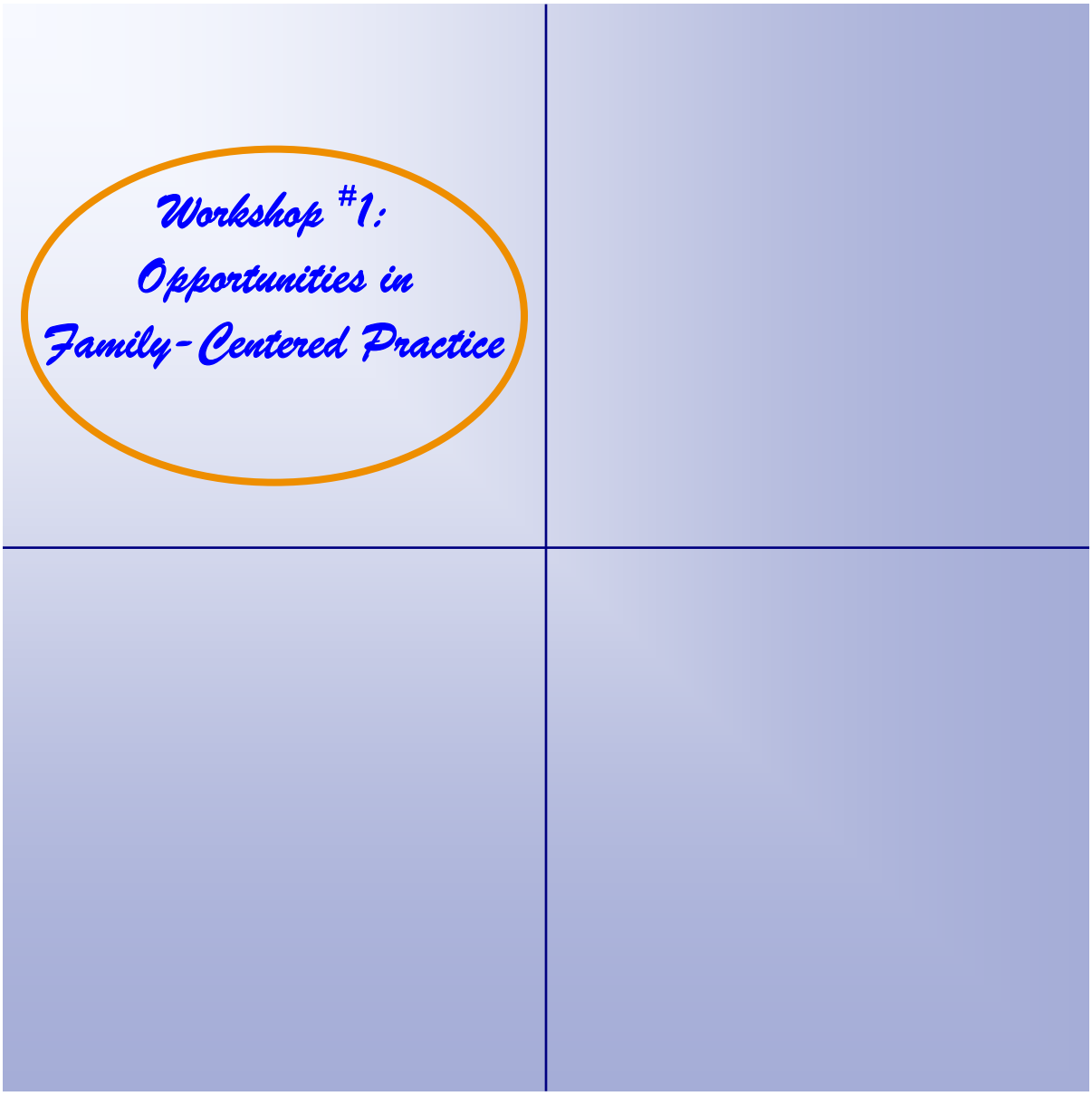
THE FAMILY-CENTERED PRACTICE TRAINING SERIES



Florida Department of Children and Families
Office of Family Safety

Participant Guide

Version 1.3

The overall goal of

The Family-Centered Practice Training Series

is to

increase positive outcomes for Florida's children and their families

by strengthening and improving the ways in which child welfare professionals work with children and their families. This training series also supports the goal of safely reducing the number of children in out-of-home care by 50% by the year 2012.

To these ends, the immediate goal of

Workshop #1: Opportunities in Family-Centered Practice,

is to introduce the foundational concepts of family-centered practice,
to firmly establish family-centered practice as an important methodology
for increasing every child's and every family's opportunities for success,
and to prepare child welfare professionals to
implement family-centered practice with skill and confidence.

Based on the foundation laid in Workshop #1,
the second workshop, *Effective Family-Centered Casework: Tools and Applications*, will prepare child welfare professionals to incorporate family-centered practice skills into their daily casework. This hands-on workshop will focus on effective performance of the family-centered practice skills that can help them execute engagement, assessment, planning, delivery, and coordination activities with even greater success.

The Family-Centered Practice Training Series is provided by
the Florida Department of Children and Families, Office of Family Safety.
These workshop materials may be reproduced without permission
for the explicit purpose of conducting training sessions for child welfare professionals
who provide services for the Florida Department of Children and Families.

Please direct all inquiries about *The Family-Centered Practice Training Series* to:

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#1: Goals and Objectives

Welcome to the workshop *Opportunities in Family-Centered Practice*! This workshop is the first in a two-part training program designed to help child welfare staff contribute to the Florida Department of Education's goal for 2012: Rescuing the number of children in foster care by 50%.

The materials in this Participant Guide will be used during the workshop, or are provided to you as a reference after the training.

Goal of the Two-part Training Series

Workshop #1: Opportunities in Family-Centered Practice, is the first of three workshops that make up *The Family-Centered Practice Training Series*. The following is the overall goal of *The Family-Centered Practice Training Series*:

> Increase positive outcomes for Florida's children and their families
> by safely reducing the number of children in foster care by 50%
> by the year 2012.

Goal of this First Workshop

To achieve the overall goal of the two-part training series, the immediate goal of *Workshop #1: Opportunities in Family-Centered Practice* is as follows:

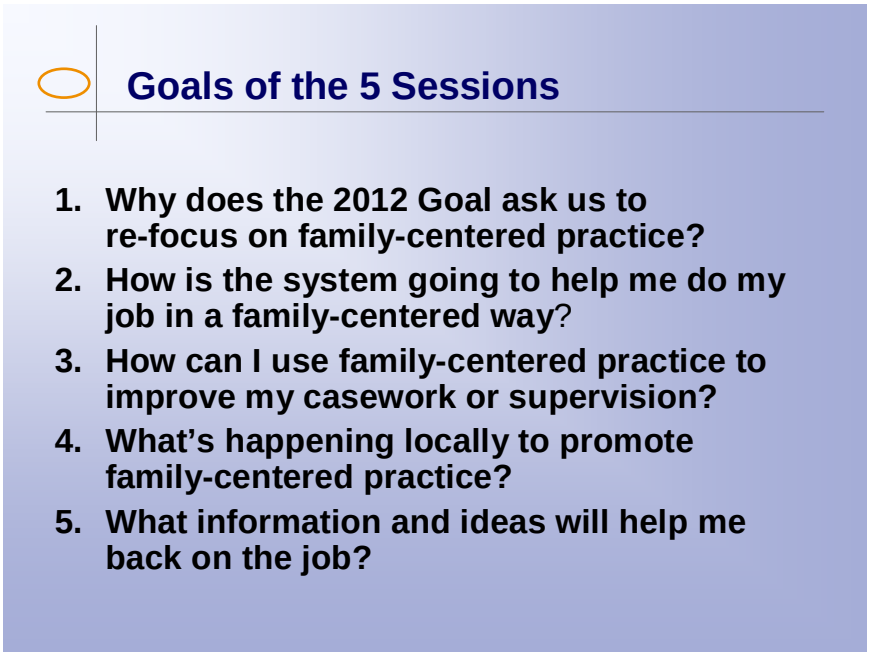
> Safely maximize
> **POSITIVE OUTCOMES**
> for children and their families
> by using a non-adversarial
> **FAMILY-CENTERED APPROACH**
> to the assessment, planning, delivery and coordination of services.

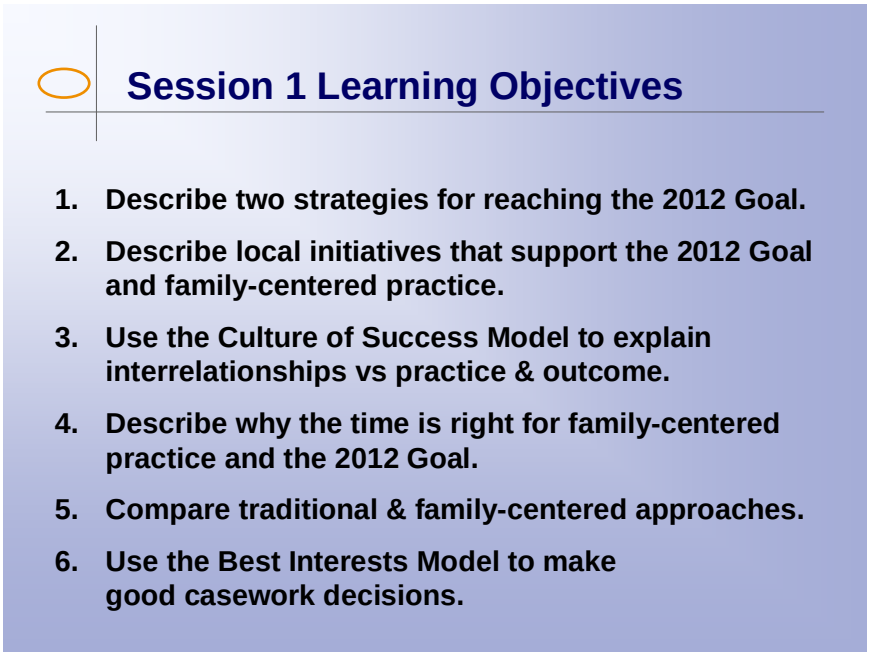
Based on the foundation laid by this first workshop, subsequent workshops will provide child welfare professionals opportunities to practice family-centered practice

skills. These hands-on workshops will focus on effective performance of the family-centered practice skills that can help them execute engagement, assessment, planning, delivery, and coordination activities with even greater success.

Session Goals and Objectives

The following copies of PowerPoint slides present the goal of each of the five sessions in the workshop, followed by the specific learning objectives for each session.





Session 2 Learning Objectives

1. Describe research findings regarding the impact of foster care on children.
2. Describe the system opportunities/challenges that affect family-centered practices implementation.
3. Describe the potential impacts of "worker passion," IV-E, and worker bias.
4. Describe system initiatives supporting a Culture of Success & effective family-centered practices.
5. Describe why it's possible to achieve a balance that ensures safety *and* promotes family preservation.

Session 3 Learning Objectives

1. Recognize differences vs "adversarial" and "family-centered" approaches.
2. Summarize the key concepts, assumptions, and service strategies of family-centered practice.
3. Use the Best Interests Model and family-centered practice principles to make decisions in a case.
4. Give specific examples of how you might apply family centered practice in your work.

Session 4 Learning Objectives

1. Describe specific local, circuit or regional initiatives—or system responses by the child welfare community for implementing family-centered practice.

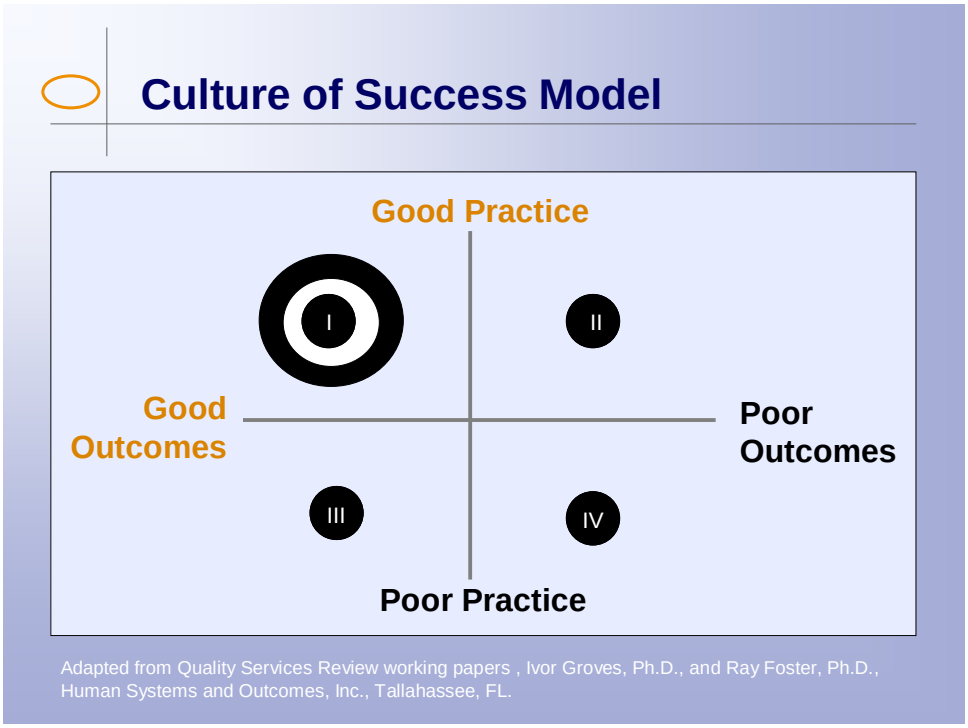
2. Describe other local, circuit or regional initiatives—or system responses by the child welfare community—that will move us toward accomplishing the 2012 goal.

