must be protected.
- Determine when the identified safety behavior occurs and specific circumstances that lead 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 DHS 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.

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 DHS-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.

MSA Requirements:

Section VII D.1.a, *Family Team Meetings* states that**:**

- At a minimum, the following events shall trigger family team meetings for in-home cases: 1) CPS case opening and transfer to an ongoing worker; 2) case service plan development and identification of safety issues; 3) prior to removal or at the earliest possible date after removal; and 4) case closure.

Section VII.A, *Assessments and Service Plans* states that:

- The service plan shall contain attainable, measurable objectives with expected timeframes, and shall identify the party or parties responsible. If parents are unavailable or decline to sign the plan, the service plan shall include an explanation of the steps taken to involve the family and shall identify any follow up actions to be taken to secure family participation in services.

Detailed Practice Guidance:

- Consider several important questions with members of the team:[26]
  - 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?

[26] *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 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 child protective services 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. 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.

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.

MSA Requirements:

VIII.A. *Services, Placement Resources and Utilization,* states that:

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

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, the reason for the services and identified strengths, trauma 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.

7. Case Planning Guide for Supervisors

Practice Guide for Supervisors		
Case Planning		
DEFINITION CASE PLANNING	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 & well-being needs. Effective assessments drive the case planning process.	
FIDELITY MEASURES	• The caseworker incorporated relevant team member perspectives when developing and adjusting the plan. • Parental protective capacity and ability to safeguard their child was discussed with the family and providers. • The treatment plan identified the needs of the child to achieve well-being and resiliency. • The case file contained documentation of family participation in and agreement to the treatment plan (i.e. signed PATP). • The treatment plan addresses traumatic stress, promotes well-being and resiliency to meet the needs of the child.	
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.	
ACTIVITY	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE
ACTIVITY 10 CASE PLANNING ***Involve families and other team members in a 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	• 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 caseworkers' 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. • 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.
ACTIVITY 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.
ACTIVITY 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.
ACTIVITY 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. • 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.

ACTIVITY 14 CASE PLANNING ***Track progress on case plan implementation and adjust as needed.***	• Reassess-ment • 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 caseworkers' 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.

8. Plan Implementation Guide for Caseworkers

Practice Guide for Caseworkers		
Case Plan Implementation		
DEFINITION CASE PLAN IMPLEMENTATION	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	• The caseworker, family, and team regularly reviewed the treatment plan and made changes as needed.	
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: o Specific to the individual needs of the parents and children. o Inclusive of the parent's viewpoint. o 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.	
USE YOUR SUPERVISOR	• Schedule, prepare and actively participate in regular case conferences with your supervisor to discuss: o What has been completed, the outcome of that effort, pending activities and possible next steps to support the case planning process. o 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. o 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. o 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.	
ACTIVITY	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE
ACTIVITY 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. • 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.
ACTIVITY 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.
ACTIVITY 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 time frames. • 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.

ACTIVITY 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.
ACTIVITY 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.
ACTIVITY 20 CASE PLAN IMPLEMENTATION ***Provide services at the time of discharge and case closure.***	• At final FTM • Reassess-ment • 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.

9. Detailed Practice Guidance for Key Caseworker Activities

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?
  - 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 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?

- 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?
  - 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)?

- 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.

MSA Requirements:

Section VII.C, *Assessments, Case Planning, and Provision of Services*, states that:

- DHS shall ensure that the services identified in the service plan are made available in a timely and appropriate manner to the child and family and shall monitor the provision of services to determine whether they are of appropriate quality and are having the intended effect. [ ]…and intervening to review and amend the service plan when services are not provided or do not appear to be effective.

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 722-6I: 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.

MSA Requirements:

VII. E. 2 *Assessments, Case Planning and Provision of Services* states that:

- Strategic planning and preparation for possible alternate permanency placement of a child shall occur concurrently with the delivery of reunification services to the child's birth parent(s), unless clearly inappropriate for case-specific reasons that are documented in the child's record.

Detailed Practice Guidance:

These steps support effective concurrent permanency planning.[27]

- 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.[28]
- 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).

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[27] NRCPFC Concurrent Planning Toolkit

[28] 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).

- 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.[29]
- 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).

[29] 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.

10. Plan Implementation Guide for Supervisors

Practice Guide for Supervisors		
Case Plan Implementation		
DEFINITION CASE PLAN IMPLEMENTATION	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	• The caseworker, family, and team regularly reviewed the treatment plan and made changes as needed.	
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: o Specific to the individual needs of the family and children. o Inclusive of the child and family's viewpoints. o 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 **Modified Settlement Agreement:** • Section VII. B. Supervisory Oversight of Assessment and Service Plans: Supervisors shall meet at least monthly with each assigned caseworker to review status and discuss case progress. **Section VII. C. Provision of Services: Determine the effectiveness of services.**	
ACTIVITY	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE
ACTIVITY 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 families' 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.

ACTIVITY 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. • 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.
ACTIVITY 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.
ACTIVITY 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.

ACTIVITY 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.
ACTIVITY 20 CASE PLAN IMPLEMENTATION ***Provide services at the time of discharge and case closure.***	• At final FTM • Reassess-ment • 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.