Session 5 Learning Objectives

1. Describe research findings regarding the impact of foster care on children.
2. Use the Culture of Success Model to explain interrelationships vs practice & outcome.
3. Compare traditional & family-centered approaches.
4. Use Best Interests Model to make good decisions.
5. Summarize the key concepts, assumptions, and service strategies of family-centered practice.
6. Describe local initiatives that support the 2012 Goal and family-centered practice.

#2: Culture of Success Model

The following Culture of Success model is a way of representing the context in which we're being encouraged to implement family-centered practice. The Culture of Success model helps us to structure and think about the ways in which our practice is related to the outcomes we're trying to achieve in our work with children and their families. The Culture of Success model is adapted from working papers from the Quality Services Review, developed by Ivor Groves, Ph.D., and Ray Foster, Ph.D., of Human Systems and Outcomes, Inc., Tallahassee, FL.



Creating a culture of success means focusing our practices, our resources, our policies — all our efforts — on getting us into Quadrant I consistently with our cases.

QUADRANT I

This is where we always want to be! Good practice drastically improves our chances of achieving the best interests of each child and their family. These are the cases when the child and family are succeeding with the assistance of the child welfare system. These children and families are achieving goals and objectives, positively progressing towards safe case closure – AND – the system is providing an appropriate level of support and assistance to meet the child and family's unique needs.

QUADRANT II

We always want to deliver good practice. However, sometimes the child and their family are experiencing problems of such severity that it's not possible to overcome them, even with the most skilled application of good practice. These cases are generally uncommon but do highlight our ongoing need for due diligence in our practice and efforts.

QUADRANT III

Sometimes the child and family manage to achieve positive outcomes *despite* our failure to deliver good practice. But of course, bad practice is never acceptable!

QUADRANT 3

Sometimes the child and family manage to achieve positive outcomes *despite* our failure to deliver good practice. But of course, bad practice is never acceptable.

Cases that fall into Quadrant III highlight family resiliency, and remind us of a family's ability to build on their own strengths and initiatives. Oftentimes, these cases have one person, a family-member or teacher, going above and beyond and holding it all together. This is often unsustainable for a long period of time. These types of cases, with some tweaking or practice, or increased and better coordinated case management, can quickly become quadrant 1 cases, thus significantly improving long-term prospects and outlook. For improving system-wide results rapidly, managers should think about what they can do to address the quadrant 3 cases.

QUADRANT IV

We never want to find ourselves in quadrant 4! If a child suffers negative outcomes, we certainly don't want that to happen because we failed to perform the very best practice possible. In quadrant 4, not only are the child and the family failing, but the system is failing, too, because of our failure to deliver best practices in child welfare.

#3: Comparison of Traditional and Family-Centered Approaches

The following table presents a comparison of two different approaches to the practice of child welfare. The first approach represents what is often understood to be a "traditional" approach to working with children and their families. The second approach represents what is typically referred to as a "family-centered" approach.

TRADITIONAL CHILD WELFARE	FAMILY CENTERED
Safety is the first concern.	Safety is the first concern.
Goal of permanent, stable home for the children.	Goal of permanent, stable home for the children.
Focus on the individual child.	Focus on the family system.
Family seen as an isolated unit.	Family seen in context of culture, networks, and community.
Focus on family deficits and dysfunctions.	Focus and build on family strengths and potential.
Family seen as people needing fixing or rescuing.	Family seen as partners in the change process.
System aligns with child to protect from parents.	System joins with parents and community to protect child.
Change comes from agency/court pressure.	Power for change resides in the family with support from the community.
Continual assessment of risk.	Continual assessment of risk, strengths, and protective factors.
Worker defines problems and chooses solutions.	Family helps define problems and selects solutions.
Counseling is primary intervention.	Blend of counseling, concrete resources, and skill building.
Formal resources primarily used.	Blend of formal and informal resources used.
Parental involvement lessens if plan is not reunification.	Some level of family connectedness encouraged in all cases.
Services delivered in the office and in family's home.	Services delivered primarily in family's home or community.
Family must fit categorical program requirements.	Interagency collaboration to meet family's unique needs.
System incentives support use of placement, sometimes outside of community.	System incentives support prevention of unnecessary placement.

This comparison was prepared by Linda Jewell Morgan for the National Resource Center on Family Based Services

Both the traditional approach and the family-centered approach support child safety. It should be noted, too, that the family-centered approach acknowledges that there will be times children will need to be removed from their homes.

Both approaches support a permanent and stable home for children. The family safety approach may be more oriented toward providing intensive and more varied services, and other interventions that make it more likely that a child can return to his or her biological parent(s).

In general, a family-centered approach takes a more collaborative and solutions focused perspective on working with families, is more flexible in its use of formal and informal services, emphasizes early intensive services, and tends to use multifunctional teams get appropriate services for the child and family.

#4: "No Margin for Error" Presentation

During one of the PowerPoint presentations in the *Opportunities in Family-Centered Practice* workshop, the trainer emphasized that our first priority in all circumstances is to ensure child safety. As Secretary Butterworth said at the 2007 Statewide Dependency Summit, "there is no margin for error when working with children." There is no margin for error when it comes to safety, and a family-centered approach recognizes there will be times when the child can stay in the home and times when the child must be removed.

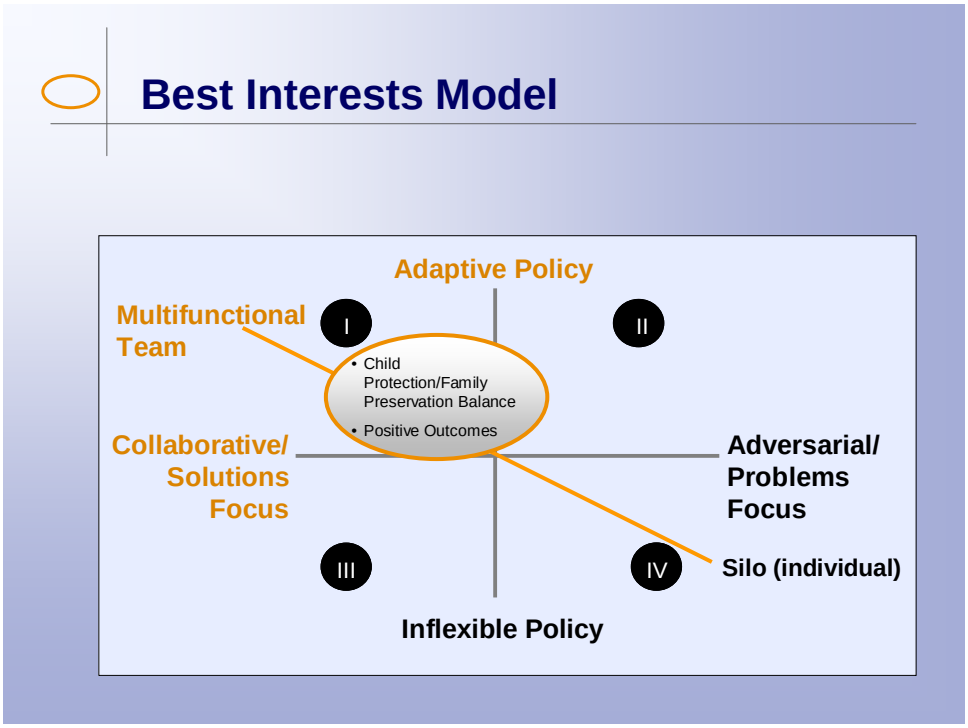
But with safety as a given, we also want to make sure our decisions take into account the child's best interests—maximizing that child's chances of flourishing socially, emotionally and educationally. To this end, the workshop cautions against a hasty "when in doubt, pull 'em out" mentality. Instead, whenever possible, we should lean toward a "when in doubt, find it out" mentality. That is, we are urged, while maintaining child safety, to get more information and/or advice to resolve doubt.

These issues are discussed in greater depth by Alan Abramowitz and Ron Zychowski from the Center for the Advancement of Child Welfare Practice in their presentation, *There is No Margin of Error: A Calm Approach to Child Welfare*. The Center makes this presentation available through a hosted Webcast, which you can view by pasting the following address into your web browser:

http://cbcta.fmhi.usf.edu/flcwp/confvids/daytona/daytonafs.html

#5: The Best Interests Model: Right Questions, Honest Answers

The Best Interests model is a way of structuring and thinking about those practices that impact the effectiveness of a family-centered approach. Just as in the Culture of Success model, our goal is to make decision that keep our work within Quadrant I.



Right Questions, Honest Answers

The Best Interests model can help you structure your thinking to answer the question

> **"What can I do right now to promote the best interests of this child and family?"**

Another critical question that should guide all of our decision-making is

> **Am I making my decisions in the best interests of the child/family?**

To answer these questions honestly and effectively, we should consider the following related questions:

1. Do I have a complete understanding of the situation and a good working relationship with the family?

2. **What other viewpoints might help me better understand the situation and make the best decision?**

3. **Can we safely "flex" our standard operating procedures to better meet the child's best interests?**

#6: Alice's Story: Part I

INTRODUCTORY INFORMATION

The following case description is a simulation story used for training purposes. Information is provided through narrative sections. A current "snapshot" is provided to put the historical and early contact with the child welfare system into context.

For the purposes of this training exercise, the primary focus of the story is the Protective Investigations phase of the child welfare system's involvement with Alice and her family. **This story is not intended to be an example of best practice. Questionable casework practice information is included intentionally to prompt dialogue and discussion.**

BACKGROUND INFORMATION: PROTECTIVE INVESTIGATION HISTORY

1st Involvement with Child Welfare System:

Alice and her family have been involved twice with the child welfare system. Alice first became known to the child welfare system following allegations of parental drug use and inadequate supervision.

The parents admitted to attending the party and drinking, but denied any illegal substance use. The parents stated they did leave all the children at home, alone, but that the oldest brother was responsible and capable of being a baby-sitter for all

All children were interviewed and examined by the investigator at their schools. No bruises or marks were documented. All reported that they thought they had "good parents." The oldest brother did share that although he was asked to watch the younger children, he actually left to go out with friends after the parents left. However, he did state that his middle school aged younger sister was staying at home, and that the two youngest were already in bed when he left. He denied ever seeing his parents use drugs.

The investigation was closed with no indicators for substance exposure and some indicators for inadequate supervision. A suggestion and referral was made for both parents to attend the local community center's parenting classes. A safety plan was also made by the two oldest siblings and the parents, that if they felt they could not adequately baby-sit the younger children, they would contact the paternal grandparents, who lived locally. The grandparents were never included in any of the initial investigation interviews.

2nd Involvement with Child Welfare System:

Alice and her family came into contact with the child welfare system a second time approximately two years ago. The child welfare system became involved following a call to the abuse hotline by the police, as the home had just been raided and the father arrested for possession of substances with intent to distribute. The mother was not at home at the time of the arrest, and the father stated that she had more or less "moved out" due to recent fighting between the two of them. The mother was believed to be staying with friends at the time. The children were taken into custody since the father was the primary caregiver. The father suggested his parents as a temporary placement, and after the investigator discussed this with her supervisor, along with no immediate local law enforcement issues identified, the children were placed with the paternal grandparents. The grandparents came to the home immediately following the arrest and took the children home with them.

Contact with the mother was unsucessful during the investigation, despite several attempts to find her. Attempts included phone calls and several visits to her last known address.

The children were interviewed and examined at school by the investigator. They were also seen by the child protection team. The two youngest children reported they were unaware of the drug use in the home. The two oldest children shared that they were aware of the drug use, but wanted to keep it a secret because they loved their father and wanted to stay with him. They shared that their mother occasionally drops by the house, often bringing gifts of clothes. They stated that, "…she was staying with a friend because dad kicked her out."

Collateral contacts were made with the police and neighbors. The neighbors expressed concerns about drug use in the home but, "…didn't want to narc or get into any of their business."

Significant amounts of illegal drugs, money and handguns were found in the home by the police. The father was interviewed by the protective investigator a second time while in jail. He was informed that the grandparents had agreed to take care of the children, "…for as long as it takes." As his legal proceeding progressed, he was ultimately sentenced to three years of prison time while pleading to a lesser charge.

The investigation was closed with Verified findings of substance exposed children, inadequate supervision and hazardous conditions. The case was staffed and accepted by the local community based care (CBC) agency for on-going case management services. Included in this staffing were the PI, her supervisor, a supervisor for the CBC agency and the CBC intake coordinator. The initial recommendations were to be adopted into the case plan.

The grandparents stated that although they would never be able to adopt their children due to financial reasons, they would care for the children as long as it took for their son to get out of prison, and, if the state would provide financial assistance. The case plan was developed by the CBC case manager and children's legal services (CLS) attorney , with a permanency plan of reunification, with a concurrent goal of adoption by the grandparents.