11. Placement Practice Guide for Caseworkers

Practice Guide for Caseworkers		
Placement		
DEFINITION PLACEMENT	The placement 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	• The child's current placement has been fully assessed and determined safe. • The case file documented how the child's current placement supports the permanency plan. • An assessment of benefits and risks of a child being removed, being reunified, or returned home were thoroughly evaluated in meetings, case conferences, or documentation. • The caseworker observed and noted the condition of the home, attitude, and behaviors of family members, relationships and interactions to assist in assessing overall safety and risk. • The history of the family's involvement with DHS is thoroughly reviewed and outlined in the case narratives.	
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.	
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.	
ACTIVITY	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE
ACTIVITY 21 PLACEMENT ***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. • 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.
ACTIVITY 22 PLACEMENT ***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.
ACTIVITY 23 PLACEMENT ***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.
ACTIVITY 24 PLACEMENT ***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.
ACTIVITY 25 PLACEMENT ***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.
ACTIVITY 26 PLACEMENT ***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.

12. Detailed Practice Guidance for Key Caseworker Activities

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.[30]

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.[31] The most frequently cited reason for a failed foster placement is the inability of foster parents to manage children's behavior problems.[32]

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.

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

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

[32] 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.

Children and youth should be placed according to their own individual needs and 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), 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.[33] 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.[34]

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

[33] 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.

[34] Ibid.

entry to care, which would afford children the stability of relative homes without requiring them to endure a subsequent change in placement.[35]

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.[36] 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.[37]

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.[38]

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.

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[35] 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.*

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

[37] 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.*

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

FOM 722-3: When making a temporary out-of-home placement, DHS 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. DHS 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, DHS must pursue this placement option immediately.

FOM 722-6: DHS 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: DHS 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: DHS 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.

MSA Requirements:

Section II.D., *Principles,* states that:

- The ideal place for children is in their own home with their own family. When DHS cannot ensure their safety in the family home, it must place children in the most family-like and least restrictive setting required to meet their unique needs and must place siblings together whenever possible. DHS must strive to make the first placement the best and only placement.

Section II.E., *Principles* states that:

- When reunification is not possible, DHS must provide children with a permanent home and/or permanent connection with caring, supportive adults as soon as possible. DHS must also ensure children in its care are connected with the resources necessary for physical and

mental health, education, financial literacy, and employment and that they acquire the life skills necessary to become successful adults.

Section X.A., *Placement Standards and Limitations,* states that:

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

Section X.B., *Placement Standards and Limitations,* states that:

- DHS shall make placement decisions pursuant to DHS placement selection criteria.

Detailed Practice Guidance:

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.

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 (USDHHS, 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.

MSA Requirements:

Section X. B. 2., *Placement Limitations,* states that:

- Siblings who enter placement at or near the same time shall be placed together, unless doing so is harmful to one or more of the siblings, one of the siblings has exceptional needs that can only be met in a specialized program or facility. If a sibling group is separated at any time, and placement together is not contrary to a child's safety, the case manager shall make immediate efforts to locate or recruit a family in whose home the siblings can be reunited.

Section VII. G. 5., *Sibling Visits*, states that:

- DHS shall take all reasonable steps to assure that children in foster care who have siblings in custody with whom they are not placed shall have at least monthly visits with their siblings who are placed elsewhere in DHS foster care custody.

Detailed Practice Guidance:

Here are recommended steps to help children and youth stay connected to their siblings.[39]

- 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 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

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

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 birth 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, DHS 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 parents' 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: DHS 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.

MSA Requirements:

Section VII.G.4., *Parent Child Visits,* states that:

- DHS shall take all reasonable steps to assure that children in foster care with a goal of reunification shall have at least twice monthly visitation with the parents. All exceptions and all reasonable steps to assure that visits take place shall be documented in the case file. If such exceptions exist, DHS shall review the appropriateness of the child's permanency goal.

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.[40]
- 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.

- 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).

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[40] 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 parents' 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.

- 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.[41]

- 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.[42]

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

- Help caregivers find ways to be active in the placement process (i.e. mentoring parents, speaking up for their own needs).
- Help caregivers work in a partnership with parents.
- Make sure caregivers are members of the family team.

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

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

- 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 guilt because of the child's maltreatment by members of their family.[43] 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.[44] All of these feelings are normal, and caseworkers can help

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

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

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 caregivers' 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.[45]

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

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.

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

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

MSA Requirements:

Section VIII D.2.b., *Foster Home Capacity and Placement Selection,* states that:

- DHS shall ensure that relatives of children in foster care and non-relatives with whom a child has a family-like connection are identified and considered as potential foster home placements for children; where a relative or non-relative with whom the child has a family-like connection is an appropriate foster home placement for a child, DHS shall ensure that appropriate steps are taken to license the relative or non-relative as a licensed foster home.

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, relational and sexual orientation 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.

13. Placement Guide for Supervisors

Practice Guide for Supervisors		
Placement		
DEFINITION PLACEMENT	The placement 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	• The child's current placement has been fully assessed and determined safe. • The case file documented how the child's current placement supports the permanency plan. • An assessment of benefits and risks of a child being removed, being reunified, or returned home were thoroughly evaluated in meetings, case conferences, or documentation. • The caseworker observed and noted the condition of the home, attitude, and behaviors of family members, relationships and interactions to assist in assessing overall safety and risk. • The history of the family's involvement with DHS is thoroughly reviewed and outlined in the case narratives.	
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.	
ACTIVITY	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE
ACTIVITY 21 PLACEMENT ***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 DHS 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.

ACTIVITY 22 PLACEMENT ***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.
ACTIVITY 23 PLACEMENT ***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.
ACTIVITY 24 PLACEMENT ***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.
ACTIVITY 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.
ACTIVITY 26 PLACEMENT ***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.

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

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

www.ocwtp.net. ***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.

www.nccdglobal.org/assessment/structured-decisionmaking-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.

www.Michigan.Gov/dhs. ***Children's Protective Service Manual, PSM-713-11. Michigan DHS Policy Manual, Risk Assessment, PSM 713-11.pdf.*** The Michigan Department of 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/dhs/0,4562,7-124-7119-15399--,00.html*. *Michigan DHS 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.

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/pubs/usermanuals/domesticviolence/domesticviolencel.cfm. 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.

www.childwelfare.gov/pubs/usermanuals/cps/cpsf.cfm#backfortythree

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.

action4cp.org/resources/archives/

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.

Comprehensive Family Assessment Guidelines for Child Welfare. 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.

www.cehd.umn.edu/ssw/cascw/Publications/cw360.asp. 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.

http://throughtheeyes.org/files/SpotlightIssue_TraumaChecklist.pdf. 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://cms.vitalsmarts.com/d/d/workspace/SpacesStore/1f1693b3-c670-4487-a8d8-568fa21d92da/Crucial%20Accountability%20Conversation%20Planner.pdf?guest=true

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.

d. 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 caseflow 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

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/Default.aspx?tabid=83. 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.

www.advokids.org/transitions.html. 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.

www.youtube.com/watch?v=WgWhvfJ8KJE. 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 DHS 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

***www.childwelfare.gov/pubs/f_basicsbulletin/f_basicsbulletin6.cfm.** 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

***www.aecf.org/OurWork/ChildWelfarePermanence/~/media/PDFFiles/IcebreakerMeetings/IcebreakerMeetingApp13.pdf.** 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.dhhs.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=E9uoqOWHosg . 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, 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.

This mentoring section provides general practice guidance regarding the key caseworker activites, 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 Guide for Caseworkers

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	• The caseworker assisted the family in navigating agency systems and processes. • The caseworker assisted the family in understanding the permanency plan for the child (including concurrent permanency planning). • Parents and/or caregivers are educated on how trauma impacts children's behaviors, mood and functioning. • The caseworker participated in regular supervision meeting with the supervisor • During supervision, the caseworker was able to identify: o What is most important to the family? o How trauma has potentially impacted each member of the family? o How is trauma addressed in the case plan? o How and if the parent wants to begin the process of change. o Child, youth and adult successes (however large or small). o Positive supports in the child, youth and adults lives. o If the current placement met the child's well-being needs. o How the child's current placement ensures the child's psychological and physical safety? o How case has progressed and what to expect in next 90 days? • The caseworker educated parents and caregivers about the impact of trauma on child behaviors, mood and functioning. • The caseworker teaming with parents and caregivers to develop a plan to address the potential impact of trauma on the child.	
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.	
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.	
ACTIVITY	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE
ACTIVITY 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 bad 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? How is aggression often self protective based on a fight response to the triggering of 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. • 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?
ACTIVITY 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, behavioral 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.

ACTIVITY 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.

3. Detailed Practice Guidance for Key Caseworker Activities

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.[46] Caseworkers must work to enhance their interview skills as the questions themselves can guide children and families and set the stage for significant change.

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

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 DHS 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.

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[47] 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[48] 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.

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[47]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.

[48]Ibid.

- Be positive and utilize STAR and STARAR Feedback techniques.
- 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.[49]
- Manage your own emotions and responses. Don't take the child's, parent's or caregiver's progress or lack of progress personally.

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.

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[49] Ibid.

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 DHS, 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.
- Provide positive feedback to reinforce positive actions and results and developmental feedback through suggestions soon enough for people to adjust and enhance their performance. [50]

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[50] Here are some ways to provide positive and developmental feedback using the STAR/AR format.

STAR Positive Feedback Definition: The ability to specify what a person or team has done well. ST- Situation or Task - What was the problem, challenge, or task? A - Action - What was said or done to engage or build rapport with the family, team members, stakeholder, during the caseworker's/supervisor's interaction? R - Result - What changed, for better, because of the person's actions, and what was the impact of that result?

STAR/AR Developmental Feedback Definition: The ability to provide specific steps, which can guide a person or a team toward a more effective approach. ST - *Situation or Task* - What was the problem, challenge, or task? A - *Action* - What was said or done that was ineffective? What was said that negatively affected the engagement or rapport building with the family, team members, stakeholder, during the caseworker's/supervisor's interaction? R - *Result* - What changed, for worse, because of the person's actions, and what was the impact or consequences of that result? *Alternative* - Something the person could have said or done differently. *R - Result* - The enhanced RESULT that the alternative action might have produced.

- Be specific about what has been accomplished and what has not been accomplished, the behaviors that have been effective and why these were effective.
- Give balanced feedback that focuses not only on what a person needs to do better or more of, but also what has been done well. Remember that comments only about strong performance can be equally ineffective.

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.[51] Caseworkers must work to enhance their interview skills as the questions themselves can set the stage for significant change.

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

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.

- Be physically and emotionally available. Respond to family's emotional distress. Answer phone calls.
- Build mutual purpose.[52]
- 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.

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[52] 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.

- 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.

- Provide support without removing responsibility.
  - Help others think and do. Ask open-ended questions that lead to an expansive view. Express genuine curiosity.
  - 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.[53] This is especially true in child welfare because it involves

[53] Siegel, 2010

"emotional labor" that engages the emotional centers of the brain that are easily triggered outside the confines of the work environment.[54]

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.[55]

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 from a significant other, the stress from helping or wanting to help a stressed person."[56] 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[57]. Yet, other staff persons most often perceive those who are experiencing physical symptoms as primarily exhibiting cognitive effects, primarily negativism.