The case plan strategies included the recommendations of the protective investigator and original dependency petition. The plan included: the case manger would monitoring the status and safety of the children, assisting the grandparents with

enrolling the children into Medicaid and help the grandparents for applying for the relative caregiver stipend program. The plan required that the medical, behavioral and educational needs of the children were to be met by the grandparents, and required that the children have ongoing contact with the father while in prison. The case plan also required the case manager to diligently search for the mother to rule out whether she would be willing to care for her children.

#7: Doyle Research Presentation

Joseph Doyle is a researcher at MIT Sloan and the National Bureau of Economic Research (NBER). On May 8, 2008, Dr. Doyle made a presentation about his research to the Florida Task Force for Child Protection. The title of the presentation was Child Welfare and Child Outcomes: Measuring the Effects of Foster Care.

The webcast and PowerPoint are made available for viewing by the Center for the Advancement of Child Welfare Practice You can view these presentations by pasting the following address into your web browser:

www.mit.edu/~jjdoyle/research.html

#8: Family-Centered Practice Model

Florida Department of Children and Families Family-Centered Practice Model for Child Protection and Child Welfare Services

Protect the Vulnerable, Promote Strong and Economically Self-Sufficient Families, and Advance Personal and Family Recovery and Resiliency.

Introduction

The purpose of this paper is to provide a high level definition of family-centered practice, its values and principles and to provide descriptive information to assist investigators, caseworkers, and supervisors implement these practices with the children and families they serve.
Beginning on page 4, the document provides content to help front line staff integrate family-centered approaches into their routine practice with children and families. It is important for managers and front line staff to assess their agencies and their individual work with children and families to determine how this way of work can be integrated or improved at the local level.

Chapter 38, s. 39.001, F.S., provides authority and rationale for implementing family-centered practice as described in this paper.

Family-centered practice is a way of working with families in Florida's child welfare system across service systems to enhance their capacity to care for and protect their children. It focuses on the needs and welfare of children within the context of their families and communities. Family-centered practice recognizes the strengths of family relationships and builds on these strengths to achieve optimal outcomes.

- Family-centered practices focuses on the family as a whole, and not just the individual child, and sees the family in the context of their own culture, networks and community. Families are seen as partners in the change process, helping to define problems and identifying solutions through the strengths in their own stories.

- Children and their families are actively engaged and involved in the assessment, planning, delivery and coordination of services when it is safe and in the best interest of the child for his/her family to do so.

In family-centered practice, staff strive to be understanding of differing cultures and ensure that services provided to children and families are respectful of, and compatible with, their cultural strengths and needs. Culturally competent agencies and practitioners are able to view a family's strengths and needs within a cultural

context and integrate culturally relevant information in helping the family develop a meaningful plan of action. Cultural competence is a skill learned by the individual and the organization, fostered by a commitment to provide services that are culturally appropriate and that make a positive difference for children and families.

Local strategies for practice activities should include but not be limited to advocating for improved conditions for families, supporting them, stabilizing those in crisis, reunifying those who are separated, building new families, and connecting families to the resources that will sustain them in the future.

Children and their families must be encouraged and supported to access services. The Department or sub-contracted community based care providers must develop and implement strategies to promote the utilization of formal and informal services to children and families. Strategies and services must support children safely in their homes with their families. The child, when age appropriate and the family must be actively involved as team members in the case planning process.

Core Values, Guiding Principles, and Practice Framework

Core Values

Children should, first and foremost, be protected from abuse and neglect.

There is an intrinsic value and human worth in every child and family.

Children should live with their families, and when that cannot be achieved through supports and services, should live near their home, maintaining family connections, and in particular, sibling relationships, while also preserving their cultural heritage.

A child's home should be safe, stable and permanent.

A child should achieve success in school and their medical, emotional, behavioral, developmental and educational needs must be met.

Families and individual members are most likely to resolve issues of concern by involving them in the change process and building on their strengths.

Guiding Principles

- Child safety must always be promoted while actively assisting the preservation of families and family connections.
- The first and greatest investment of public resources should be made in the care and treatment of children in their own homes and communities.
- Every child deserves to live in a family which provides basic safety, nurturing and a commitment to permanent caretaking.
- The cultural and ethnic roots of the child/family are a valuable part of its identity. In order to understand and communicate with the child/family, cultural sensitivity must be a primary feature of service delivery.
- Children's need for safe and permanent family caretaking can be met by

providing appropriate and adequate resources in a timely and effective manner.

- Our approach to working with children and families should be child-centered and family focused with the needs of the child and family dictating the types and mix of services provided.

- Services to children and families shall be individualized based on their unique strengths and needs and should be delivered pursuant to an individualized plan, constructed with the family and their team.

- Services developed through the individualized teaming and planning process should be delivered with sufficient intensity to address presenting and underlying needs and should be well-coordinated.

- Practice is always local: Our work with children and families should be community based, and the focus of services as well as child welfare system management and decision-making responsibility, should rest at the community level.

- Family-centered approaches facilitate planned, appropriate placement when necessary, based on sound information about the needs of the child.

- Family-centered services offer the best hope of breaking the cycle of hopelessness and helplessness that engulfs many families. Families should be supported and encouraged to access services.

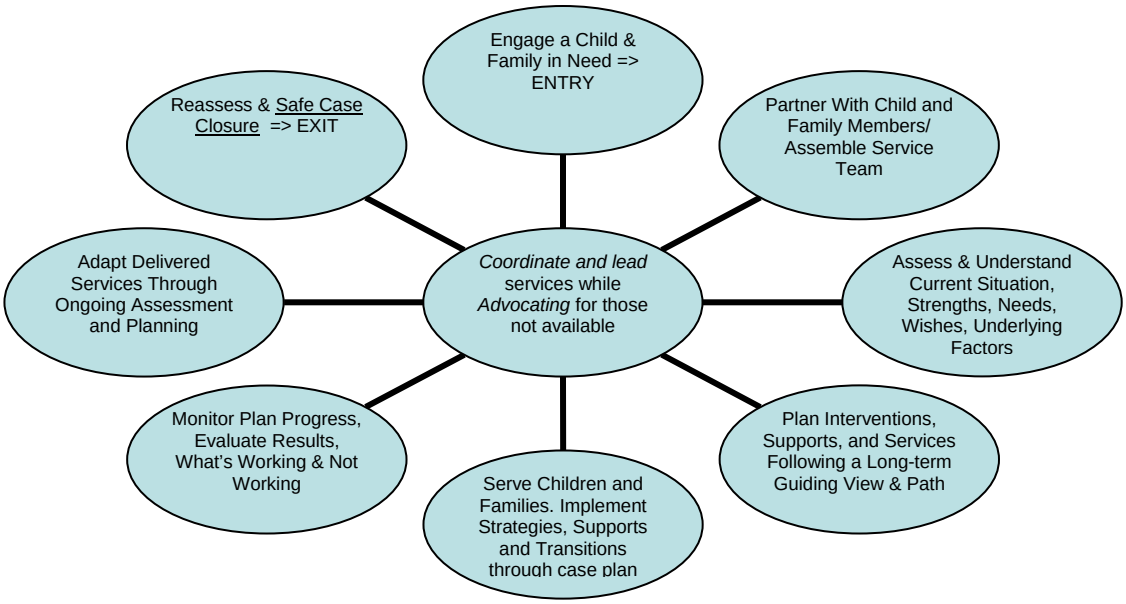
- Intervention into the life of children and families should ideally offer as much service as necessary to achieve intended goals, and no more.

- The rights to privacy and confidentiality must be treated with respect when assisting children and families.

Practice Framework

A practice framework encompasses the range of the major aspects and activities of child welfare practice and service delivery. Core practice functions include: engaging families and assembling families' individual teams; assessing children and families strengths and needs; collaboratively developing and implementing case plans; involving and supporting parents and caregivers in decision making; and monitoring and modifying services. The following diagram highlights the relationship between core practice functions. Ultimately, these core practice functions, and the many initiatives, strategies, steps, interventions, approaches and activities within them, are intended to drive the service delivery process to achieve the outcomes of ensuring child safety, strengthening family functioning, achieve permanency for children, and meet the children and families well-being needs.

Core Practice Functions[1]



Family-Centered Engagement: Working with families and youth is at the core of good family-centered practice. To conduct assessment, case planning, and case management successfully, caseworkers must be skilled in communicating with children, youth, and families to help them strengthen interpersonal, parenting, and problem-solving skills. The goal of family engagement is to build strengths-based, trusting, and working relationships with children and families. When engaging families child welfare professionals should:

- Listen carefully
- Demonstrate respect and empathy for family members
- Develop an understanding of the family's past experiences, current situation, concerns, and strengths
- Respond to concrete needs quickly
- Establish the purpose of involvement with the family
- Be aware of one's own biases and prejudices
- Validate the participatory role of the family
- Be consistent, reliable, and honest

Building the family's team: The purpose of the family's team is to ensure the skills, abilities and technical assistance needed to assist the family in achieving its individual goals are actively involved in the planning and service delivery process. The family team always begins with the child and family and the composition of other team members will vary, but be based on the child and family direction and needs. Team members may include formal service providers, such as; Children's Legal Services, teachers, therapists, foster parents and Guardian Ad Litems. Teams may also include informal supports such as relatives, friends, and other community supports. Effective teamwork requires coordination across the family's team to improve the integration and quality of service provision.

[1] Diagram adapted from Iowa's Department of Human Services Model of Practice which was developed with the assistance of Human Systems and Outcomes, Inc., Tallahassee, FL.

Family-centered assessment: Assessment forms the foundation of effective practice with children and families. Family-centered assessment focuses on the whole family, values family participation and experience, and respects the family's culture and ethnicity. Family-centered assessment helps families identify their strengths, needs, and resources and develop a service plan that assists them in achieving and maintaining safety, permanency, and well-being. There are many phases and types of family-centered assessment, including screening and initial assessment, safety and risk assessment, and comprehensive family assessment. Assessment in child welfare is intended to provide a big-picture understanding of the families' strengths and underlying needs and should be across the service team. Assessment is always ongoing.

Family-centered case planning: Family-centered case planning ensures the involvement and participation of family and other needed team members in all aspects of case planning, so services are tailored to best address the family's needs and strengths. It includes the family members' recommendations regarding the types of services that will be most helpful to them, timelines for achieving the plan, and expected outcomes for the child and family. Case planning requires frequent updates based on the caseworker and family's assessment of progress toward goals. Case plans should be well thought out, focused on outcomes, and offer logical strategies, that if implemented with adequate intensity, will drive the change process towards achieving outcomes for children and families. Case plans may include formal services, such as counseling, parenting classes or service for substance abuse or mental health issues. Case planning may also include assisting families with meeting practical needs, such as assisting the family with needs such as food, housing, transportation, employment, income support, providing information on child development, and helping build and daily living skills.

Family-centered case management and monitoring and modifying service delivery: Through frequent, planned contact, the family-centered practitioner assists the family in achieving the goals and objectives of the service plan. This includes helping families access a range of supports and services and creating opportunities for them to learn and practice new skills. Family-centered case management includes communication and planning with multiple service systems to ensure provision of appropriate services and assess service effectiveness and client progress. Families are encouraged to use their skills to access resources, fully participate in services, and evaluate their progress toward desired goals and outcomes. When interventions are not working, the case manager, working in collaboration with the team, must adjust strategies and services in order to continue to achieving the child and family's goals.

Working with community resources: Family-centered practitioners view all family members, including maternal and paternal relatives, fictive kin, and informal helpers, as important resources and sources of support for the family. They are skilled in engaging informal and formal community resources by involving them, as appropriate, in family assessment and case planning and in providing ongoing support to families before, during, and after services are ended by the formal child welfare agency and other community agencies. Elements of effective service planning with families include engaging families and youth; providing direct assistance with challenges the family is facing, including counseling, parent coaching, and modeling; and continuing to assess with the family their strengths, needs, and progress.

Advocating for families: Caseworkers advocate for services for individual families and help families learn to advocate for themselves and negotiate with service systems to obtain needed help. Caseworkers can also play a prominent role in empowering and advocating for families to become interdependent members of the community. Family advocacy focuses on the principles of family development, communication skills for workers, and promoting the participation of community residents and families in the design of services.

In summary, these core practice functions provide a foundational framework for child welfare practice. Family-centered practice is the result of child welfare professionals completing their case activities associated with these core practice functions in accordance with, and guided by, the values, goals and principles of the family-centered model of practice.