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[54] Calagari, 2010

[55] Williams & Glisson, 2013

[56] Figley, 1995

[57] Henry, 2013

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."[58] 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.

Unaddressed pain within the workplace creates a toxic environment.[59] 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.[60] 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.

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

[59] Frost, 2007.

[60] Williams, Glisson, 2013.

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.
- 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.

4. Practice Guidance for Supervisors

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	• The caseworker assisted the family in navigating agency systems and processes • The caseworker assisted the family in understanding the permanency plan for the child (including concurrent permanency planning). • Parents and/or caregivers are educated on how trauma impacts children's behaviors, mood and functioning. • The caseworker participated in regular supervision meeting with the supervisor • During supervision, the caseworker was able to identify: o What is most important to the family? o How trauma has potentially impacted each member of the family? o How and if the parent wants to begin the process of change. o Child, youth and adult successes (however large or small). o Positive supports in the child, youth and adults lives. o If the current placement met the child's well-being needs. o How the child's current placement ensured the child's safety? o How case has progressed and what to expect in next 90 days?	
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.	
ACTIVITY	WHERE IN THE LIFE OF THE CASE	PRACTICE GUIDANCE
ACTIVITY 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.
ACTIVITY 28 MENTORING	From the first point of contact	• 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.

Create a learning environment through observation and feedback.	through case closure	• 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 that is specific, timely and balanced. Verbal/written. • Identify type of feedback that is required as positive or developmental feedback. The feedback will be given to the caseworker by the STAR feedback method. • 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.
ACTIVITY 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 plan implementation occur. • Model the delivery of written and verbal developmental feedback.

5. 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://dx.doi.org/10.1016/j.chiabu.2013.09.003. 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.

*www.michiganchildwelfaretraining.com/LinkClick.aspx?fileticket=toR0oQLXXj0%3d&tabid=101 . 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 www.nrcoi.org and www.nrcfcppp.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.

****www.michiganchildwelfaretraining.com/LinkClick.aspx?fileticket=x6CPXHffBYk%3d&tabid=132***. 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.

Practice Model Fidelity Assessment Plan

OVERVIEW

This fidelity assessment plan focuses on the development of instrumentation that will track the work performance of caseworkers in the implementation of the practice model and identify areas needing improvement as part of Michigan's continuous quality improvement efforts. Using a fidelity assessment process is a way to help ensure the practice model is being implemented as designed throughout implementation.

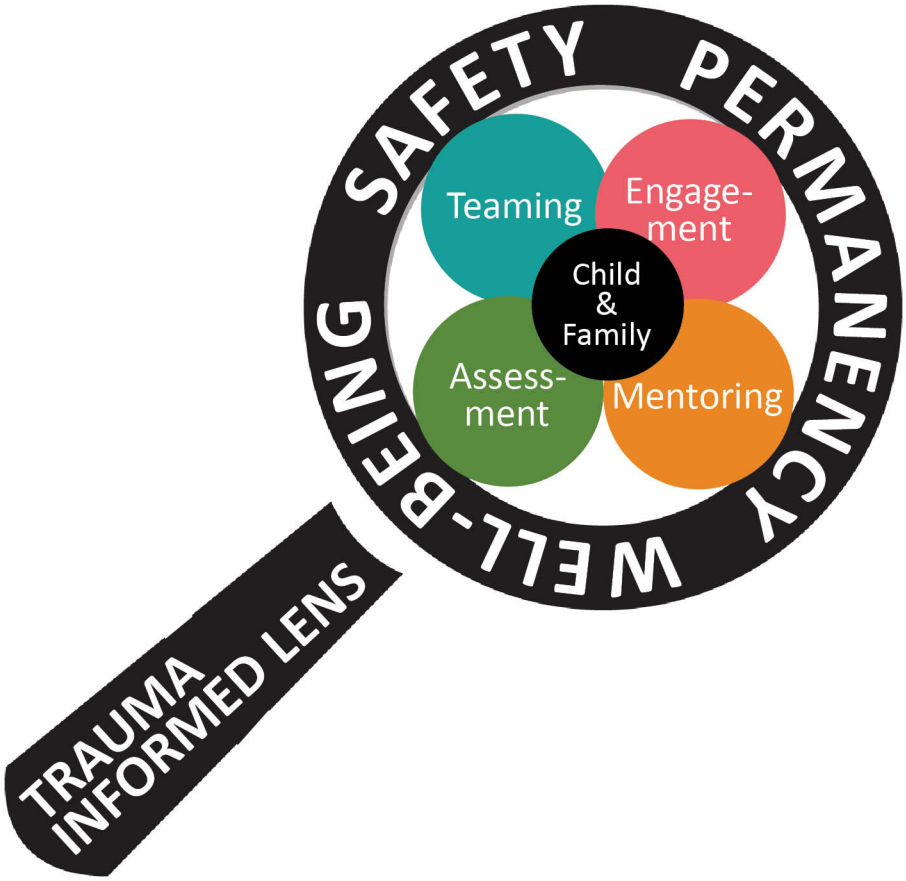
The practice model and the integrity of its implementation will interact to produce intended outcomes. The fidelity data will also be used to determine the extent to which positive results can be linked to the implementation of the practice model. An intervention such as the practice model that is not implemented as intended can have little or no impact on children and families and could lead to an adjusted approach to improving outcomes for children and families. Also, interventions such as the practice model may be fully delivered as intended and still have little or no impact on families, which could also lead to a reconsideration of the improvement intervention.