APPENDIX 1

COMPARISON OF TRADITIONAL AND FAMILY-CENTERED CHILD WELFARE PRACTICES

Traditional Child-Welfare	Family-centered Child Welfare
Safety	
Safety is the first concern	Safety is the first concern
Engagement	
Efforts focus on getting the facts and gathering information, and not in the building of the relationships.	Families are engaged in ways relevant to the situation and sensitive to the values of their culture.
Assessment	
The assessment focuses on the facts related to the reported abuse and neglect; the primary goal is to determine immediate safety risks and emerging dangers, as well as to identify the psychopathology of the "perpetrator".	The assessment protocols look at families' capabilities, strengths, and resources throughout the life of the case and are continuously assessed and discussed. Awareness of strengths supports the development of strategies built on competencies, assets, and resources.
Safety Planning	
The plan is developed by Child Protective Services, courts, or lawyers without input from the family or from those that know the child.	Families are involved in designing a safety plan based on information and support or worker/team members.
Out-of-Home Placement	
Biological, adoptive, and foster families have little contact with one another.	Partnerships are built between families and foster/adoptive families, or other placement providers. Respectful, non-judgmental, and non-blaming approaches are encouraged.
Implementation of Service Plan	
Implementation most often consists of determining whether the family has complied with the case plan, rather than providing services and supports or coordinating with informal and formal resources.	Workers ensure that families have reasonable access to a flexible, affordable, individualized array of services and resources so that they can maintain themselves as a family.
Permanency Planning	
Alternative permanency plans are introduced only after efforts at parental rehabilitation are unsuccessful.	Families, child welfare worker, community members, and service providers work together in developing alternate forms of permanency.
Reevaluation of Service Plan	
Few efforts are dedicated to determining the progress of the family in reaching the plan's outcomes. Re-evaluation results are not shared with the families.	Information from the family, children, support teams, and service providers is continuously shared with the service system to ensure that intervention strategies can be modified as needed to support positive outcomes.

APPENDIX II

Listing of Several Family-Centered Approaches to Child Welfare Practice

Family-centered, community-based principles are at the heart of a number of practice approaches. These approaches are used at different points in the helping process for purposes of assessment, case planning, and decision-making, and to address identified needs and concerns. Some are developed to address a specific population, such as substance-involved families or families of prisoners. Family-centered practice approaches include but are not limited to the following:

- **Family Group Decision Making.** Family group decision-making is a generic term that includes a number of approaches in which family members are brought together to make decisions about how to care for their children and develop a plan for services. Different names used for this type of intervention include family team conferencing, family team meetings, family group conferencing, family team decision-making, family unity meetings, and team decision-making. Approaches differ in various aspects, but most consist of several phases and employ a trained facilitator or coordinator.

- **Neighborhood-based Foster Care.** Family-centered, neighborhood-based foster care approaches, based on the principles of strengths-focused, neighborhood-based, culturally sensitive care for children and their families, include neighbor to neighbor, neighbor to family, and family to family. These approaches focus primarily on innovations in the provision of foster care services, building on the support of community collaborations and networks for families.

- **Alternative Response.** Traditionally, child welfare agencies have responded to allegations of child abuse and neglect by investigating the report, determining whether maltreatment has occurred or if the child is at risk, and putting an appropriate intervention in place. In these models, the focus is on assessing the strengths and needs of the family and child while ensuring the child's safety, usually without requiring a determination regarding maltreatment. Families may receive services through diversion to community agencies.

- **Shared Family Care.** In Shared Family Care (SFC), parent(s) and children are placed together in the home of a host family who is trained to mentor and support the parents as they develop skills and supports necessary to care for their children independently. SFC can be used to prevent out-of-home placement, to provide a safe environment for the reunification of a family that has been separated, or to help parents consider other permanency options, including relinquishment of parental rights.

- **Family Mediation.** Family mediation, also known as alternative dispute resolution, collaborative negotiation, conflict resolution, or conflict intervention, is increasingly used in making child welfare, child placement, and permanency decisions for children. In contrast to the traditional

adversarial, rights-based decision-making process, in this collaborative model, court- and community-based mediators work with families to resolve child abuse and neglect cases, expedite permanency planning, and develop post-permanency plans for ongoing birth family involvement in the lives of their children. The process emphasizes the needs of the child, family empowerment, and cooperation between families and professionals.

- **Services to Children and Families of Prisoners.** Parental incarceration and the disruption of family relationships can produce negative outcomes for children, including poverty, poor academic performance, aggression, depression, delinquency, and substance abuse. Incarcerated mothers and fathers are unable to work on parenting skills that may be necessary for reunification, and separation interferes with the ability of parent and child to form or maintain a strong attachment. Family-centered services for incarcerated parents, their children, and families focus on parenting programs, family strengthening activities, nurturing of family relationships, community supports for families during incarceration and following release, and gender-specific interventions.

- **Other Family-Centered Practice Approaches.** Services to children and families in systems other than child welfare employ family-centered principles and practices. Some of these approaches are being incorporated into community-based child welfare interventions that employ multiple systems in addressing the needs of families while ensuring the safety and well-being of their children. These approaches are often described using terms such as integrated services, systems of care, and wraparound, and may also include models such as drug courts and informal community-based service systems.

#9: Family-Centered Assumptions

1. **Every Florida child should have a permanent family to support and nurture growth and development and freedom from abuse and/or neglect.**

   We are committed to child safety and a permanent home. We will work intensely with the child's family to secure a safe environment for the child. If absolutely necessary, though, we will seek termination of parental rights more quickly than we have in the past.

2. **All children should live in families in their communities.**

   We are aiming to reduce non-relative foster care placements that remove a child from his or her community.

3. **Most families are or want to be competent caretakers and providers for their children and should have the opportunity to receive assistance on a voluntary basis in the least intrusive and most positive manner.**

   We are trying to be less confrontational and less dependent on court involvement. To a large degree, our success will depend on us. Can we show up-front, from the family's perspective, that we are responsive to the family's needs and interested in helping them, not hurting them? Do we have what it takes to make the first step, and the patience to wait for the family to respond?

4. **The best methods for protecting children involve early assessment and family-centered supportive services for purposes of family preservation or, when appropriate, reunification.**

   We are committed to developing a better understanding of the family to help the family succeed. We will become better at listening, helping the family to find supports, encouraging them to build on their strengths and to reduce risks. That takes a more careful assessment and a commitment to maintaining a helping relationship.

5. **Our services should support the everyday needs of the family.**

   We will listen and observe more carefully to understand the family's needs as they express them and we are able to assist them to identify.

6. **Families need relevant services that build on informal supports and natural community resources.**

   Too often we think of formal services to meet the family's needs. Informal services can more readily be targeted to the family's actual needs, be acceptable to the family, and be more readily available and accessible.

7. Every family is unique, with needs that change over time.

It is easy to get into a routine in which a new family becomes just another family. Each family feels its pain and shows its strengths in a unique way. We respect that and adapt our approach as appropriate. Also, we recognize that assessment is an on-going process.

#10: Summary: Child Welfare Practice Research & Best Practice Findings

The original document from which this summary is excerpted was authored by Alisa Ghazvini, Ph.D. (lead author) and Matthew Claps, MSW (co-author). The materials were produced for Iowa's Department of Human Services; Assessment Through the Life of the Case, Training Curriculum - and - The District of Columbia, Child and Family Services Administration, Achieving Permanency Training Curriculum; both developed by Human Systems and Outcomes, Inc.

Engagement, assessment, family teamwork, permanency planning for safe case closure, and monitoring the family change process are key elements of effective child welfare practice. This document contains a summary of research and best practice findings in these practice areas. A bibliography is also included.

Engagement

Engagement refers to those strategies that are used to involve family members in key decisions. Success in the provision of services depends on the quality and durability of relationships between those receiving services and those providing the services. This means that active efforts must be undertaken by those involved in the provision of services to reach out to children and families, to engage them meaningfully in all aspects of the service process, to build and maintain rapport and trusting relationships that endure through the course of actions taken, and then to thoughtfully conclude when circumstances requiring change or conditions for family independence and safe case closure are achieved. Engagement strategies are intended to build a ***mutually beneficial partnership*** with the child, siblings, parents/caregivers, key family members, invited family friends and supporters, and/or others and to ensure that families have an active role and voice in decisions, including the education and treatment of children. This is a partnership that builds and sustains their interest in and commitment to an active treatment or family change process until conditions for safe case closure are met.

- ***Engage families, when possible, on a voluntary basis*** – many families, particularly those that neglect their children, may not meet the threshold for protective service involvement but need assistance; voluntary participation is associated with engagement and success in improving child and family well-being

- ***Invest in intensive, strategic outreach to new cases*** – engage families at times and places that are most convenient for them; multiple visits early in the case are associated with greater case success

- ***Develop relationships with all family members*** – engage all pertinent family members, including intensive efforts to develop relationships with fathers

- ***Start with concrete services*** – early access to needed services (e.g., transportation, housing assistance, financial benefits) is associated with greater family engagement

- ***Provide supportive home-based interventions*** – a combination of services that include in-home supports and interventions provides greater opportunities for relationship development and engagement

- ***Involve parents in their children's therapy*** – parents are more likely to reinforce and take responsibility if they are empowered to be part of the change process

- ***Deliver culturally competent services*** – when service delivery processes are sensitive to cultural differences, caseworkers "look like" the families they serve, and caseworkers know the communities where families live, there is greater engagement and success

- ***Provide supports for family meetings*** – transportation, child care, and a safe place to meet support family engagement

- ***Recognize the family as a complex, adaptive system*** – caseworkers that know and understand family systems and concepts are better able to engage the whole family; overall family systems work best when subsystem boundaries are clear (neither too open nor too closed), interactions are clear, lines of authority are visible, rules are overt and flexible, changing alignments replace rigid coalitions, and stressors are confronted instead of pushed into scapegoats

- ***Ensure caseworkers are trained to recognize trauma responses and provide trauma-informed care*** – engaging children and families that have experienced trauma requires specialized training; with training, caseworkers can identify maladaptive functioning and development that serves as an adaptive response to trauma and provide trauma-informed supports and treatment

- ***Provide caseworker training in child and family development, parenting tasks, and issues of grief and loss*** – developmental tasks and transitions are impacted by family crisis, and there are frequent complications in the grieving process; specialized knowledge and skills are needed to engage and help families with these issues

- ***Develop job requirements, interview processes, and hiring procedures to support attainment of staff with good leadership skills*** – starting with good people helps decrease staff turnover, and identifying individuals with personality traits of empathy, trust, and respect for families promotes engagement

- ***Provide supportive supervision to facilitate staff retention, satisfaction, and growth*** – caseworkers are able to differentiate supportive supervision from an otherwise unsupportive work environment, and they view supervision as more important

- ***Ensure sufficient staff support*** – regular supervisory meetings, staff team meetings, and case presentations are associated with staff effectiveness; attention to staff safety is also important to effectiveness

- ***Develop staff awareness of program outcomes*** – staff knowledge of program goals and outcomes is associated with staff motivation and effectiveness

- ***Use multi-disciplinary teams and collaborative community partners to promote case success*** – using a combination of professional, paraprofessionals, and volunteers within the child welfare agency and across community partners provides better support for families; family needs are too complex for one agency to address

- ***Ensure team members include those that can help identify, develop plans for, and monitor the change process for underlying issues*** – supporting a successful change process requires special attention to and coordination of services around issues related to mental health, substance abuse, domestic violence, and cognitive deficit

Program and Process Outcomes Associated with Engagement and Leadership

- ✓ ***Engagement of families through a family empowerment approach is linked to better case outcomes*** – when family members are active participants and are responsible for helping design and track the family plan, the change process is more successful

- ✓ ***Engagement of extended family members in permanency planning contributes to successful reunification*** – there is growing evidence that families with support from extended family members are more likely to successfully complete the change process

- ✓ ***Good caseworker-family relationships are associated with successful case closure*** – families respond best to caseworkers they believe are committed to their well-being

- ✓ ***Clear communication between caseworkers and families regarding changes required for reunification is linked to better outcomes*** – when the change process is planned together and expectations are clearly delineated, success is more likely

- ✓ ***Caseworkers with a social work education and more experience tend to facilitate more timely permanence*** – there is growing evidence of the importance of education and experience to good skills as a leader in case planning

- ✓ ***Integrated service delivery is associated with improved family outcomes*** – indicators of family well-being are more positive when services are coordinated and there is a case manager assisting the family to navigate services and supports than when access to services is disjointed and requires multiple applications, efforts, and contacts

Family Teamwork

Family team planning and decision making is a child welfare practice strategy that recognizes families as appropriate and respected decision makers and brings together a wide range of formal and informal support resources for the family with the goal of providing safety and stability for the children. Target family members work with child welfare staff, extended family members, community service providers, and other neighborhood representatives to make critical decisions about meeting the needs of the children and family. Family teamwork draws upon a family's strengths, experiences, knowledge, and resources to create a plan that provides for the safety and well-being of children in the family. Collectively, the family team should have the technical and cultural competence, family knowledge, authority to act on behalf of funders and commit resources, and the ability to flexibly assemble resources and supports in response to specific needs. Although there are different types of family teamwork structures (e.g., family-to-family team decision making, family group conferencing, family team conferencing), they share common principles and standards of practice. Successful family team planning and decision making is not simply another "tool in the tool kit"; it requires state-community partnerships, extensive facilitator training, and a commitment to enhancing family responsibility.