MITEAM PRACTICE MODEL

The MiTEAM Practice Model is an approach to case practice that incorporates the vision, guiding principles and the key caseworker activities needed to implement the mission of the Michigan Department of Human Services (DHS) successfully. It is a vehicle for aligning practices among private agencies, tribal partners, policies, training and other organizational resources within DHS. It provides consistent direction to child welfare agency staff and other stakeholders on casework activities and services to children and families utilizing a trauma informed approach. It links the organizational values and guiding principles of DHS to specific interventions and activities that all children and families should experience, such as comprehensive assessments of their strengths, traumatic exposure to stress and needs, meaningful involvement in case planning, and effective services tailored to their needs.

The MiTEAM Practice Model is 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. MiTEAM builds on recent research revealing that traumatic stress can have serious physiological, psychological and relationship consequences on child and youth development.

With the overarching goal of improving safety, permanency and well-being outcomes for children and families, the trauma-informed practice model is comprised of four core competencies; engagement, teaming, assessment (case planning, plan implementation and placement) and mentoring.



Twenty-nine (29) key caseworker activities have been identified to help caseworkers understand what it means to implement these core competencies and to 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.

Caseworkers are the primary persons responsible for implementing the practice model with children and families throughout Michigan, so that is the reason for the development of a plan for assessing fidelity focused on these persons. Using supervisors in the process of assessing fidelity is intended to support them in their role to provide feedback and coaching as envisioned in the practice model.

The instruments used by supervisors, the questions they ask and the items they track unavoidably communicate to staff what is truly important. Consequently, the plan for assessing fidelity must be supported by instrumentation that is consistent with the overall practice model.

The primary position we take as a supervisor is that of collaborating with our caseworkers in order to facilitate their competence and success so that they in turn will deal with their clients in a collaborative, respectful manner, who will then treat their children in a respectful, responsible manner and thus keep

them safe. The by-product of supervision is change: A novice, inexperienced worker becomes a thoughtful worker who practices a respectful and empowering approach to insuring safety for clients.[1]

IDENTIFYING INDICATORS

Key indicators were identified by a workgroup consisting of public and private agency staff, representing field (direct caseworker supervisors) and administrative personnel (program managers, central office). This workgroup reviewed the practice model manual, reviewed other fidelity instruments, and used their individual expertise to generate an initial list of indicators. This initial list was then refined to a more focused collection of indicators, field tested in two draft stages, and then released.

METHODOLOGY

METHODOLOGICAL CONSIDERATIONS

Throughout the development of the fidelity instrument, indicators were selected based on these criteria: first, the degree of precision with which the indicator could be objectively observed (that is, independent raters would likely score the item in the same way). Second, the degree of impact the presence of this indicator would have on the case progress (that is, if this caseworker behavior was truly present, would such be expected to have a real benefit to the child and family involved?).

A variety of data collection procedures are included in the fidelity instrument: observation of caseworker interactions with families, case file reviews, supervision meetings with caseworkers, and supervisor interviews with family members. This range of data collection procedures was agreed upon for three primary reasons. First, a range of collection procedures increases the validity of the data being gathered; that is, there is greater reason to believe the desired caseworker behaviors are truly present if a variety of collection methods document the behavior is occurring. Second, the workgroup agreed that the fidelity instrument should mirror the sort of social work activities being measured. For example, since the instrument is attempting to measure Engagement, then the instrument itself should utilize engagement strategies (e.g. interviews with family members). Finally, the supervisor interview with parents, caregivers and/or children, if appropriate, was specifically identified as useful since this practice should serve to increasingly move child welfare in a family-centered direction.

READINESS TO IMPLEMENT

The Michigan champion counties (Kalamazoo, Lenawee, Mecosta/Osceola, Kent) will pilot test the Michigan Fidelity Instrument with CPS and foster care caseworkers prior to broader implementation of the instrument. Pilot testing will be conducted to determine if revisions are needed in regards to any of the specific items and to gain experience with completing the instrument and utilizing information gained from the instrument. Pilot testing will inform future efforts to implement the instrument on a broader scale. Steps to develop a tool for adoption and licensure caseworkers will be occurring during this time as well. The remainder of this document reflects the Fidelity Instrument Workgroup's ideas about how to approach broader implementation of the instrument but these ideas will be strengthened based on lessons learned during the pilot testing of the instrument in the champion counties.

[1] Building Solutions in Child Protective Services. Insoo Kim Berg and Susan Kelly. P. 218.

In addition, sections of the Fidelity Instrument will be used in the MiTEAM Coaching Labs and Small Groups to familiarize supervisors and workers with the indicators of quality work relative to the core competencies. The Observation section of the instrument will guide the model, practice and feedback steps for building confidence and skills.

In addition to supervisors and workers accessing and practicing with the instrument during the Coaching Labs and Small Groups, supervisors will have access to a webinar for information.

SAMPLING

The primary unit of analysis of the fidelity assessment will be the caseworker.

The Fidelity Instrument will be completed by each direct supervisor on 15 cases per quarter – one per worker per month - for both public and private agencies. Cases should be randomly selected for review, though after review a case should be removed from rotation for the rest of the year. In this manner, every case that is open for at least one year has a high likelihood of being reviewed at some time (one case per worker per month equals 12 cases per worker per year).

INSTRUMENT

As a review of the Fidelity Instrument will demonstrate, this instrument is comprised of a series of 'yes' and 'no' questions related to the presence of a particular behavior (e.g. what the caseworker was observed to say or do when meeting with a family) or casework product (e.g. the case file contains documentation of required items). As described earlier, collection of data for the instrument involves supervisors observing caseworkers in action, supervisors talking with families about their experience, supervisors reviewing case files, and supervisors conducting supervision meetings with caseworkers.

Supervisors will complete the Fidelity Instrument using Survey Monkey on the internet. There will be no case identifying information to avoid any issues with linking the review to a specific case.

PROCEDURES FOR OBSERVATIONS

Observations will be conducted by supervisors who have been trained in overall functionality of the fidelity instrument. Observations will take place in multiple settings. Caseworkers will be observed during family team meetings and while working with children, parents, caregivers and other members of the family. Observations will occur both in the field and in the office, but will always involve direct contact with a child, parents, caregivers and other members of the family.

PROCEDURES FOR ADMINISTRATIVE DATA GATHERING

Administrative data gathering is comprised of: 1) conducting interviews with children, parents, caregivers and other members of the family; 2) reviewing documentation; and 3) gathering information as a part of the regularly scheduled supervision. Interviews with family members will be conducted following observations and a review of the documentation. These interviews may be conducted in-person or over the phone based on the preference of the person being interviewed. Interviews should be conducted using engagement skills and in a conversational manner. An interview protocol is in development.

DATA ANALYSIS AND USE OF DATA TO IMPROVE PRACTICE

SCORING AND ANALYSIS

Because the instrument is largely employed to assess the overall capacity and progressive development of caseworkers to implement the practice model, the instrument is best suited to be utilized by supervisors. The data obtained and compiled should remain in the hands of supervisors. The primary nature of this instrument is the focus on individual status and growth, therefore it is necessary to track scores individually by caseworker. To also assure the supervisor's adherence to the MiTEAM competencies, as this is essential to the growth of the entire unit, the data collected will be maintained for each unit and reviewed by the program manager and/or director.

Peer coaches, program managers and other supervisors may review a certain portion of the cases being reviewed by supervisors to ensure consistency among reviewers. The compilation of data sets by supervisors, and subsequent maintenance of data summaries by the program managers, is essential for each units overall growth, outcomes and process development. Completion of the Fidelity Instrument may involve not applicable responses and these responses should not be included in the data analysis.

The integrity of the MiTEAM Fidelity Instrument will be supported by intentional focus on accurate scoring and analysis. The most functional methodology for activating this process is through the implementation of a tiered approach for scoring and analyzing data. This will allow for adequate dissemination of information, not only from the supervisor to worker, but also from the program manager to manager. The individual completing the form will be responsible for the scoring of each instrument. The scores will be logged in a shared data set, to be viewed by each unit and the peer coach.

Tiered Approach:

- The manager will review data with individual staff, either directly or indirectly through case consultation to aide in overall growth.
- Program managers will assist managers in reviewing this data and openly conversing about the ways in which improvement could occur, or citing areas of excellence.

This is a dynamic process and issues will emerge that require attention. If they find certain needs, for example, they can modify the relevant coaching lab to strengthen skills in that area.

FEEDBACK AND COACHING PROCESS

The department's ability to continuously reflect upon practice and evaluate internal strategies for success will be essential to ensuring that the desired impact is achieved. Caseworkers will be more likely to embrace the model if supervisors are using the instrument consistently and if data is used and analyzed appropriately. The feedback provided to caseworkers based on direct observations will lead caseworkers to make the adaptive changes needed to improve practice and outcomes, even more so than training.

Recommended uses of the data:

- Information pertaining to strengths and challenges of individual caseworkers will be used at case conferencing or one-on-one meetings, providing each caseworker specifics about what he or she has done well and developmental feedback to guide him or her to a better approach.[2]

- The peer coach will develop tailored coaching opportunities with staff based on data results, patterns of poor practice and visibly promote areas of strength.

- Data will be shared frequently with the Strengthening Our Focus Advisory Council and relevant teams on the county level to address system barriers and enhance overall practice throughout the State.

- Reviewed by supervisor, peer coach and program manager to evaluate best practices and areas of improvement for individual staff members who have been trained and continue to struggle. The goal will be to determine additional ways to support caseworkers and develop needed skills.

- Areas identified as needing further support will be addressed and a plan developed with the identified staff to increase competence in the target area(s).

- Accumulated information will be shared when appropriate with identified Local Office CQI/ Data Analysis Teams.

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[2] **Criteria for Effective Feedback: a) Positive Feedback** (STAR) specifies what the person or team has done well. **ST-*Situation or Task***-identify the situation; for example, let's look at your discussion with Ms . ____ **A-*Action*** – describe the behavior specifically; for example, 'your scaling question about how worried is she about her son's behavior, followed by your silence' were highly effective. It opened the door to her sharing **R-*Result* –** describe the results; for example, 'the scaling questions and use of silence opened the door for Ms. ___ to explore her underlying thoughts and fears. **b) Developmental Feedback** (STAR/AR) which guides a person or team toward a more effective approach. **ST-*Situation or Task* -** identify the situation; for example, let's look at your discussion with Ms . ____ **A-*Action* -** describe the behavior specifically; for example, 'the self-disclosure you provided about your frustrations with your son was long'**R**-***Result*** describe the results; for example, 'your example put the focus too much on you and your experiences rather than helping Ms. ____ look more closely at herself.' ***Alternative Action* –** provide option(s) or recommendation; for example, 'self-disclosures can help someone be more comfortable in exploring deeper; to be effective, we do need to keep our self-disclosure brief and immediately bridge back to the person's experiences. You might say 'my son and I locked heads when he was 15 and I found myself arguing with him too much of the time – what about you, how would you describe your time with your son.' **R**-Enhanced ***Result* –** describe the desired results, for example, a succinct self-disclosure conveys your desire to connect yet keeps the relationship focused on your role as the helper.