- ***Ensure time for careful planning in initial implementation efforts*** – to build a coalition of support at multiple levels; develop consultation processes; craft mission statements, guiding philosophy, and protocols; provide information and training to diverse stakeholders; adapt policy; and identify shared resources and funding streams

- ***Support family teamwork implementation with strategic alliances and diverse community partnerships*** – to gain local and sponsoring agency ownership and identify shared resources and skills, supervisory support is essential

- ***Recognize the importance of the role of the coordinator in family teamwork*** – although there is no research evidence that any one particular way of providing coordinators (e.g., social workers versus community and non-social work coordinators) is best, there is evidence that the perception of facilitator effectiveness is a significant predictor of success for parents, family members, friends, professionals, and providers

- ***Ensure adequate preparation of participants*** – to ensure that families understand their role as decision makers; to create a climate of safety; to promote family leadership; and to ensure other professionals understand their roles

- ***Recognize that family members come when invited*** – despite concerns that families will not participate, research and evaluation findings indicate that the concern is unfounded and family member participation rates are high

- ***Support a balance in the number of family members and the number of professionals*** – there is evidence that too many professionals can impact family decision making but professionals are important team members to provide information on the critical child safety concerns and the available resources; principle of commensurate response asserts that the team should be no bigger than necessary to understand the family situation and provide support and services for the change process

- ***Recognize the importance of written policies and procedures*** – to define how, when, and where family teamwork meetings will be held and to formalize partnerships

- ***Support the use of a comprehensive curriculum and training*** – to ensure skill development opportunities for coordinators, supervisors, facilitators, workers, and partners

- ***Provide quality assurance mechanisms*** – to ensure consistent application of the practice model and to assess the effectiveness of the model

- ***Ensure a comprehensive evaluation*** – third-party evaluation can assess the realization of desired outcomes and assure funders

Program and Process Outcomes Associated with Family Teamwork

- ✓ ***Family teamwork provides child safety*** – a number of studies report reduced rates of re-abuse in family teamwork families versus non-family teamwork families

- ✓ ***Family teamwork creates stability for children*** – children's placements are stable or moves are minimized in family teamwork families versus traditional samples

- ✓ ***Family teamwork results in higher rates of reunification with birth parents or kinship placements*** – findings also indicate that these placements generally remain stable

- ✓ ***Family teamwork results in timely decisions reducing the amount of time children spend awaiting permanency*** – reductions in use of long-term foster care are associated with family teamwork

- ✓ ***Family teamwork increases the likelihood that siblings will be placed together*** - studies indicate a decrease in number and percentage of divided sibling groups

- ✓ ***Family teamwork is associated with less restrictive placements*** – findings indicate an increase in number and percentage of children placed in less restrictive environments and a reduced likelihood of movement into more restrictive placements

- ✓ ***Family teamwork is associated with improved well-being for children and other family members*** – improvements in indicators of well-being have been found following family teamwork

- ✓ ***Family teamwork increases family supports and helps family functioning by enhancing social support networks*** – increased client satisfaction and engagement is associated with family teamwork

- ✓ ***Family teamwork safeguards other family members*** – brings together domestic violence and child welfare resources and results in decreased family violence

- ✓ ***Family teamwork results in plans that are seen to be safe*** – on average, only 5% of family teamwork plans are judged to be unsafe/not accepted by authorities

- ✓ ***Family teamwork plans blend formal services and informal support*** – there is an increased likelihood of connection to community and non-traditional services associated with family teamwork

- ✓ ***Family teamwork plans are rich, diverse, and original*** – studies show that family teamwork plans challenge typical pre-purchased service structures

- ✓ ***Family teamwork decreases the disproportionate number of children of color in care*** – through increased placements with birth parents and in kinship care

- ✓ ***Family members are satisfied with the process reporting that their feelings are respected, they have a role in decision making, and the decision process is fair*** – increase in client engagement and satisfaction

- ✓ ***Family teamwork increases the involvement of fathers and paternal relatives*** – increase in client engagement and satisfaction

- ✓ ***Social workers and service providers are satisfied with family teamwork reporting less conflict with families and greater service coordination*** – increase in human service staff engagement and satisfaction

- ✓ ***Social worker rates of referral for family teamwork fluctuate related to concerns regarding personal liability and risk, increased workload, lack of support for the process, and lack of time***

- ✓ ***Referral processes for family teamwork need further review*** – minorities are less likely to take part in some areas; in other areas, participation rates among cultural and ethnic groups are similar to the total population rates of families served

- ✓ ***Family teamwork provides cost neutrality or savings***

Permanency and Safe Case Closure

Safe case closure indicates that conditions have been met that signal readiness for independence of the family from the child welfare service system. These conditions involve achieving and maintaining specific outcomes relative to situational stability, safety and management of risks or threats, skills and behaviors for daily functioning in essential life activities and roles, concurrent alternatives to permanency, sustainable supports for basic necessities and adequate family functioning, resiliency and coping for children, recovery/relapse prevention for older youth and adults, successful transitions and life adjustments, resolution of legal issues, and satisfaction of any other court-ordered requirements. Once defined outcomes have been met in the change process, the conditions for family independence and safe case closure have been met.

- ***Ensure a thorough and comprehensive assessment process*** – improved outcomes are associated with functional assessments that are ongoing, determine underlying problems, identify strengths and risks, and involve all pertinent members of the family; use of findings to inform the case plan goals, objectives, and adjustments; and assessment that includes attention to parent-child and intergenerational patterns of attachment

- ***Utilize concurrent planning*** – based on final reports from the Federal Child and Family services Reviews, concurrent planning was linked to positive results (i.e., reduced time to permanency) in at least 11 states

- ***Ensure concurrent planning requires full documented disclosure and early aggressive search for birth family resources and identification and consideration of all other permanency options*** – requirements include a clear plan that outlines for birth parents problems, necessary changes, possible consequences, and timeframes; early use of foster/adoptive or kinship placements; and frequent and constructive use of parent-child visitation

- ***Recognize that effective concurrent planning requires "front loading" of services*** – the Colorado Expedited Permanency Planning process realized a gain in attaining timely permanency by empowering families' teams to develop concurrent plans and provide services quickly (up to $5,000 per family was available to family teams upon a child's entry to foster care); within one year, rates of permanency attainment ranged from 84 to 85 percent for treatment groups versus 22 to 32 percent for non-treatment groups

- ***Provide coordination of services across multiple systems to support effective concurrent planning*** – lack of coordination and role clarity across systems and failure to include mental health, substance abuse, and domestic violence service providers are barriers to safe case closure; flexible funding and use of fiscal

incentives for service providers are associated with moving children more quickly toward permanence

- ***Recognize the relationship between caseworker consistency and safe case closure*** – a single change in caseworker-family assignment during the year reduces the likelihood of permanency by 52 percent

- ***Develop supports for fewer placements*** – each placement is associated with a reduction in permanency by 32 percent

- ***Facilitate ample parental visitation*** – each day of visitation triples the odds of permanency

- ***Focus efforts on developing strong formal and informal support networks*** – evidence indicates that families in the child welfare system need comprehensive, intensive, and long-term services, and support networks are the most cost effective long-term support mechanism

- ***Develop effective support network building through a family team approach, using multidisciplinary teams, assigning cases geographically so that workers develop a better understanding of neighborhood formal and informal supports, and reconvening the same team*** – a shared commitment to the family and a knowledge of their story and living conditions affects permanency

- ***Ensure relapse and safety planning*** – an individualized plan reduces immediate and long-term risks for the family; such planning is particularly important for families with substance abuse, mental illness, cognitive impairments, and domestic violence issues

- ***Provide for comprehensive caseworker training*** – staff with in-depth training in child development, early relationship and attachment issues, family team decision making, and support network building are better equipped to move families toward safe case closure

Program and Process Outcomes Associated with Safe Case Closure

- ✓ ***A long-term view of safe case closure provides child safety*** – assuring that conditions of safe case closure are met reduces rates of re-abuse

- ✓ ***A long-term view of safe case closure creates stability for children*** – children's placements are stable or moves are minimized if conditions for safe case closure are met

- ✓ ***Placement stability enables secure attachments to develop*** – matching strategies to needed changes in such a way that minimizes placements for children can have long-term positive effects on developmental status

- ✓ ***Openness in concurrent planning is linked to more voluntary relinquishments and open adoptions*** – decision making can proceed more quickly when families are included at the earliest possible point in considering all reasonable options for placements that result in the best outcomes for children

- ✓ ***Youth are adequately supported in transitioning to independent living*** – improved independence outcomes are realized when long-term planning for safe case closure addresses developmental and educational conditions for independence of youth

The Change Process

The change process involves the development, implementation, and assessment of an agreed-upon combination and sequence of actions designed to alter the underlying dynamic factors that limit, incapacitate, or disrupt adequate daily functioning and well-being and/or build capacities necessary for the family to achieve and sustain safety, adequate daily living, well-being, and permanency. This process moves beyond matching services to needs and to matching strategies to changes to be made to reach safe case closure requirements. Successful change processes must involve ongoing assessment and planning and be child/family-centered, culturally-competent, safety-focused, evidence-based, and well-reasoned. In addition, strategies for change must be commensurate with needs and of sufficient power (precision, intensity, duration, fidelity, and consistency) to produce desired results and make timely progress. Tracking and adjustment are requirements for finding what works and making the intervention process effective for children and families. Effective tracking requires maintaining ongoing situation awareness, and effective adjustments depend upon understanding and acting on what is working and not working in helping the family meet conditions of safe case closure.

- ***Recognize the importance of safety management plans that address conditions of safety in the home, demonstrated parental behavior change, and family supports*** – implementation of strategies to achieve and maintain safe conditions in the family home result in safe case closure

- ***Provide early identification of multiple permanency strategies (i.e., concurrent planning)*** – a well-reasoned plan for permanency identifies strategies for family reunification, independence for youth, long-term care for children with severe disabilities, and alternative placement (foster-to-adopt and kinship care) and reduces placement moves for children

- ***Consider child and family development*** – case plans should take into consideration where children are developmentally and the developmental tasks and transitions before the family; typical individual and family maturation, which involves change, tension, stress, and disruptions, may be magnified, stalled, or disrupted during crisis

- ***Ensure acquisition and demonstration of appropriate parenting knowledge and skills*** – parents with realistic child development expectations are more likely to use appropriate guidance techniques and complete the developmental tasks associated with the stages of parenthood

- ***Ensure demonstration of sustained behavior change*** – documentation of completion of a course or attendance at a treatment program provides insufficient evidence of necessary behavior changes; research and best practice evidence requires documented behavior change by an objective observer

- ***Focus on development of sustainable support systems*** – changes in the family system that include sustainable formal and informal supports to help parents meet basic caregiving necessities, and support network members that participate in relapse and safety plans are linked to safe case closure

- ***Ensure treatment for attachment disorders*** – attachment disturbances exist in as many as 80 percent of children in high risk families; effective treatments include therapies that create attachment patterns, address relationships systemically, are holistic and integrative, and address early trauma

- ***Ensure treatment for trauma*** – early trauma can result in major disorders (e.g., anxiety disorders, eating disorders, sleep disorders, impulse control disorders, acute stress disorder, depression, post-traumatic stress disorder, disassociative disorder, and behavior and relational problems), affect existing disorders, and perpetuation across generations; combination therapies (e.g., cognitive, behavioral, and drug therapies) have demonstrated effectiveness in assisting children and families in overcoming or reducing effects of trauma

- ***Ensure treatment for substance abuse*** – when substance abuse is involved, there is a 13 times higher likelihood of repeat maltreatment, and another maltreatment report is likely within 60 days of the first report in 26 percent of cases with an alcohol or drug problem

- ***Ensure treatment for other mental health issues*** – for almost any psychological disorder and its behavioral symptoms, a therapeutic alteration in the chemistry of the brain, nervous system, or physiology can produce a dramatic result and improved well-being and functioning

- ***Understand the cultural/ethnic context*** – cultural/ethnic context impacts developmental tasks and transitions, event meaning and interpretation, family roles and rituals, and sources of support; strategy selection must vary based on the context

- ***Provide relapse prevention and coping skills training*** – combined with other addiction treatment approaches, these strategies are associated with decreased relapse of addictive behaviors; special attention may be needed for ethnic-minority abusers since they may experience disproportionately high numbers of adverse health consequences and may be underserved by treatment services

- ***Prepare adoptive families*** – adoptive families that receive intensive and ongoing training and support relative to the legal process; child development expectations and child special needs; attachment, separation, loss, trauma, and bonding issues; family life cycle expectations; financial planning; and other behavioral, health, and educational issues are more successful at mastering family developmental tasks

- ***Provide comprehensive integrated community-based services*** – families are best served by an integrated service delivery design, with community-based providers sharing and coordinating resources to assist the family holistically

- ***Provide post-placement services sustained over time*** – there is increasing evidence that post-placement services of less than three months are ineffective in ending cycles of chronic maltreatment

- ***Extend services beyond age 18 for youth in foster care to support more positive transitions to adulthood*** – youth that receive services beyond 18 are more likely to receive independent living assistance, complete more education, and access health and mental health services

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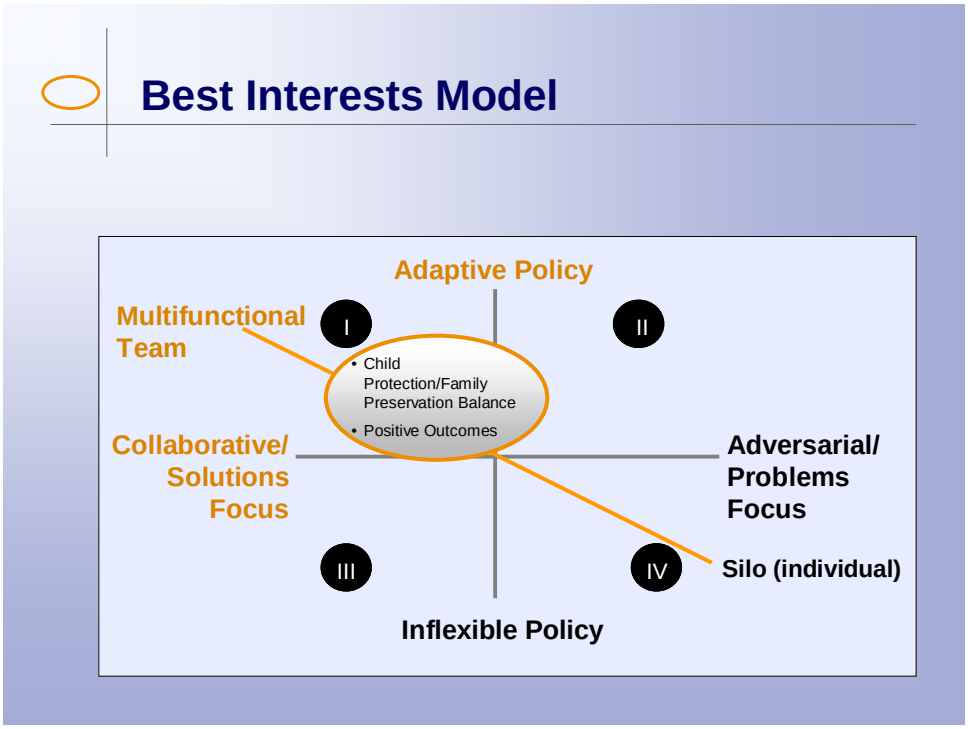
#11: Case Story Questionnaire

Directions:

Your team will have 30 minutes to answer the following questions about your case. After that, your team will present the case at the "case review meeting."

Questions:

1. Based on the presented case summary, where would you put this case on the Best Interests Model? Draw a small circle for your answer.



2. Under ideal ideal circumstances, what should be done—what family-centered practices should be used—to advance the case?

COLLABORATIVE/ SOLUTION-FOCUS	WHO	MULTIFUNCTIONAL TEAM	WHO	ADAPTIVE POLICY	WHO

3. Describe the effects of the case practices you selected on:
   a. Child safety:

   b. Strengthening families:

   c. Building quality relationships:

   d. Sharing risk:

   e. Return to the model diagram in question #1 and draw a circle to indicate where the case is when your practices are implemented.

4. What are the major challenges that you see to implementing your ideal approach?

#12: Alice's Story-Part 2

INTRODUCTORY INFORMATION

The following case description is a simulation story used for training purposes. Information is provided through narrative sections reflecting simulated results of record reviews, observations, and interviews. For the purposes of this training exercise, the primary focus of the story is Alice. ***This story is not intended to be an example of best practice. Concerning information is included intentionally to prompt dialogue and discussion.***

BACKGROUND INFORMATION

Name of Child: Alice

Age: 14 years

Current Grade: 8th

Alice, an adolescent girl of mixed ancestry, is the second of four children who are currently living with their paternal grandparents. One of Alice's uncles (age twenty-two), also lives in the home, and from time to time, other family members have lived with the family. Alice's father is in jail for drug trafficking, and the family has limited contact with him. He should be released in 9 to 12 months.

Alice's mother lives in the community and has limited contact with the family. Her relationship with Alice and her siblings is described as "distant." The mother is now involved in another relationship and has a five-month-old daughter. She has a history of substance abuse which led to child welfare system involvement and the children living with their grandparents. Any substance usage at this time is unknown. Both mother's and father's parental rights still remain. There is a history of domestic violence between Alice's parents.

The children were taken into care when police found drugs in the family's apartment and the father, who was the primary caregiver, was arrested. The children were removed at the time of the arrest and were placed with the paternal grandparents. The investigation was closed with verified findings, the children were determined dependent and the paternal grandparents remain the temporary guardians, pending the father's discharge from prison and possible reunification of the family at that time. Alice and her siblings have lived with the grandparents for nearly two years. The father has expressed interest in reunification. Alice's biological and legal parents are still married. The father does not know about his wife's recent child by another man.

The grandparents receive relative caregiver stipend funding and all children in the home receive Medicaid. The grandmother most frequently attends service planning meetings conducted by the agencies serving Alice and is also the primary contact for school. Alice is currently receiving services through special education, mental health, juvenile justice, and child welfare.

Alice has an older brother who moved out of the home to live with friends following dropping out of high school. He is believed to be involved in criminal activity. Alice's older sister is a junior in high school and has marginal school performance. She is not receiving any special education services. Her younger brother is in elementary school and is described as being hyperactive and a slow learner. He was "tox-positive" for crack cocaine at birth.

The grandmother is involved in her church and other community civic endeavors. She includes her grandchildren in church activities whenever possible. She is a strong advocate for Alice and their family. The uncle occasionally lives at the residence.

THE CURRENT SITUATION

Alice was arrested during the summer, just prior to the beginning of the 8th grade school year. She was found riding in a stolen car with teenage boys. They were all drinking at the time of arrest. She was temporarily placed in a juvenile detention center. Due to prior juvenile justice involvement stemming from fighting at school, her probation was continued, with the delinquency court ordering additional individual counseling. This was to be provided through her community mental health provider. The school was not aware of her prior status with the Juvenile Justice Services and only became aware of juvenile justice involvement following this incident.

The child welfare caseworker is a new employee of the case management agency and has had Alice on her caseload for just two months. She is still learning the history and details of the case. She is new to child welfare work having recently graduated from college and completing pre-services training. The worker has a caseload of 14 families. The grandmother has been her primary contact point in the case. She has made two home visits and has met all the children. She is aware that other agencies are involved with Alice but has not had time to attend any meetings held by the other agencies or to get copies of their plans. She is aware that there are some problems in this case. But said: "The children are safe for now, the home is OK, the father won't be back for months, Alice is only 14 years old, and we still have lots of time." There is a judicial review scheduled in four weeks. All case plans and court ordered documents have been filed with the court on a regular basis. The current child welfare attorney has been involved for the last twelve months and has expressed that the judge is becoming impatient with the progress to date. Although requested, a Guardian Ad Litem is not active in the case due to lack of available resources.

A new IEP meeting was called at the start of the school year. Alice's grandmother, her mental health care coordinator, SPED teacher, exceptional student services coordinator, school vice principal and juvenile justice worker attended the meeting. The updated IEP provided behavioral goals of improved school attendance, a decrease in behavior referrals for fighting, and fewer outbursts related to frustration. The plan included meeting with the school guidance counselor for individual therapy and group counseling, to have a behavioral focus on managing her impulsivity and controlling angry outbursts. Learning objectives in the IEP included goals for improved language arts and reading skills. She would continue to remain in mainstream classes, with the exception of reading. There were no other

mental health services referenced in the IEP.

Despite some recent academic progress in the classroom, particularly in math and reading following implementation of a specialized reading plan, behavioral issues remained a challenge. Alice acted out aggressively when she believed she was being insulted or teased by the "regular" students outside of her special education classroom. She continues to have unexcused absences, multiple referrals and in-school suspensions for fighting. She is currently a "C" or average, student. Reading levels remain at least two years behind.

THE FAMILY'S STORY

Grandmother - Caregiver

Alice's grandmother indicated she was relieved her granddaughter was getting some services, but was skeptical regarding her progress. She reported that at home she was not very respectful or helpful, and that she tolerates what she defines as normal 'teenager' behavior. When asked, she responded that she considered normal teenage behavior to be occasional disrespect for authority, some sneaking out, not always attending to chores, and occasional anger/frustration outbursts. She stated that she continues to fight with her siblings, and recently, Alice seems to be more aggressive than in the past. The grandmother shared that Alice keeps a diary, which she just recently read for the first time. She said that the diary is mostly fantasy related stories, remarked being startled at some of the most recent entries, describing them as graphic and having fairly explicit sexual detail.

She says Alice gets regular medical, dental, and other related checkups as needed, and that she is only taking Ritalin. She indicated that the topic of medications hasn't been brought up for some time, but believes they are generally working.

The grandmother has limited awareness of the content of the counseling sessions, only getting information through Alice infrequently. She has not met with the individual therapist since the initial evaluation and interview, which did occur in the family's home. The therapist attempted to make a schedule that would work with the grandmother, but they were unable to find one. As a result, the individual therapist began scheduling counseling sessions at Alice's school, which typically occurred over lunch. She recalls some phone contacts since then, but since individual therapy has moved to being provided at the school, she has not had any contact. She expressed some concern about Alice's after-school activities, which tended to be unmonitored. She talks with the probation officer infrequently, mostly about compliance with court responsibilities.

The grandmother expressed concern about Alice's biological parents. The family has no interest of locating or contacting the mother. Alice's father should be released within the next year and the family doesn't talk about the issue. The topic is avoided and the family appears embarrassed when it is discussed.

The grandmother also indicated that she was feeling a bit fatigued and stressed. Her husband has diabetes and hypertension, and there are some concerns regarding his health. She has been taking care of him as well as the children and is feeling a bit worn out. She expressed that she feels responsible for Alice "turning out right", particularly due to the situation with her biological parents. She has limited

awareness of community resources beyond church and family.

She fears Alice may end up being a criminal. She also thinks Alice could be smart, but has no idea of her potential or any long-term view or goals for her. She appreciates the state-provided resources, and believes it is likely Alice would have ended up in juvenile jail if she were not getting support.

Alice

Alice is of average size and build. Case notes state her strengths are enjoying and playing music, having supportive grandparents and attending school. She is well spoken and interested in pop-culture and television. She is not involved in any organized athletics or recreational activities. Her after school activities are described as "hanging out." She says she doesn't have any long-term goals, other than "I figure I'm gonna work," but doesn't know what she wants to do.

She reported that group and individual counseling at school was helpful but was not so enthusiastic about her individual therapy. She thought the therapist was "alright" but she didn't really feel like she had anything to say to her and thought it was a waste of time.

Alice often wonders when her father is coming home and what things will be like when he returns. Her contact with him has been limited to occasional letters and phone calls around holidays and birthdays of family members. She worries about how her father will react when he hears about her mother's new baby and boyfriend. She's never shared these concerns.

PERSPECTIVES OF OTHER PEOPLE INVOLVED WITH ALICE

Special Education (SPED) Teacher

Alice's SPED teacher provides education for language arts and reading. She has worked with Alice since the 7th grade and has developed a good working relationship with her. She indicated that she believes Alice has made improvement in her class. Her class participation has improved, and she is more willing to interact with her peers appropriately for classroom assignments. She shared that Alice responds well to supervision, but can get off task if she believes she is being "hounded over." She responds well to positive reinforcement and praise, and her teacher has learned to read her affect for cues to her mood and behavior. She has contact with Alice's grandmother through behavior and assignment logs. Feedback she gets from those logs is generally consistent. She has contact with school-related service providers, but at this time is unaware of the situation with therapy or the legal/probation situation.

Math Regular Education Teacher

Alice's math teacher expressed that he was happy that Alice earned a B in the most recent grading period. This was her highest grade achieved to date. He indicated that Alice's math skills were at about the 7th or 8th grade level in some areas and she required close supervision and redirection towards task. The teacher has intervened verbally on several occasions when it appeared Alice was going to react inappropriately towards what she perceived as intentional teasing by another peer

in class. He was unaware of any of Alice's child welfare, mental health or juvenile justice involvement.

Juvenile Probation Officer

The probation officer indicated that Alice still had approximately 25 hours of community service remaining of her responsibilities, and was slow about attending to it. However, it appeared she did consistently do some community service per week. There have been no recent legal violations since the summer and it appears Alice is generally compliant with her probation requirements. The probation officer had no information regarding Alice's education other than her absences appear to have decreased. He indicated he only had contact with the vice principal regarding discipline and attendance.

Mental Health Individual Therapist

The individual therapist had established goals of improved self-esteem, decreasing fighting behaviors, and verbalizing and understanding Alice's feelings about her family relations and abandonment issues. Therapy is intended to focus upon the specific building of skills to make choices about impulsive behavior and developing an appropriate behavior management plan for school and home. Progress in counseling is described as mixed. She has been to the home and met with Alice's grandmother once, and had several phone contacts since. She indicated she wanted to do some family therapy but was unable to arrange a suitable schedule. She has no contact with the school guidance counselor, outside of arranging the logistics of school visits. The most recent psychological evaluation included the following diagnosis:

Axis I: 312.8 Conduct Disorder, Childhood Onset, Moderate Severity
314.01, Attention Deficit Hyperactivity Disorder, Combined Type
315.00 Reading Disorder (Dyslexia)

Ritalin is currently being prescribed by Alice's general practitioner. Consent was provided by the grandparents. A court order was also issued in lieu of the father's consent.

School Guidance Counselor

The guidance counselor runs a group focused on effective communication skills and anger management. Alice attends regularly, participates and seemed to enjoy the group. The guidance counselor has not had contact with the child welfare worker or probation officer. He does believe he would be informed if anything important occurred with Alice.