S**teps for Providing Effective Feedback**: How feedback is delivered is important. The following steps will increase self-awareness and learning by the worker. 1) Self-assessment - ask the worker for his/her assessment of what he/she did well; STAR2) Other's assessment – ask the worker for his/her perception of how the 'other' person experienced the interaction, for example, 'what would Ms. ____ have said about what you said or did that increased her awareness?'3) Your assessment – provide your STAR assessment 4) Repeat steps 1-3 for STAR/AR.

The feedback will be specific: Tell people ***WHAT*** they have accomplished. Describe ***HOW*** people achieved the results. Explain ***WHY*** people's actions were effective.

Feedback is the provision of meaningful and thorough information about the process and behaviors displayed by the caseworker by the supervisor.

UNDERSTANDING RESULTS IN A BROADER DATA CONTEXT

This instrument will assist in the development and maintenance of improved practice as it relates to the engagement and inclusion of families in child welfare cases. A necessary foundation to understand this data is the implementation of a formalized QSR process prior to utilization of the Fidelity Instrument. The QSR will provide a baseline from which counties can collect information and evaluate practice and systems. The Fidelity Instrument will then guide interventions; providing managers, program managers and directors with concrete information relating to progress in areas of improvement identified in the QSR. The QSR will provide a roadmap for administrators and the Fidelity Instrument will provide the essential answers to questions pertaining to what led to these outcomes.

The KPIs and outcomes answer the “what” questions, and fidelity measures help to answer the “why” questions. They lead us what is needed to make improvements.

APPENDIX – MICHIGAN FIDELITY INSTRUMENT

Observational Instrument			
Teaming	**Yes**	**No**	**NA**
Caseworker and parents placed an emphasis on parent and child strengths.			
Formation: Caseworker identified and formed the family's team that included a qualified group of people – the 'right people' - who support the child, youth, and parent/caregiver in shared decision-making; the 'right people' provide technical and cultural competence for the family's needs. The qualified and committed team members involved in shared decision making included: • Child (if appropriate) • Mother or female guardian (primary caretaker?) • Father or male guardian (primary caretaker?) • Step-parent • Current caregiver • Maternal relatives • Paternal relatives • Fictive kin (persons in the community identified as important supports to the family and/or child) • Service providers to the child • Service providers to the parents • Child's teacher (if relevant) • Lawyer Guardians ad Litem			
Functioning: The family's team met on an ongoing basis and the caseworker has a working relationship with the team that supports the family in achieving both near-term needs and long term goals.			
Coordination: The caseworker facilitated teamwork by preparing team members to plan, implement, monitor, modify and evaluate the family's progress.			
The team shared a commitment and unity of effort.			
The caseworker educated parents and other team members on the potential impact of trauma.			

The team utilized an understanding of the impact of trauma to develop case plans for both the child and the parent			
The team addressed specific safety concerns of the child.			
The team addressed specific permanency plans and issues of well-being for the child.			
Engagement	**Yes**	**No**	**NA**
Respect: The caseworker honored the family's right to make their own choices.			
Empathy: The caseworker communicated an understanding of the family's experiences or perceptions.			
Genuineness: The caseworker gave the family full attention and presented as open and transparent.			
Competency: The caseworker provided and welcomed feedback.			
The caseworker clearly explained their role for the child and recognized the inherent tension in parent/worker power differential.			
The caseworker asked the parents, child (if appropriate) and team members to identify relatives and people in the community who are part of their support network.			
The caseworker asked about the parent about potentially traumatic events that the child and or parent may have experienced.			
Assessment	**Yes**	**No**	**NA**
The caseworker asked the family what they thought were the primary issues and strengths identified.			
The caseworker asked the family how s/he can be of assistance to the family.			
The caseworker inquired about the child's perspective on their (physical and psychological) safety and well-being during visits with the child/ youth. [3]			
The caseworker inquired about the caregiver's perspective on the (physical and psychological) safety and well-being of the child/youth.[1]			
The caseworker requested family input to identify strengths, needs, and effectiveness of services.			
The caseworker incorporated relevant team member perspectives when developing and adjusting the plan.			

[3] Recommended Resource: National Resource Center for Family-Centered Practice and Permanency Planning, Hunter College of Social Work. Ensuring Safety, Permanency, and Well Being: Suggestions for Conducting Contacts with Children and Caregivers. 2009

The development of the comprehensive family assessment included input from service providers and other members of the team.			
Parental protective capacity and ability to safeguard their child(ren)/youth was discussed with the family and providers.			
Caseworker inquired about what the caregiver believes about the impact of traumatic events on the child.			

Mentoring	**Yes**	**No**	**NA**
The caseworker assisted the family in navigating agency systems and processes, as evidenced by, the family: • Demonstrated a clear understanding of expectations regarding service referrals; • Verbalized a clear understanding of the next steps; • Verbalized an understanding of agency processes; and • Demonstrated an understanding of the outcomes of possible case disposition.			
The caseworker assisted the family in understanding the permanency plan for the child (including Concurrent Permanency Planning).			
The caseworker educated parents and/or caregivers on how trauma impacts children's behaviors, mood and functioning.			
The caseworker teamed with the parents and/or caregivers to develop a plan to address potential traumatic impact on the child.			