Mental Health Care Coordinator at the Provider Agency

The care coordinator has recently received the case when the provider agency shifted the coverage assignments within their network. The previous care coordinator is no longer working for the provider agency.

#13: Family Centered Practice: Self-Assessment

Directions: Write your answers to the questions below. You'll have about 10 minutes.

1. Based on what you've learned about family-centered practice at this worksheet, what aspects of it are most different from how you do your work now?

2. What aspects of family centered practice are most similar to your current practices?

3. What do you see as the main opportunities for your work when you apply the family centered approach?

4. What do you see as the main challenges for your work when you apply the family centered approach?

5. What's in it *for you* if you apply the family centered approach to your case work?

#14: Family-Centered Practice: Implementation in Case Work

Directions: As a group, determine how the family centered approach could be implemented in your work and why it should be done. As group members gives answers, write them below the appropriate questions. Choose a reporter to present your group results. You will have approximately 20 minutes for this activity.

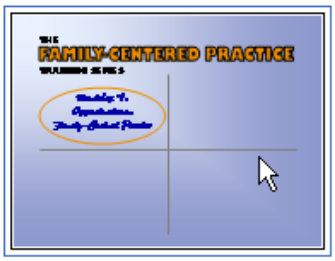
1. What are the pros and cons of implementing family centered practice in your job?

PROS	CONS

2. What are the key things that we or others who work for our agency would need to do to implement the family-centered approach?

3. Why should we implement a family centered approach?

#15: PowerPoint Thumbnails



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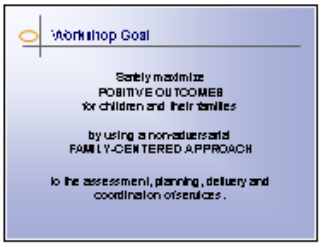

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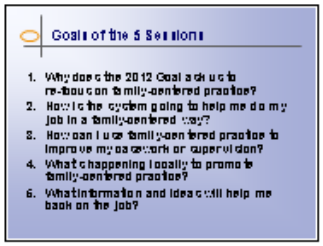

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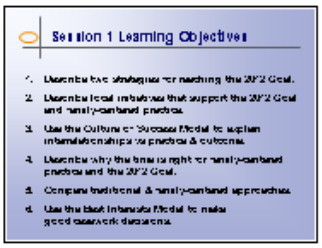

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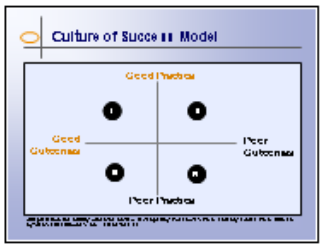

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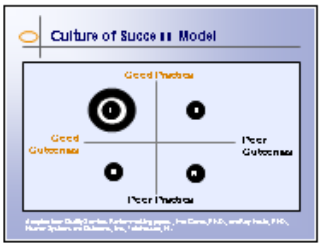

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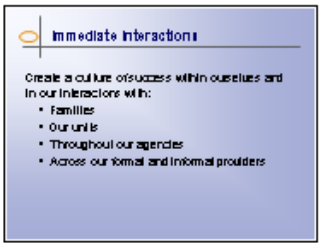

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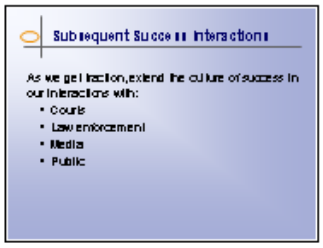

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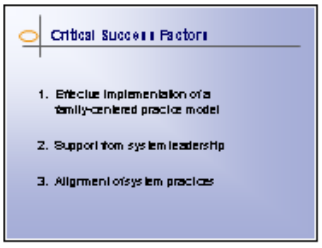

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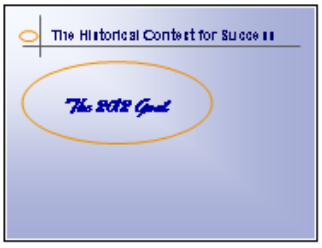

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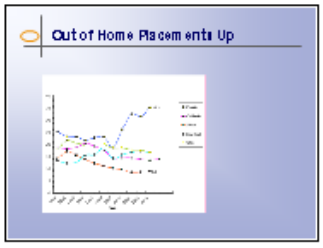

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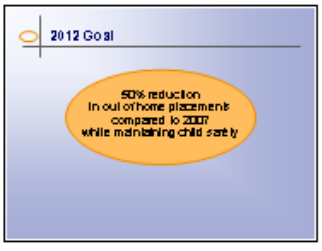

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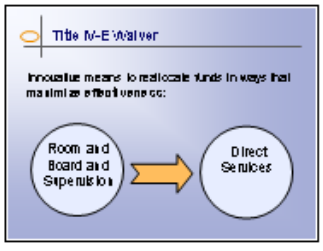

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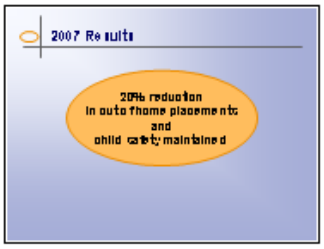

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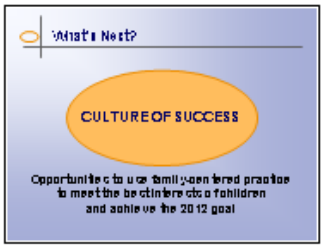

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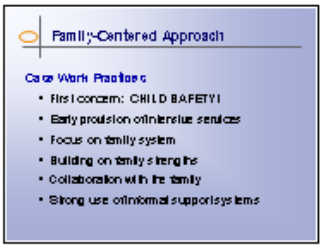

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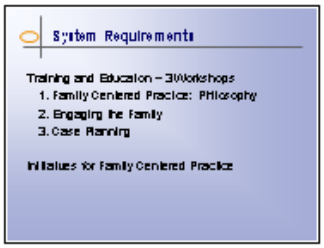

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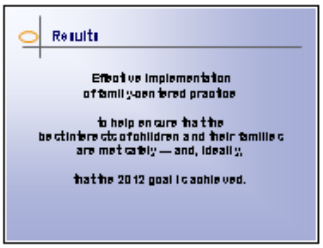

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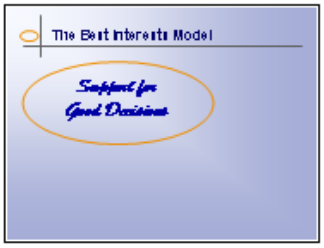

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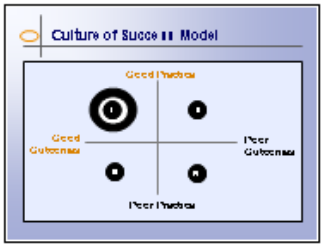

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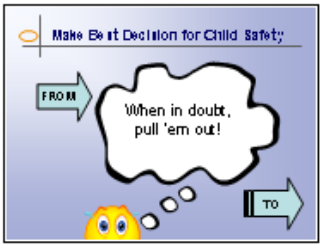

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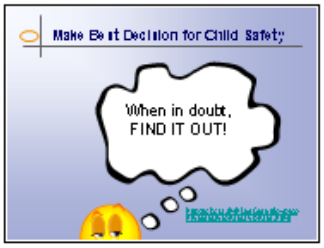

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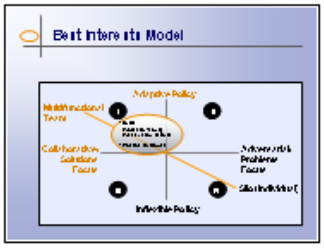

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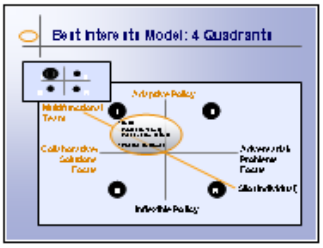

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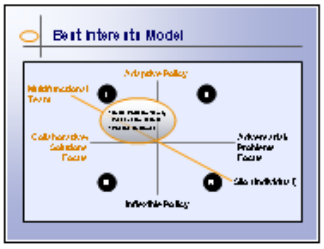

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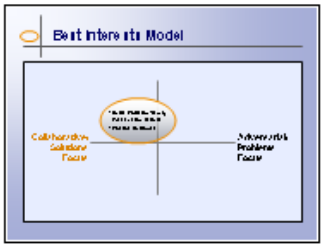

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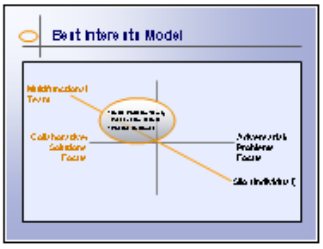

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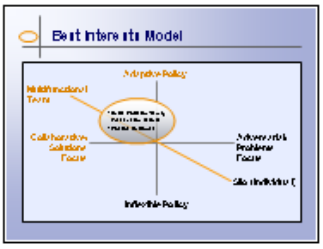

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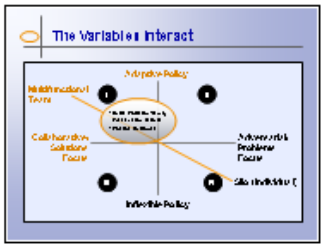

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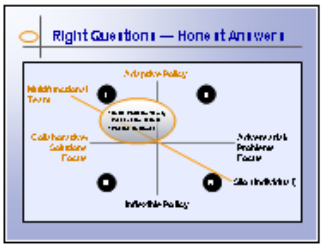

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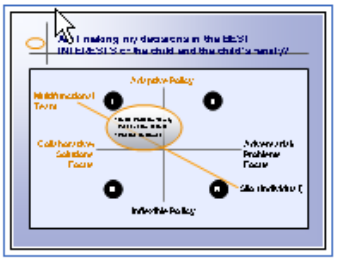

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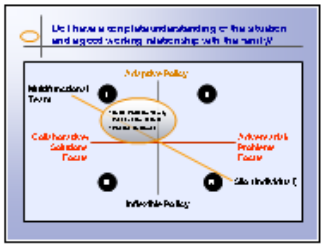

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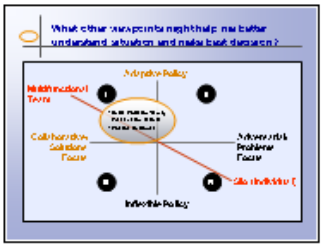

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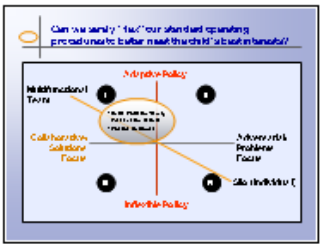

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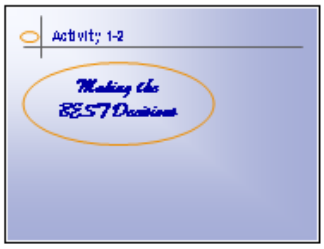

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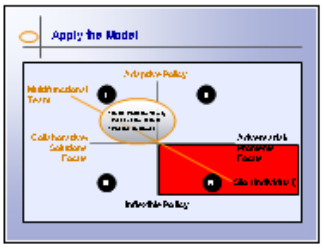

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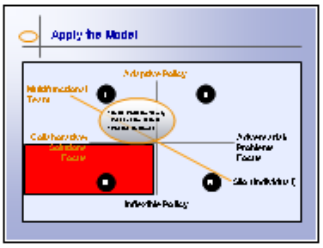

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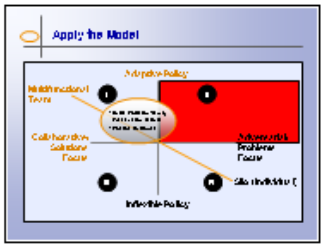

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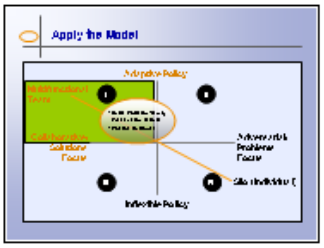

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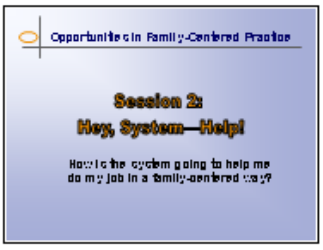

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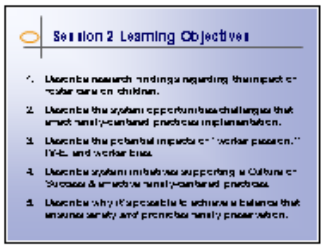

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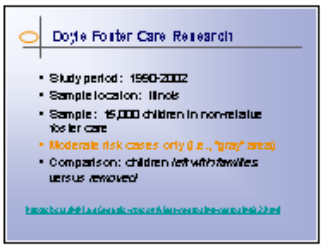

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Doyle Research Findings

ARRESTED AT LEAST ONCE
- Children removed: 44%
- Children with families: 14%

PREGNANT TEEN MOTHERS
- Girls removed: 68%
- Girls with families: 33%

JOBS FOR AT LEAST THREE MONTHS
- Children removed: 20%
- Children with families: 33%

46

Summary of Other Research

Children with Foster Care history are:
- More likely to drop out of school
- More likely to abuse drugs
- More likely to score lower on the FCAT
- More likely to be diagnosed with a learning disability
- Twice as likely to be held back a grade

47

Summary of Other Research

Children with foster care history are:
- 4 times more likely to receive food stamps
- 17 times more likely to be homeless
- 3 times more likely to be in prison or on parole

48

Factors that Impact Our Work

Worker Passion
Worker Bias
IV-E Waiver

49

Worker Passion

- What situations or circumstances bring out a sense of passion for the work you do?
- What effect does that work passion have on the results of your work?
- How might your work passion impact your use of a family-centered approach?

50

The "Bias" Challenge

51

The "Bias" Challenge

What percentage of marginal cases affected by bias is OK?

4%?

10%?

15%?

52

IV-E Waiver

- Title IV-E of the Social Security Act is the federal funding source for foster care
- IV-E funding is designated for out of home room and board and program administration
- Florida received a waiver in 2006 – the only state to do so
- Waiver permits state to determine how to spend funds, rather than room and board

53

IV-E Waiver

Driving system change in reducing child removals
More funds for intensive early services with families (prevent removal)
More funds for services to reduce foster care length of stay and number of child placements

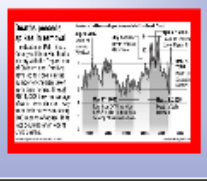
54

Restoring Balance

The time is right for family-centered practice

55

Child Safety Pendulum Factors



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Other Pendulum Factors

- Little respect for government workers, especially child welfare
- Insufficient family preservation services
- DCF and CBC working relationship

Result:
Pendulum swing to "child safety" extreme rather than a balanced approach.

57

Restoring the Balance

- Leadership buy-in
- Cost of NOT changing is too high
- IV-E Waiver innovations
- Distributed system of care
- Research findings on foster care
- Federal Children and Family Services Reviews

58

System Must Step Up

System reactions to child deaths create a "Show Me" culture rather than a "Culture of Success"

For culture change to occur, leadership must back up what they say with action.

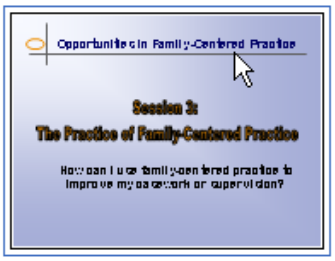
59

System Must Step Up

NEEDED:
- Education and training
- Leadership to define and support policies and resource priorities
- Shared risk
- Team work

Change needs to be widespread, but it HAS started
You can step up, too!

60



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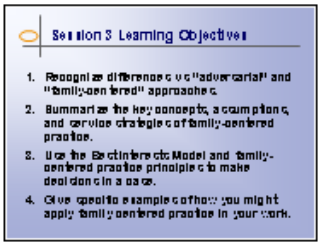

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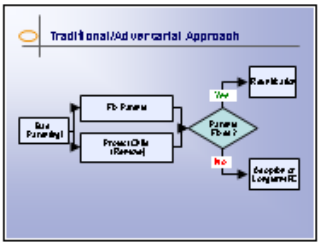

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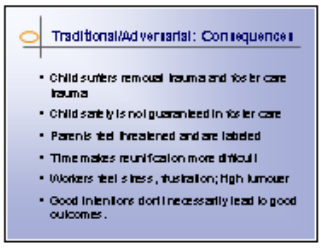

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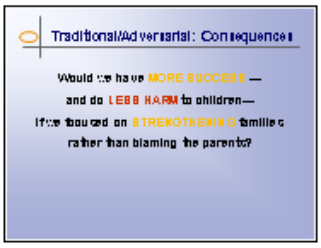

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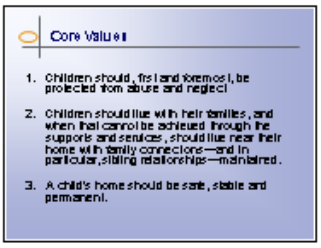

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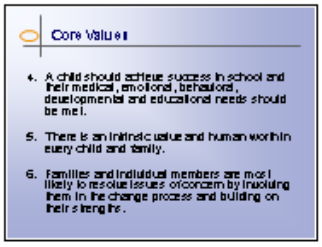

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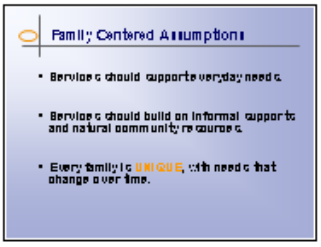

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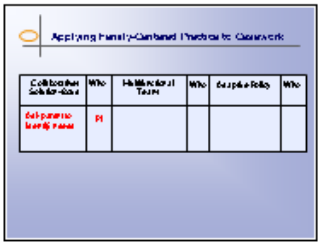

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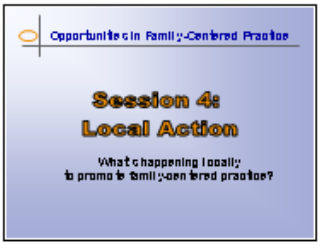

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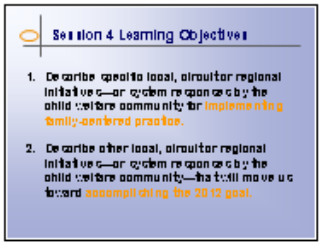

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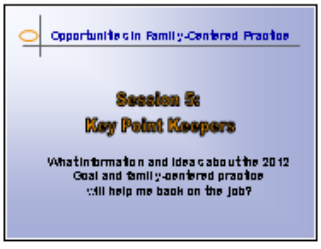

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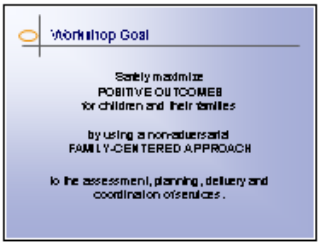

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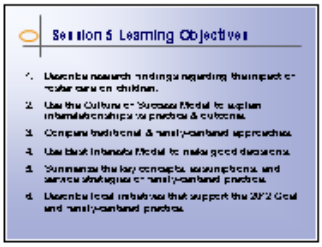

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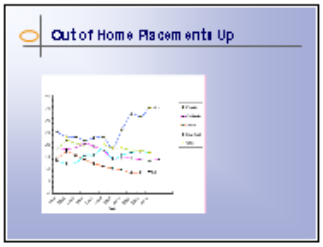

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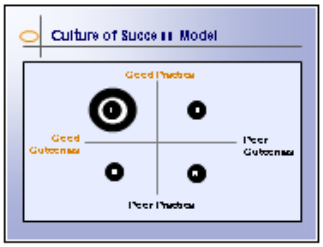

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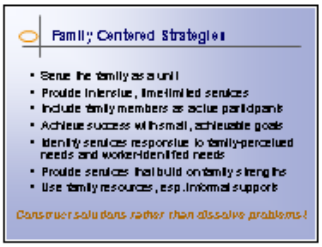

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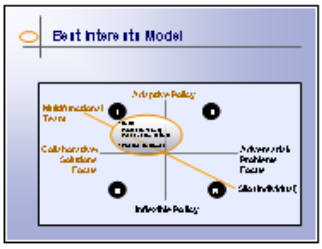

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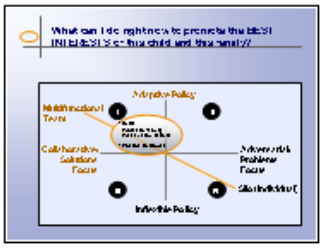

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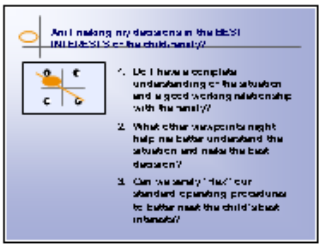

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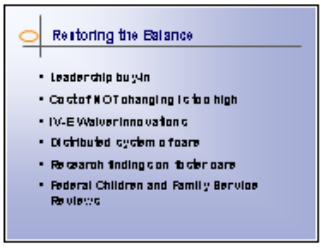

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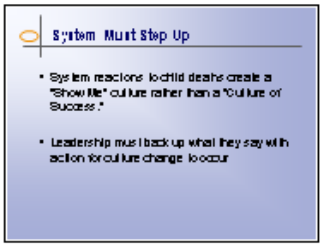

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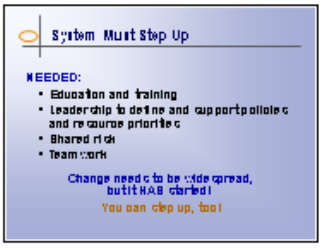

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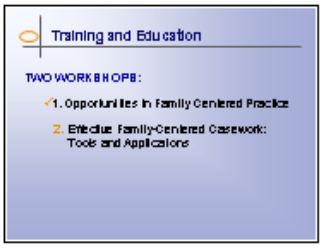

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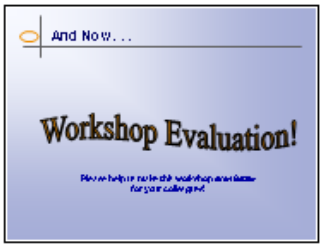

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#16: Workshop Evaluation Form

The Family-Centered Practice Training Series

Workshop #1: Opportunities in Family-Centered Practice

WORKSHOP EVALUATION FORM

Name (**optional**): _____

Email (**optional**): _____ Phone (**optional**): _____

Date of Workshop: _____

Name of Trainer: _____

DIRECTIONS: Please check the box that BEST represents your response, or provide written feedback, as relevant. Space is provided on the last four questions for your written feedback, and on the last page for additional feedback. If you have time to provide written feedback, it will be greatly appreciated!

1. In all, approximately **how many years** have you worked as a child welfare professional?

   ☐ 0 – 2 years ☐ 3 – 5 years ☐ 6 – 8 years ☐ 9 – 12 years ☐ 12 or more years

2. **How knowledgeable** were you about the formal methodology of "family-centered practice" (as defined in this workshop) <u>prior</u> to attending this workshop?

   ☐ Very knowledgeable ☐ Somewhat knowledgeable ☐ Familiar with the term but did not know much detail

3. **How often** did you employ "family-centered practice" strategies in your work (as defined in this workshop) <u>prior</u> to attending this workshop?

   ☐ Frequently ☐ Regularly ☐ Occasionally ☐ Rarely ☐ Never

4. This workshop **helped me understand some of the reasons why the time is right** for Florida's child protection system to redouble its efforts to strengthen a family-centered approach to casework.

   ☐ Strongly Agree ☐ Agree ☐ Occasionally ☐ Rarely ☐ Never

Name (optional): _____

5. When making critical decisions about a child's physical, emotional, behavioral, educational needs, **the Best Interests Model** is a helpful way of remembering and structuring the basic questions I might ask myself.

☐ Strongly Agree ☐ Agree ☐ Occasionally ☐ Rarely ☐ Never

6. This workshop **helped me understand some of the reasons why the time is right** for Florida's child protection system to redouble its efforts to strengthen a family-centered approach to casework.

☐ Strongly Agree ☐ Agree ☐ Occasionally ☐ Rarely ☐ Never

7. As a result of this workshop, I am more confident that **Florida's child welfare system will be supportive of my efforts** to apply a family-centered approach in my daily work.

☐ Strongly Agree ☐ Agree ☐ Occasionally ☐ Rarely ☐ Never

8. This workshop **clearly and completely explained a family-centered approach**, including the key concepts, assumptions, service strategies, and best practices.

☐ Strongly Agree ☐ Agree ☐ Occasionally ☐ Rarely ☐ Never

9. This workshop has confirmed or strengthened my confidence that a family-centered approach has **great potential for SAFELY increasing positive outcomes** for children and their families.

☐ Strongly Agree ☐ Agree ☐ Occasionally ☐ Rarely ☐ Never

10. This workshop **gave me useful ideas for how I can apply a family-centered approach** in my daily work more often and/or more effectively.

☐ Strongly Agree ☐ Agree ☐ Occasionally ☐ Rarely ☐ Never

11. This workshop **strengthened my ability and/or resolve** to apply a family-centered approach in my daily work more often and/or more effectively.

☐ Strongly Agree ☐ Agree ☐ Occasionally ☐ Rarely ☐ Never

12. In general, how beneficial were the **presentation(s) by local leadership**?

☐ Very Beneficial ☐ Somewhat Beneficial ☐ Didn't Matter ☐ Not Beneficial ☐ Not at All Beneficial

13. How would you rate the amount of time devoted to **practice activities** in the workshop?

☐ Far too much ☐ Too much ☐ About right ☐ Too little ☐ Far too little

14. How would you rate the amount of time spent on **interactive discussion**?

☐ Far too much ☐ Too much ☐ About right ☐ Too little ☐ Far too little

15. In general, how would you rate the **trainer's skill** in making the workshop a productive, worthwhile experience for you?

☐ Very High ☐ High ☐ Average ☐ Low ☐ Very Low

If you have time:

16. What training activities were **most** worthwhile to you?

17. What training activities were **least** worthwhile to you?

18. In your opinion, what were the strengths of the training?

19. In your opinion, how could we improve the training?

Additional feedback:

Name (optional): _____