Observational Score (Total in Each Column)			

Comments:

Administrative Data Gathering

Teaming – (review documentation)	**Yes**	**No**	**NA**
There is documented evidence that a team has been formed and is functioning; a team that provides support to the child and family. Check yes if one or more of the following are present. • Informal support persons were present during in-person meetings with the family; • Support persons were present for FTM's; • Family identified informal supports and those informal supports were utilized during the report period, if informal supports are identified; or • Treatment plans specified role of informal support persons.			
Before: Scheduled in-person contacts with the family (e.g. home visits or FTM) were preceded by a clearly documented preparation conversation between the caseworker, family and team members which included: • What would be helpful to the family?; • Explanation of the caseworker purpose for the meeting; • Family identified topics they would like to discuss; and • The family was offered the opportunity to identify support persons they would like present at the meeting.			
During: Documentation of in-person meetings with the family clearly documented family perspectives on safety, permanency, and well-being and the team's unified commitment for the family's short-term needs and long-term goals. As evidenced by: • The family's team members being involved in the assessment and shared decision making; and • The family's suggestions and comments are documented in the case file.			
After: Documentation that the caseworker maintained contact with the family and support persons between in-person meetings.			
Engagement – (conduct interview)	**Yes**	**No**	**NA**
The supervisor's interview with parent, caregiver and/or child (if appropriate) demonstrated:			
The parent, caregiver and/or child (if appropriate) were able to identify helpful activities of the caseworker.			

The parent, caregiver and child (if appropriate) felt understood by caseworker.			
The parent and child (if appropriate) reported the caseworker approached them from a position of respect and cooperation as evidenced by: • The caseworker responded promptly to phone calls • The caseworker offered special accommodations to the family to support engagement, participation and partnership. • The caseworker consulted with the parent, caregiver or child/youth before decisions were made • The caseworker actively assisted in addressing obstacles to engagement.			
The parent, caregiver and/or child are satisfied with services offered/referred.			
The caseworker recognized and acknowledged religious and cultural beliefs.			
The parent described collaborative decision making occurred in the case.			
The caseworker educated parents and caregivers on how early traumatic experiences may impact their parenting.			
The caseworker addressed the potential impact of trauma to the child with the parent.			
Assessment – (review documentation)	**Yes**	**No**	**NA**
The case file contained documentation of a trauma screening for the child.			
The case file contained documentation of an age-appropriate, developmental questionnaire (e.g. ASQ-SE, Pediatric Symptom Checklist).			
The case file contained a comprehensive family assessment[4] on each family member as required by policy, as evidenced by: • The assessment documented the family's report concerning services and supports that have been helpful (or not) in the past. • The assessment documented family information from past or current service providers. • The assessment documented the family's formal and informal support system (e.g. Eco Map or Genogram). • The assessment addressed the impact of trauma on the child and parents.			
The perspectives of the child, parent, caregivers, etc. were reflected in the case documentation.			
The agency (re)assessment of progress was written in a behaviorally specific manner.			

[4] For example, CPS ISP, Foster Care ISP, Adoption Reports

The caseworker identified parental protective capacity and the parent's ability to safeguard their child(ren) and/or youth.			
The development of the family assessment included input from service providers and other members of the team.			
Case Planning: The treatment plan addresses traumatic stress, promotes well-being and resiliency to meet the needs of the child.			
Case Planning: The case file contained documentation of family participation in and agreement to the treatment plan (e.g. signed PATP).			
Case Plan Implementation: The caseworker, family, and team regularly reviewed the treatment plan[5] and made changes as needed. Check yes if one or more of the following are present. • Social work contacts summarized treatment plan review • Treatment plan was regularly updated AND signed by family members • Service plans summarized treatment plan updates and rationale			
Placement: the child's current placement has been fully assessed and determined safe (e.g. signed DHS 588 in file; timely 3130a in file).			
Placement: case file documented how the child's current placement supports the permanency plan.			
Placement: An assessment of benefits and risks of a child being removed, being reunified, or returned home were thoroughly evaluated in meetings, case conferences, or documentation.			
Placement: The worker observed and noted the condition of the home, attitude, and behaviors of family members, relationships and interactions to assist in assessing overall safety and risk.			
Placement: The history of the family's involvement with DHS is thoroughly reviewed and outlined in the case narratives.			
Mentoring – (during regularly scheduled supervision)	**Yes**	**No**	**NA**
The caseworker participated in regular supervision meeting with the supervisor			
During supervision, the caseworker was able to identify:			
• What is most important to the family?			
• How trauma has potentially impacted each member of the family?			
• How is trauma addressed in the case plan?			

[5] For adoption, Quarterly Adoption Progress Report or similar document

• How and if the parent wants to begin the process of change.			
• Child, youth and adult successes (however large or small)			
• Positive supports in the child, youth and adults lives			
• If the current placement met the child's well-being needs. In the following areas: - Educational - Physical (medical and dental) - Emotional Skill-Building			
• If current placement met the child's well-being needs through preserving important relationships to the child and increasing his or her self-esteem.			
• How the child's current placement ensured the child's physical and psychological safety			
• How case has progressed and what to expect in next 90 days			

Administrative Score (Total in Each Column)			
TOTAL Score (Observational plus Administrative)			

Comments: